

REEXAMINING THE SUBSTANDARD QUALITY OF INDIAN HEALTH CARE IN THE GREAT PLAINS

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

FEBRUARY 3, 2016

Printed for the use of the Committee on Indian Affairs



U.S. GOVERNMENT PUBLISHING OFFICE

21-662 PDF

WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
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REEXAMINING THE SUBSTANDARD QUALITY OF INDIAN HEALTH CARE IN THE GREAT PLAINS

WEDNESDAY, FEBRUARY 3, 2016

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:33 p.m. in room 216, Hart Senate Office Building, Hon. John Barrasso, Chairman of the Committee, presiding.

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

The CHAIRMAN. I call this hearing to order.

Today, the Committee will hold an oversight hearing entitled, Reexamining the Substandard Quality of Indian Health Care in the Great Plains.

In 2010, the Committee held an oversight hearing entitled In Critical Condition: The Urgent Need to Reform Indian Health Service's Aberdeen Area. At this hearing the Committee listened to testimony detailing an investigation led by the former Chairman Byron Dorgan and his report on the Indian Health Service. He is here with us today.

The Dorgan Report found atrocious evidence showing the lack of quality of care by the Indian Health Service in the Aberdeen area, now called the Great Plains area, to Indian tribes.

Over five years later, the very problems identified in the Dorgan Report have not been resolved. In fact, some issues have become worse over time, and new ones have developed.

After hearing loudly from the tribes on the lack of quality of health care in the Great Plains Area, I dispatched Committee staff to the field to understand what is really is happening in the Great Plains Area.

What we found is simply horrifying and unacceptable. In my view, the information provided to this Committee and witnessed first hand can be summed up in one word: malpractice. You do not have to take my word for it. You will hear today, the Indian Health Service has known about these issues all along.

The Centers for Medicare and Medicaid Services, another agency within the Department of Health and Human Services, has confirmed not only that these same problems continue to fester, but that they pose immediate risk to patient safety.

The impacts of these deficiencies are not theoretical. These persistent failures have led to unnecessary suffering by patients, by families, and by whole communities. In fact, they have led to multiple patient deaths.

The Administration is responsible for providing and delivering health services to American Indians and Alaska Natives across the Country. Their Federal obligation mandates that they promote health and safe Indian communities while honoring tribal governance. This is not happening.

The Indian Health Service has failed their patients. This Committee knows it, the congressional delegations joining us today know it, the tribes know it all too well, and every single witness here today knows it. Without question, this is a tragedy and a disgrace.

I stress to the Administration that the status quo will not be tolerated. How can we take your word that these issues have been resolved, when 5 years ago, you said to this Committee you had a plan? How can we trust information coming from Health and Human Services and the Indian Health Service or others in the Administration?

This Committee will not accept any more cover-ups or politicking. This is not a game. People's lives are at risk.

We are now at a place where you must prove to us, each step of the way, that you are living up to your word and fulfilling your responsibilities.

Last year, I wrote to Secretary Burwell about the need for leadership at the Indian Health Service. To this day, the director position remains unfilled. The Administration's failure to act on such important matters speaks volumes.

Testimony submitted by the Administration references many plans but we need and the people in the Great Plains need, concrete results. Simply changing an area name from "Aberdeen" to "Great Plains" will not suffice.

I urge the Administration to listen to the Indian tribes and witnesses here today. Listen to their testimonies. Listen to their statements. These are the people you serve, and they know what their communities need. I hope you will treat them with the respect they deserve, and work with them honestly and openly.

As a physician, I know that more can and must be done to ensure safe, quality healthcare is delivered at Indian Health Service facilities in the Great Plains area. I believe positive change is possible. It will be difficult and, at times, uncomfortable. This cannot stand in the way of real reform.

We must put patients first, and that is exactly what we are here to do today. We need both short-term and long-term solutions, not only to the problems identified by the CMS surveys, but also to the many other problems identified by patients, tribes, the brave Indian Health Service employees who have spoken to the Committee and others.

I will continue to press the Administration for answers and real solutions. I will continue to investigate and convene hearings here in Washington or in the field until we are sure patients are safe in the facilities that were built to provide them care.

I would also like to say that although this oversight hearing will focus on the Great Plains area, the Committee has also heard concerns from tribes in other areas served by the Indian Health Service.

We have been told that conditions are most dire in the Great Plains, but again, we are not going to take the Administration's word for it. We realize that these and other issues impacting patients may plague other regions, and will demand answers and action in these areas as well.

When our Committee staff visited the Great Plains area recently, they saw firsthand the culture of cronyism and corruption that permeates the system. Many Indian Health Service personnel have come to the conclusion that they are untouchable and that they are accountable to no one. As far as I can tell, until now, they have been allowed to act with impunity.

Instead of being reprimanded for failing to appropriately care for patients or for retaliating against providers who report deficiencies, these "untouchable" employees are being recycled throughout the Great Plains area. Some are being promoted, even though they are not qualified for the positions they hold. Some have been involved in preventable deaths identified by CMS.

These "untouchable" employees have continued to see patients and collect taxpayer dollars, without fear of being held accountable for the many lives they were hired to protect and care for. I fear that some members of the IHS leadership think they are untouchable as well.

One particularly egregious incident involves the Chief Medical Officer for IHS. In a recent phone call, the Chief Medical Officer responded to concerns from congressional staff about incidents involving unsafe pre-term deliveries by saying, "if you have only had two babies hit the floor in eight years that is pretty good." This is a sad new low for IHS.

Another example involves a young toddler lost her life to a preventable infection because the IHS facility in her community repeatedly failed to provide proper care, and by the time they referred her out of the IHS system, it was too late. This is a heart-break that no parent, no family, no community should have to bear.

Yet, tragically, this story is all too familiar. Too many lives have been lost because no one was held accountable for their actions. The same mistakes are being made again and again. This must change immediately.

To be clear, the total lack of accountability is just one of many problems identified during my staff's visit to the Great Plains area last month, and relocating troubled staff will not be enough to effect real and lasting improvements.

True reform will require a cultural change at IHS, from the top officials responsible at department headquarters, down to the employees at each facility.

The information we have uncovered is overwhelming and disturbing, and it will be an important part of addressing the problems we discuss here today.

We must work together to stop the bleeding in the Great Plains, and find permanent solutions, so that we are not here again in an

other five years facing the same problems, after an untold number of additional preventable deaths.

Before we hear from our witnesses, I want to thank Senators Thune, Rounds and Sasse for joining us today. They have been and will continue to be great advocates for the tribes in the Great Plains. I also want to thank Senator Tester for his attention to this issue.

I would like to turn first to Senator Tester for an opening statement.

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

Senator TESTER. Thank you, Mr. Chairman. Thank you for holding this hearing.

Unfortunately, for many of us sitting up here and for the tribal nations throughout Indian Country, another congressional hearing on the inadequacies of the Indian Health Service is not a surprise.

As disturbing as the news from the Great Plains area is, we hear from tribes, as the Chairman said, all over the Country with similar stories of inadequate care, a painfully slow bureaucratic system of billing and collections and simply poor health care delivery for their people.

We have to work with the tribes to find solutions to these problems. Our Country has made a number of commitments to the tribes in our Country and that includes providing quality health care.

Those of us on this Committee know all too well the health care conditions the American Indians and Alaska Natives across this Country continue to face. The statistics are staggering.

Native Americans are affected by heart disease, cancers and diabetes at higher rates than any other ethnic group in this Country. In some places, the life expectancy of a Native American is significantly shorter than their non-Indian peers.

In my home State of Montana, an average American Indian man or woman will live about 20 years less than their non-Indian counterpart. This is an unacceptable reality that both Congress and the Administration must work to fix.

That is why it is my hope that this hearing can shed more light not only on the problems that face the IHS but the steps that we can take to find solutions to these problems. Despite seeing modest increases over the last several years, we all know that funding is a major challenge.

The Administration and Congress have worked together in recent years to improve these funding streams but the impact of the ongoing threat of sequestration has had negative effects on these efforts.

In addition to funding, we also must ensure that the IHS has the tools it needs to be successful. Quality of care should be a top priority for the IHS. We need to examine what mechanisms are in place to ensure that IHS is providing first rate care.

Part of ensuring that tribal communities consistently receive high quality care means making certain that we are recruiting and retaining quality health care professionals to serve in our IHS facilities.

Another area of concern is the ability of the department to rapidly and effectively respond to health emergency incidents to guarantee that care is not being disrupted.

This current situation is even more frustrating knowing that when similar conditions existed in the Veterans Administration health care system, Congress did the right thing and made changes to the law to ensure that veterans are receiving health care we have promised.

American Indians and Alaska Natives are still waiting. Despite the Federal treaty and the trust responsibilities we have, these conditions go largely unnoticed by the general public.

I would encourage my colleagues on this Committee and in Congress to ask themselves how can we, in good conscience, pass legislation to fix the VA but ignore the needs of the Indian Health Service?

I hope we have some solutions proposed today. I look forward to working with everyone to make certain that American Indians and Alaska Natives are getting the health care they deserve.

Finally, before we begin, I would like to welcome Jace Killsback, a member of the Northern Cheyenne Tribe from Montana. Jace serves on a number of health advisory councils at home. As well he serves as the Executive Health Manager for his tribe.

He has been involved in these issues for over a decade and will provide us with valuable insights on how to improve health care on the ground in Indian Country.

I would also like to welcome my good friend, Byron Dorgan, the former chairman of this Committee. Byron, your presence is still felt here even today. I want to thank you for your counsel and for testifying as we move forward.

I would also welcome a couple more folks. To Dorothy Dupree, the former head of Billings-Rocky Mountain Region, thank you for your good work. Even though it was on a temporary basis, you make a difference. I want to thank you for that.

To Robert McSwain, thank you for being here today. There are plenty of reasons that you should not be here today. I am not going to elaborate on those but there are serious issues going on in your personal life. I want to thank you for being here to testify.

With that, Mr. Chairman, thank you for holding this hearing.

The CHAIRMAN. Thank you, Senator Tester.

Would anyone else like to make a statement? Senator Hoeven.

**STATEMENT OF HON. JOHN HOEVEN,
U.S. SENATOR FROM NORTH DAKOTA**

Senator HOEVEN. Mr. Chairman, if I could, I would like to welcome former Senator Byron Dorgan who served both in the House of Representatives and in the Senate from 1980 to 2010. I would like to thank him for being here and for his commitment on behalf of Native Americans, not only throughout North Dakota but across the Country, for many, many years. I welcome back to this hearing today.

Also, I would welcome Deputy Secretary Mary Wakefield for her commitment to rural health care both on and off reservation and for her presence and testimony here today.

Thank you so much to both of you.

The CHAIRMAN. Thank you, Senator Hoeven.
Senator Udall?

**STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO**

Senator UDALL. Thank you very much, Chairman Barrasso and Vice Chairman Tester, for focusing on this very, very urgent issue. I would echo what they said about Senator Dorgan. It is great to have you here and to have you involved in Native American issues across the Country.

The conditions recently reported at facilities in the Great Plains region are horrific and unacceptable. My State also experienced halted emergency medical services at an IHS medical center in Crownpoint, New Mexico last year.

Patients deserve competent and timely care and it is intolerable that any IHS emergency facility close for any amount of time. The difficult topics we are going to discuss today are not new. Unfortunately, staffing issues and the facility disrepair are becoming synonymous with the Indian Health Service.

To help address these ongoing staffing difficulties, I have introduced a bill with Senator Murkowski that would make the IHS Health Professions Awards Program exempt from a Federal income tax requirement as the National Health Service Corps currently is.

IHS currently spends approximately 30 percent of its health professions account to pay taxes to the Federal Government, taking needed funding away from investments and skilled medical professionals. We need more resources for the agency to recruit and retain competent and committed staff.

I will continue to push for this change and I hope that the Administration has more ideas about how to tackle this issue.

I also want to take this opportunity to bring to your attention a public health crisis in my State. The area in and around Gallup, New Mexico has long experienced an alarming number of alcohol-related deaths of Native people. Last winter, 17 people died from alcohol-related incidents, including exposure to harsh cold temperatures.

The NCI Detox Center in Gallup is currently the only detox facility serving the population in this remote and rural part of the State adjacent to the Navajo Nation and the Pueblo of Zuni. An estimated 98 percent of clients served there are Native American.

The center offers a desperately needed social detox program geared primarily toward protective custody. Since the facility serves such a large Native population, IHS needs to be a part of the team working with local officials and other stakeholders to solve this public health crisis in northwest New Mexico.

I am pleased that the IHS officials from Rockville recently visited the NCI Detox Center which is expected to run out of funding at the end of next month. Senator Heinrich and I have been working together on this critical issue and he and his staff have been great to work with.

Later in this hearing, I will have some urgent questions about how the Administration can creatively leverage current resources to help work on long term solutions to this problem. I look forward to discussing the great need to help address the crisis in the Great

Plains and the larger issues of IHS staffing and quality patient services and poor facility conditions.

As was said earlier, this has been around for a long time. When Senator Dorgan was our chairman, we highlighted this. We would hope that the Administration would come forward with plans to remedy this in an urgent manner.

Thank you very much again, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Udall.

Senator Rounds.

**STATEMENT OF HON. MIKE ROUNDS,
U.S. SENATOR FROM SOUTH DAKOTA**

Senator ROUNDS. Thank you, Chairman Barrasso and Ranking Member Tester, and members of the Committee for allowing me as a non-member of the Committee to give a very brief statement.

I do appreciate the work you are doing and I have to also give a shout out to your staff members who actually went out to the Dakotas. I know they spent over 12 hours in one day alone simply taking testimony and learning first hand of the challenges we face in the upper Midwest with regard to this particular and very serious issue.

I would also like to mention that we appreciate the Honorable Sonia Little Hawk-Weston, Chair of the Health and Human Services Committee, Tribal Council of the Oglala Sioux Tribe for being here today from Pine Ridge, South Dakota.

We also appreciate Mr. William Bear Shield, a member of the Health Council at the Rosebud Sioux Tribe.

Afterwards at the listening session, I understand that the Chairman of the Cheyenne River Sioux Tribe will be giving testimony, our good friend, Mr. Harold Frazier. I think we also have the Chairman of the Oglala Sioux Tribe from Pine Ridge, Mr. John Yellowbird Steele, who was trying his best to get in here. He made it, great.

We are having a blizzard in that part of the Country, so thank you for being here, Mr. Chairman.

Nearly 122,000 tribal members rely on the Great Plains Area Office to deliver safe, reliable and efficient health care. For rural tribal members, their IHS facility may be the only hospital for more than 100 miles. This is the case for many tribal members in my home State of South Dakota.

For too long, the Federal Government has failed to live up to its promise and its trust responsibility to provide adequate care for the Native American community. That is the reason that I am here today.

In 2010, this Committee released a report citing chronic mismanagement, lack of employee accountability and financial integrity at IHS facilities. The report also identified five IHS hospitals in the Aberdeen area at risk of losing their accreditation or certification from the Center for Medicare and Medicaid Services. Fast forward six years and we find that the Winnebago facility, the Rosebud and Pine Ridge hospitals in South Dakota are all threatened with similar problems. It feels as if nothing has changed.

The health care crisis within the Indian Health Care Service needs to be resolved. There is no excuse for hospitals to not reach

basic benchmarks for providing proper care. Reports and hearings can be very good if we also help to facilitate a plan of action to remedy the current situation and then insist on proper execution of the plan with a follow up to assure results.

Mr. Chairman, thank you for the opportunity to make this statement today. Thank you very much for bringing proper attention to this very important and critical issue to over 122,000 member citizens in the upper Midwest.

The CHAIRMAN. Thank you, Senator Rounds.
Senator Heitkamp.

**STATEMENT OF HON. HEIDI HEITKAMP,
U.S. SENATOR FROM NORTH DAKOTA**

Senator HEITKAMP. Thank you, Mr. Chairman.

I want to welcome two great North Dakotans today, one whose footsteps I followed in my commitment to do better and to change outcomes, Senator Byron Dorgan, and ahead of him, both Senator Kent Conrad and certainly Senator Quentin Burdick were champions for Indian people, champions for meeting their needs and doing what we must do to fulfill our obligations that we took a sacred vow when we signed treaties.

Somehow in every hearing we have, we see the failure of meeting those treaty obligations and the failure to do the right thing.

I want to welcome Mary Wakefield who served as Senator Burdick's Chief of Staff and has a long history of trying to improve the quality of health care in rural areas and certainly the quality of health care in Native American communities.

I want to make what seems to me to be a very simple point because we come to these Committee hearings all the time and, talk about the parade of horrors. It is not just in health care; it is in housing and education. We could just make a long list.

Yet, let me give you some numbers. The average Medicare spending per beneficiary is almost \$12,000 a year. The average spending, national health means everyone, is about \$8,000. The average spending in the veteran system is \$7,000. The average spending in Medicaid, per enrollee, is almost \$5,600.

When we look at what we spend in Indian health, it is barely \$3,000. Is anyone shocked that we are here? Is anyone shocked that we have these problems?

We have to be serious about fixing this problem. If we are serious about fixing this problem, we are going to be serious about funding the fix. No one should tolerate what we read in this report. No one thinks this is okay.

You have to do better with what you have and you cannot accept a culture of failure because we see it over and over again whether it is BIA, Indian health or Indian education. We have accepted bad results. That has to change.

Congress shares responsibility. The President shares responsibility. If we are serious about fixing this, we are serious about funding it.

I want to lay out some concerns I have. We need to know what it will take to fix it and how we are to get the resources so that we can.

The CHAIRMAN. Thank you, Senator Heitkamp.

Senator Thune.

**STATEMENT OF HON. JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA**

Senator THUNE. Thank you, Mr. Chairman.

I too want to thank you and Senator Tester for holding this hearing and shining a light on what is a major crisis in Indian Country in the Great Plains.

As Senator Rounds did, I want to acknowledge the people who are here. I think all nine tribes from South Dakota are represented. I particularly look forward to hearing from Sonia Little Hawk-Weston from the Oglala Sioux Tribe and Willie Bear Shield from Rosebud.

As Senator Rounds also mentioned, I welcome both President John Yellowbird Steele and Chairman Harold Frazier.

Mr. Chairman, this is déjà vu all over again. We have been through this drill. With Senator Dorgan's good work back in 2010, we came out of that with what I thought was a plan, but it is disappointing to me that we find ourselves right back here where we started.

In December of this year, when IHS notified me of CMS's findings, I immediately followed up with IHS and HHS. In a conference call on December 4 between my staff and IHS, members from IHS stated that a majority of the concerns at the Rosebud facility had been addressed and abated.

These statements were made merely hours before my staff was informed that the Great Plains area office had contacted President Kindle of the Rosebud Sioux Tribe and informed him that the emergency department at the Rosebud hospital was being put on diversion status that following day.

Mr. Chairman, I would just say how could that happen? We have a serious breakdown in communication or somebody is not telling the truth. I bring this up as an example of the continuing evidence of IHS communication issues.

Just hours before the Great Plains IHS decision to divert patients from Rosebud's emergency department, staff in Great Plains and at headquarters were painting a picture to congressional staff that did not match events and reality on the ground.

Since this Committee's report in 2010, I continued to monitor the actions of the Great Plains IHS. In April 2014, I sent a letter to the then Acting Director IHS requesting an update on the ongoing work of the IHS to address the Committee's findings.

On June 30, 2014, I received a response to that letter. The letter stated "The Great Plains area has shown marked improvements in all categories. Significant improvements in health care delivery and program accountability have also been demonstrated."

Yet, here we are a year and a half later and one hospital in the region has had its provider agreement terminated and two more hospital provider agreements have been placed in jeopardy.

What has to be acknowledged is that CMS findings indicate people's lives are in jeopardy. This is unacceptable. We cannot tolerate this. CMS's recent findings regarding patient experiences at these facilities are beyond comprehension.

Incredibly the report of dirty and unsanitized medical equipment left exposed in an emergency room might be the least shocking of these stories. One patient who suffered from a severe head injury was incorrectly discharged from the hospital only to be called back later the same day once the test results arrived. The patient was immediately flown to another facility for care and never should have been sent home in the first place.

Another facility which has been mentioned was in such disarray that a pregnant mother prematurely gave birth on a bathroom floor, a bathroom floor, without a single medical professional nearby which shockingly is not the first time it has happened at that facility.

Each one of these incidents is egregious and needlessly puts people's lives at risk. CMS's recent findings are not only astounding but they are absolutely unacceptable. These are life and death circumstances and IHS must make fixing these recurring issues a priority.

Time and again we have had a variety of task forces, reports and oversight commissions formed to uncover the failings within the Great Plains area IHS, yet to date it is evident that IHS has failed to follow through on many of the report's findings.

In addition to poor patient experiences at IHS facilities, gaining access to a physician or health care professional is made all the more difficult due to severe staffing shortages. According to the Robert Wood Johnson Foundation in 2015, there were six physicians in all of Oglala, Lakota County where the Pine Ridge hospital and Kyle Clinic are located.

In fact, the doctor to patient ratio in Oglala Lakota County is 2,343 patients for every one physician. Keep in mind that in addition to Oglala Lakota County, the IHS facilities on the Pine Ridge Reservation also serve Jackson County which contains another 3,216 people.

In nearby Todd County, the location of the Rosebud Sioux Reservation, in 2015, the Foundation reported there were only two primary care physicians or 4,971 patients for every one physician.

Currently, to my knowledge, there are now three providers in Rosebud. However, there is funding for 11. Filling these positions could go a long way to ensuring patients have access to care.

I just wanted to do this for purposes of comparison but if you look at similarly populated counties throughout the Country, they tend to have way better access to primary care physicians. For instance, Plumas County, California, with a population of 18,859 or roughly the population of the Pine Ridge Reservation according to the South Dakota Department of Tribal Relations, has 15 physicians or 1,293 patients for every physician.

The 12,503 people who live in Millard County, Utah, similar in size to Todd County, South Dakota enjoy a ratio of 1,796 patients for every doctor, making primary care physicians over twice as accessible in Millard County than in Todd County.

I would say we just have to do better. People are counting on us to do better. To date, we have failed to deliver on our promise to provide tribal citizens of this Country the quality of care they deserve. I am committed to seeing true and lasting reform come from

this hearing and the discussions that will follow. IHS must have accountability and transparency to our tribes and to Congress.

Again, I am grateful, Mr. Chairman, for you and Senator Tester allowing those of us not on this Committee to participate because this is an issue that obviously is of great interest and one about which we care deeply.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Thune.

With that, I would like to invite Senator Dorgan to the table. We are going to hear from a person who is a familiar face to the Committee and who is the former Chairman of this Committee, who led the 2010 investigation we are revisiting today.

We thank you for your continued service, Senator Dorgan, to the Great Plains and to all of Indian Country. We welcome your statement and your participation.

I would also be remiss not to mention that earlier this year the Senate passed with unanimous consent the Indian Tribal Energy and Self Determination Act of 2015. I recall under your chairmanship we were able to get the ball rolling. Thank you for that effort and your leadership as well.

With that, Senator Dorgan, welcome back to the Committee.

STATEMENT OF HON. BYRON L. DORGAN, FORMER U.S. SENATOR FROM NORTH DAKOTA; FOUNDER AND CHAIRMAN, CENTER FOR NATIVE AMERICAN YOUTH

Senator DORGAN. Thank you very much, Mr. Chairman.

I was surprised and pleased to be invited and very happy to come. I know that everyone sitting at this table has a passionate desire to fix these problems. You know how difficult they are. You pledged to yourselves, the Congress and your constituent groups that this must be fixed.

I am really pleased to be here. When I left the Senate, I created something called the Center for Native American Youth which is a nonprofit focused just on Native American youth. All the spotlights are on that spot. We work on teen suicide prevention, educational opportunities, health care and a range of things.

I am going to talk to you about the Indian Health Service. I have to grit my teeth a little bit because we hold quarterly meetings with Federal agencies that are kind of stovepipes and we get them talking to each other.

There has been no agency that has been better and more faithful in sending some terrific people to those quarterly meetings than the Indian Health Service. I say that because I know today there are some wonderful people working at the IHS, both people working with us at CNAY and also people this morning who got up and went to work at the Health Service areas dedicated professionals, dedicating their lives to these things.

I regret that when we talk about all this, somehow it tarnishes the good work of some really good people. I feel sad about that but we do not have a choice.

This morning again I looked at the 2010 investigation we did. We had a series of bullet points but let me read the first one. "Over the course of the last ten years, the IHS has repeatedly used transfers, reassignments, details, lengthy administrative leave to deal

with employees who have had records of misconduct and poor performance.”

I do not need to read a lot more than that but just say that this system does not work unless there is accountability. When there is fraud, misconduct, incompetence, criminal activity, you do not need a long investigation for that. You fire folks involved and move on with competent people to run the system.

That has not happened. It has not happened not just for the five years or the last 10 or 15 years, decade after decade we have seen these problems; in Administration after Administration, we have seen these problems.

There is just no way to sugar coat what we are dealing with. It has been and still is a tragic failure in delivering health care in far too many areas for American Indians. We are talking about the Great Plains region but I tell you, I am certain this extends beyond it.

I commend you because taking on this issues is hard but you have to start. You have to start with the first step. Building on the 2010 report I think can be very helpful.

The Indian health care issue is underfunded by half. You can work on that but the fact is it is underfunded by half which promotes full scale rationing of health care. It ought to be front page headlines in major city newspapers but it is not.

In fact, most people do not know of it, see it or hear of it. It suffers in quality and is underfunded by half. That is a significant problem.

It is easier to criticize poor quality, but we also need to criticize the decision-making of all of us who, with a country, signed treaties and made promises to deliver health care and have not honored those promises with the adequate funding that is necessary. That is a fact as well.

Senator Heitkamp talked about responsibilities. We are responsible for health care for those we incarcerate. We incarcerate a lot of people in this Country. We are responsible not only for those we incarcerate for health care but also by treaty and by promise and by trust, for health care for American Indians.

We spend twice as much per person providing health care for those we incarcerate in America’s prisons than we do to meet the promise of health care for American Indians that we agreed to by treaty and trust. That is unbelievable to me. None of us experience it because none of us get our health care in these ways.

I want to mention a couple of facts about the 2010 investigation. I mentioned earlier there are some terrific people working for the Indian Health Service. There is no question about that. I have seen them and you have seen them.

If you visit these facilities and walk the halls, you see some people you care a great deal about and say thank God for doing this. Often it is in remote areas and so on but they are not the issue.

The fact is, too many of them are working with outdated equipment, I mentioned inadequate funding, but it is also the case that there is kind of a split personality in my judgment. Having watched the IHS for a long, long time, I see kind of a split personality.

There are some really great people, some people who care, people who sign up and commit their lives to the Indian Health Service and deliver good health care. Then I see something else.

I see the weaving of friendships and favors, relatives, incompetence, corruption and yes, even criminal behavior. It has all too often and continues to be, in my judgment, overlooked, excused and denied. That cannot continue.

No organization in American of which I am aware can work properly in those circumstances. You have to determine what works and who works, what does not work and who does not, and then make the necessary changes.

This is not some ordinary issue because as a number of you have mentioned. This is about people who die; this is about living and dying. We take for granted every year and every day for us and for our families' health care administration that is routinely denied to many American Indians.

Let me give you a couple of examples. It is not about philosophy or theory; this is about what they confront. Adele Hale Berry is having a heart attack. Because there is no contract funding left, it is that time of the year, do not get sick after June, she is sent to a hospital in a city.

When she arrives on a gurney at the hospital, she has taped to her thigh an 8 x 10 piece of paper that explains to the hospital that if you admit this woman, there will be no funding from the IHS, contract funding for that tribe is over. A heart attack victim on a gurney with a taped piece of paper to her thigh explaining why she is not going to get funded for health care for a heart attack is unbelievable.

I was at the Three Affiliated Tribes once on a tour. We walked around the hallway and the doctor who was a terrific guy working for the IHS said, here is where we are going to put the new x-ray machine. The old one is outdated and does not work very well but this is where the new one comes in. It is going to be a big deal.

I said when is it coming? He said, not sure. He said, it has been approved and the paperwork has been waiting in Aberdeen for 18 months to be signed, 18 months on someone's desk. I am sure that makes you feel as I do. What on earth is happening?

Finally, something I have described at great length, I want to do again because when we finally, after 17 years, passed the Indian Health Care Improvement Act, I asked it be named after Ta'Shon Rain Little Light. She was the inspiration. I took to the Floor a photograph of this beautiful six year old girl every single day that I spoke on that bill.

She was a six-year-old girl with sparkling eyes, dressed in traditional dance dress, because she was a little dancer. She loved to dance. She died. She became sick and they took her three times to the Indian Health Service, two different services. Each time she was diagnosed and they sent her home saying she was depressed so she should take medicine for depression.

In fact, she had terminal cancer. Some months later, she died in her mother's arms and said, Mom, I am so sorry I am sick. That evening she died. The fact is this is about life and death for kids, for adults, and for elders.

I know this is going to be a hard hearing. I am going to conclude because you have a big agenda today. I want to say to you as one person, this is not about politics; everyone on this dais knows that. This is about the willingness of Republicans and Democrats and all people of goodwill to address problems and fix them because they need to be fixed.

I say to you, Mr. Chairman and Vice Chairman, thank you for doing this, thank you for putting this on the agenda because it matters. You are going to save and improve lives. You will never know their names but that is what you will do because you have put this on the agenda.

I want to make one final point. I know you are going to hear from a friend of mine today, Mary Wakefield. I have known Sylvia Mathews Burwell for decades. I think the world of her. I really like her, like the job she does.

Mary Wakefield, you will excuse my being a homer about this but Mary is a North Dakotan who I am so enormously proud of. I know that Mary is tough and really smart. When she is told, as she has been, you are going to be accountable for this, she is going to fix this.

It is hard to do but I have great confidence in Mary Wakefield and I hope as you understand this that she is new on the scene but she is one of the best breaths of fresh air I have seen to begin putting her fist around this issue and tackling it because she cares about Indian health care just as all of us do.

I was given many years ago, as some of you perhaps have been, an Indian name called Shante Unwiica, a Sioux name that means thinks with his heart. I just think with all my heart, Mr. Chairman, when you called me I was happy to say I would be happy to come and be a part of what you are trying to do.

I think with all my heart that what you and members of this Committee can do and will do by putting the spotlight on this spot will save lives. God bless you for doing it.

Thank you very much.

[The prepared statement of Senator Dorgan follows:]

PREPARED STATEMENT OF HON. BYRON L. DORGAN, FORMER U.S. SENATOR FROM NORTH DAKOTA; FOUNDER AND CHAIRMAN, CENTER FOR NATIVE AMERICAN YOUTH

Good afternoon Chairman Barrasso, Vice-Chairman Tester, and members of the Committee. My name is Byron Dorgan. I'm pleased to have been invited to come back to the Committee today. I served here as a member and Chairman for many years, and know how hard you work to deal with significant issues confronting the First Americans.

Following my service in the U.S. Senate, I founded the Center for Native American Youth at the Aspen Institute, and currently serve as Chairman of the Board of Advisors. Although I retired from Congress, I did not want to retire from working on making positive changes in the lives of Native Americans, particularly Native American youth. While in Congress, I had the opportunity to visit the tribal nations in the Dakotas and also many tribal nations throughout this country. I was always impressed with the strength, resilience, and cultural knowledge of the youth I met along those journeys. I realized that they are the leaders of the next generation and we need to make sure that they have the resources available to them to become successful.

You invited me here today to discuss an earlier investigation of Indian Health Service (IHS) health care in the Aberdeen Region. I'm pleased you are reexamining the delivery of health care services by the federal government to American Indians in the Great Plains and throughout the country.

The IHS has the important mission of carrying out our federal government's trust responsibility to provide health care services to Native Americans. Most people living in tribal communities rely on the IHS as the sole source for their health care needs.

It is not an easy task for the IHS to meet these needs. Failed federal policies towards Native Americans over the past two centuries have resulted in this segment of the population having the highest levels of health disparities within our country. It is a travesty! Further, it is a problem that will continue to have negative impacts for generations to come. I spent much of my time as Chairman of this committee focused on increasing funding for the IHS and trying to force some systemic changes in the bureaucracy that plagues that agency. It is an agency that seems far too resistant to change.

In 2010, as Chairman of this Committee, I led an investigation that culminated in a report titled "The Urgent Need to Reform the Indian Health Service's Aberdeen Area" that was issued in late 2010. The extensive investigation was prompted by years of serious complaints about the healthcare services provided throughout tribal communities in my home state and the surrounding states. I have traveled to hundreds of tribal nations and communities, met with thousands of individuals, and tribal leadership. Although histories, cultures, and languages may be diverse, one theme was always consistent—the challenges of accessing healthcare and life-saving services. That combined with very serious allegations about mismanagement, theft, and full-scale healthcare rationing led me to launch this investigation.

Let me be clear about the purpose of the investigation and report: it was not intended to criticize specific employees of the IHS. In fact, I have found that the IHS is full of passionate, committed employees who seek out their positions to serve and care for their families, loved ones, and community members. While there are definitely some problem employees within the IHS, merely replacing employees will not solve the systemic problems.

The purpose of the investigation and report was to identify the systemic problems within the IHS so that Congress could force changes needed to solve the problems and improve the delivery of health care.

The purpose was to let Congress know about patients like Ardel Hale Baker who while having a heart attack could not get lifesaving treatment but instead had a deferral letter taped to her leg saying that if any hospital treated her, the IHS did not have the money to pay for her treatment.

The purpose of the report was to inform lawmakers about the tens of thousands of dollars being spent on expensive temporary healthcare providers rather than hiring fulltime doctors, the lost and mismanaged equipment, and kids not getting mental health services in communities with suicide rates ten times the national average.

The goal of the investigation was to identify challenges and compel major changes within the IHS system in order to save lives. This government has a solemn obligation to our First Americans to provide adequate healthcare and there is an agency—the Indian Health Service—specifically charged with that task. Yet, we continue to see the same problems plague that agency year after year without real progress being made to improve the system. This is unacceptable and I hope the Committee will continue to put a spotlight on the IHS until real improvements are made.

Our investigation included: reviewing over 140,000 pages of documents; visiting and interviewing three IHS service units; and meeting with tribal leaders and IHS employees. Over the course of the investigation, more than 200 individuals also reached out to the Senate Committee on Indian Affairs to share stories related to the IHS' healthcare delivery system.

In September of 2010, the Committee held a hearing on the findings of the investigation. The hearing highlighted deficiencies in IHS management, employee accountability, financial integrity and oversight, which led to reduced access and quality of health care services available in the Great Plains region. Testimony for a second hearing was collected and included in the final report, which was released in late-December 2010.

The findings of the final report revealed policies and practices within the IHS that negatively impact healthcare provided to tribal patients. I will briefly highlight some of the more significant findings today, but encourage people to read the full report. Some of the major findings from the 2010 report are as follows:

- Over a ten year period, IHS repeatedly used transfers, reassignments, details, or lengthy administrative leave to deal with employees who had a record of misconduct or poor performance.
- There were higher numbers of Equal Employee Opportunity (EEO) complaints in the Aberdeen (Great Plains) Area compared to the entire IHS, as well as insufficient numbers of EEO counselors and mediators.

- Three service units had a history of missing or stolen narcotics and nearly all facilities failed to provide evidence of performing consistent monthly pharmaceutical audits of narcotics and other controlled substances.
- Three service units experienced substantial and recurring diversions or reduced health care services from 2007 to 2010, which negatively impacts patients and quickly diminishes limited Contract Health Service (CHS) funding.
- Five IHS hospitals were at risk of losing their accreditation or certification from the Centers for Medicare and Medicaid Services (CMS) or other deeming entities. Several Aberdeen Area facilities were cited as having providers with licensure and credentialing problems, Emergency Medical Treatment and Active Labor Act (EMTALA) violations, emergency department deficiencies or other conditions that could place a patient's safety at risk.
- IHS lacked an adequate system to detect instances of IHS health care providers whose licenses have been revoked, suspended or under other disciplinary actions by licensing boards.
- Particular health facilities continued to have significant backlogs in posting, billing and collecting claims from third party insurers (i.e., Medicare, Medicaid and private insurers). One facility repeatedly transferred its third party payments to other facilities in the Aberdeen (Great Plains) Area.
- There were lengthy periods of senior staff vacancies in the Clinical Director and Chief Executive Officer positions, resulting in inconsistent management and leadership at Aberdeen Area facilities.
- The use of contract providers (locum tenens) was costly (\$17.2 million in the last three years). While the overall cost of contract providers had decreased compared to 2009, two facilities had increased their locum tenens expenses in 2010.

The findings of the report paint a very stark picture of the IHS and its ability to provide adequate health care services to Native Americans. Some of my colleagues in Congress at the time read these findings and suggested that maybe one solution was to completely eliminate the IHS. But, that is not a realistic solution. There are some wonderful, dedicated individuals who do their best, amid substantial challenges, to provide necessary, lifesaving care every day. And, there are some IHS facilities that are performing well and have the support of the local tribal community. The reality is that many tribal communities in remote areas need facilities located on their lands to serve their people and others living on their lands. The facilities that are doing well provide services in a culturally appropriate manner, are well-managed, and regularly engage with the local tribal leadership and community about how to improve access to services.

I believe that addressing a few key issues would substantially improve the IHS system: (1) Congress needs to improve the level of funding to the IHS, (2) the leadership of IHS needs to focus on recruiting and properly training individuals who can be good managers of the IHS Service Units, (3) problem employees who are under-qualified or violate laws need to leave the IHS, and (4) IHS needs to focus on health professional recruitment.

The IHS is severely underfunded compared to other federal agencies. You may have heard the phrase "Do not get sick after June," because if you do, you will not be able to get care. This, to me, is a rationing of health care—care that is guaranteed by treaty. If we start funding IHS at levels commensurate with need, I believe we will solve a lot of the issues revealed in the 2010 report and the ones occurring elsewhere in this country.

Funding challenges aside, it is also clear that the IHS—and tribal patients—would benefit from improving accountability and oversight within IHS. But, accountability and oversight cannot be improved if you do not have adequate managers. One of the biggest concerns that I heard from on-the-ground employees was the lack of good managers. After investigating the matter, it became clear to me that many problem employees get transferred and promoted in order to get them out of their existing environment. Over time, this led to some of those problem employees being placed in senior positions of the health facilities for which they were underqualified. This situation led to many of the day-to-day employees feeling demoralized, unhappy with their jobs, and many good employees ended up leaving the IHS. The vast majority of the problems identified in the report could be resolved if there was a concerted effort by the IHS national leadership to recruit good, qualified, and experienced managers.

Once you have good managers in place, the issue of problem employees can be properly addressed. When an employee engages in misconduct, there need to be systems in place that deal with, and correct, that behavior. It is not enough to simply

transfer that employee to another facility, where they will inevitably engage in the same misconduct, and hope the problem goes away on its own. We saw this pattern repeat itself again and again. And, it led to the good employees within the IHS becoming disgruntled, inefficient, and ultimately poor performing.

I know that there have been genuine efforts by some senior level career IHS officials to address these problems, but the problems persist. I long worked with Robert McSwain at the IHS, to try and address some of these problems, but in some circumstances, the problems have gotten worse. I know that the Winnebago Hospital, which is located in the Great Plains region of the IHS, recently lost its accreditation from the U.S. Centers for Medicare & Medicaid Services (CMS) for its in-patient and emergency services managed by the IHS. I do not know all of the details surrounding this situation, but am aware that CMS conducted an investigation and concluded that there were deficiencies that represented an immediate jeopardy to patient health and safety. And, unfortunately, the CMS investigation was started only after a death of a patient. Too often these problems are ignored until there is a tragedy. We know what the problems are, and while finding solutions will be difficult, spending the time to solve these problems is worth it.

When I retired from the Senate, I created the Center for Native American Youth to raise awareness of the challenges that Native American children face and to find solutions to teen suicide, substance abuse, high drop-out rates, and many others. We are making significant progress on tackling those issues by partnering with tribal leaders, tribal organizations, community members, and parents who work hard each day—with limited resources—to address the challenges faced by their children. We are also working with federal agencies, like IHS, to ensure that Native youth are a priority and that agencies are doing all that they can to meet their needs.

Over the last five years we have connected face-to-face with more than 5,000 youth to hear directly from them about their priorities; held public events to raise awareness of Native youth issues; convened a quarterly roundtable series with over 30 federal agencies and ten national tribal organizations to increase coordination and collaboration among those important entities; and celebrated Native youth through our Champions for Change program and the Generation Indigenous initiative. Our work is framed around listening to Native American children and working with tribal communities to elevate and address their priorities.

During our discussions with youth, we hear time and time again that their health is a priority for them, yet they are unable to receive the healthcare they need. Whether it is dental care, mental health services or routine check-ups, youth are not able to access what they need in order to lead full, healthy and successful lives. This has to change. Native children are already facing a steep uphill climb when compared to their non-Native peers on a variety of issues. Suffering in pain or in sickness because they cannot get into a doctor should not be one of them.

As I mentioned, we interact with young Native Americans every day. Within our Champions for Change program we have some especially talented young people who are addressing health and access to care in their home communities. Cierra Fields, a high school student from the Cherokee Nation works with her tribe to promote diabetes prevention and cancer awareness among her peers. Another Champion, William Lucero, a college student from the Lummi Nation, has spent several years educating his peers and other community members about the dangers of smoking. Lastly, Joaquin Gallegos, a recent college graduate from the Jicarilla Apache Nation and Pueblo of Santa Ana, has worked tirelessly to expand access to much-needed dental care for tribal nations. We need to ensure that amazing young people like these three have the health care they deserve so that they can continue to do great work for their communities.

I want to again thank the Committee for taking the time to examine this important issue, and I would like to offer the Center for Native American Youth as an ongoing resource to you. Thank you.

The CHAIRMAN. Thank you, Senator Dorgan. You are always welcome here. You are family on the Committee dais. It is wonderful to see you. Thank you for that compelling testimony once again highlighting the needs of so many people. You do think with your heart and we are grateful for you.

Senator DORGAN. Thank you.

The CHAIRMAN. We will now hear from our second panel of witnesses. As Senator Dorgan mentioned, Mary Wakefield will be first to testify. I would ask the second panel to please come forward.

Mary is a Ph.D., R.N. and Acting Deputy Secretary, U.S. Department of Health and Human Services. We will also hear from Mr. Andy Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services. He will be accompanied by: Mr. Thomas Hamilton, Director, Survey and Certification Group, Center for Clinical Standards and Quality, Centers for Medicare and Medicaid Services. We also have with us the Honorable Robert G. McSwain, Principal Deputy Director, Indian Health Service, U.S. Department of Health and Human Services. We also have Susan V. Karol, M.D., Chief Medical Officer, Indian Health Service, U.S. Department of Health and Human Services.

Thank you all for being here. I will remind the witnesses that your full written testimony will be made a part of the official hearing record. Please keep your statements to five minutes so that we may have time for questions.

We look forward to your testimony beginning with Dr. Wakefield. Please proceed.

STATEMENT OF MARY WAKEFIELD, Ph.D., R.N.; ACTING DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. WAKEFIELD. Chairman Barrasso, Vice Chairman Tester and members of the Committee, thank you so much for inviting me here today to discuss the quality of Indian health care on the Great Plains.

Let me start by saying that the deficiencies cited in the reports by the Centers for Medicare and Medicaid Services are unacceptable. They are unacceptable to me and they are unacceptable to the leadership of HHS.

Our department's mission is to improve health, the health and well being of all Americans. As these reports have shown, we must do better for the Native communities that we serve.

As was indicated, I am from North Dakota and both of my parents spent time working for the tribal community near us. I grew up witnessing firsthand the resilience of Indian Country and the strength with which they overcame so many challenges.

As was indicated, I am also a nurse. From the day I started working in a small hospital as a nurse's aide, the reason that I sought a career in health care was to care for patients and to support families.

I have had the privilege of caring for American Indian newborns in a hospital nursery and American Indian elders in nursing homes. I have also seen firsthand some of the best that IHS has to offer. I know there are many dedicated healthcare professionals who are committed to serving their tribal communities well. To me any failure in the quality of care that patients and their families receive is one failure too many.

Today I want to discuss with you our actions to address challenges in the Great Plains area. We have an intense effort underway right now to address the problems cited by CMS at these three hospitals. To assist IHS in these efforts, additional Commissioned Corps officers are augmenting IHS personnel now in the Great Plains region.

More broadly though, we have instructed the leadership of IHS to redouble their efforts to ensure that sustained quality care is delivered consistently across IHS facilities. To facilitate this, we have augmented leadership at both the local level and also at the national level to implement our expectations for high quality, consistent and sustained care.

As part of this effort, IHS has hired two new deputy directors, two leaders, Mary Smith, an enrolled member of the Cherokee Nation and a longtime advocate for Indian communities who has been at IHS for about four months. As deputy director, she has a primary focus on management.

IHS created a new position, Deputy Director of Quality Health Care, late last year. Dorothy Dupree is an enrolled member of the Fort Peck Assiniboine Sioux Tribes and the former Acting Area Director in Billings. She just joined us recently in this role.

From the Phoenix IHS, Dorothy led the implementation of groundbreaking quality improvements. These improvements are being refined, expanded and considered for wider implementation.

In her new role, Dorothy is working closely with tribal, State and local partners to execute a quality strategy that improves safety and the patient's health experience. In consultation with tribes, this strategy will be implemented for the Northern Plains facilities and broadly across IHS facilities.

However, IHS is not the only part of HHS that serves these populations. That is why we are also establishing a council of senior executives across HHS. We will have programs that serve American Indians and Alaska Natives.

This executive council on quality care will use their expertise from across the department to ensure that our resources are closely aligned and leveraged on behalf of American Indian families and communities. Specifically, this group will augment IHS's efforts to ensure that sustained quality care is delivered across IHS facilities.

In addition, this group will address the long term, chronic challenge of provider recruitment and retention. Among other factors, the remote locations of Native communities, the housing shortage, and employment opportunities for spouses contributes to staffing shortages at many of these facilities.

This group will use their combined expertise to further leverage and develop new approaches to addressing workforce shortages. I will give you an example.

When I served as the Administrator of the Health Resources and Services Administration, we cut red tape and made all IHS facilities eligible as National Health Service Corps sites. Before we made these changes, there were about 100 approved tribal sites with 150 National Health Service Corps clinicians serving these communities.

Today, we have more than 670 tribal sites that host more than 420 National Health Service Corps clinicians. We want to develop more ideas like this from our senior leaders who serve these communities.

Finally, we look forward to working in partnership with you to enact the President's budget for fiscal year 2017. We do need the financial resources to invest in the high quality care that these communities deserve.

This Administration takes the challenges to delivering high quality care to these communities very seriously. You have my commitment that we will work tirelessly to make meaningful, measurable progress. We will undertake that work with you, tribes and our IHS health professionals in close consultation.

Thank you so much.

[The prepared statement of Mr. Wakefield follows:]

PREPARED STATEMENT OF MARY WAKEFIELD, PH.D., R.N.; ACTING DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Bai-rasso, Vice Chairman Tester, and Members of the Committee:

Good Afternoon. I am Mary Wakefield, acting Deputy Secretary for the Department of Health and Human Services. I am pleased to join you today to discuss the Great Plains Area Indian Health Service (IHS) Hospitals. I want to begin by assuring you that Secretary Burwell and I are committed to working hard to provide high quality care for the American Indian and Alaska Native people we serve and are committed to making improvements to the quality of the care that we provide.

By way of background, I am a native of North Dakota. At different points in time, both of my parents worked for a neighboring tribal community. Through those early ties, and my own subsequent interactions with American Indian communities in training nurses and working in rural health policy, the remarkable strengths of Indian people and the challenges they face are familiar and very much appreciated by me. Before becoming acting Deputy Secretary, I was the Administrator of the Health Resources and Services Administration (HRSA) for six years. During my time there, I made working with tribes and Indian people a priority. Consistent with Secretary Burwell's vision, I am working to leverage other Agency assets beyond IHS programs to help strengthen the health care services we provide to Indian country; in Indian Country. The challenges facing hospitals in Indian Country, and those that IHS is responsible for helping to address include challenges that are common to many hospitals in rural America, such as being less able to take advantage of economies of scale because of low volume and difficulties in recruiting and retaining qualified healthcare providers.

I also recognize that, although facing issues similar to many rural hospitals, the IHS has a mission that differs from other hospitals. There are circumstances that are unique to AI/AN communities, including ensuring that they receive culturally sensitive health care services. These and other important characteristics influence both what care is provided, as well as how that care is provided. Those issues range from the behavioral health issues related to historical trauma that the Substance Abuse and Mental Health Services Administration (SAMHSA) works in tandem with IHS to address, and the economic conditions that the Administration for Children and Families (ACF) works with tribes to address, to the special needs of Indian elders that the Administration for Community Living (ACL) works to help tribes meet. For example, SAMHSA's Native Connections grants help tribes reduce suicidal behavior and substance use and promote mental health among Native youth. ACF funds tribal TANF programs to help Indian families in poverty that reach nearly 300 tribes and Alaska Native Villages. And ACL's Older Americans Act Title VI program helps fund tribes to provide the delivery of home and community-based supportive services for their elders, including nutrition services and support for family and informal caregivers. These and other HHS programs support tribes so that they can provide health and social services for their people in a culturally appropriate manner.

At HHS, we strive to work together with and for Indian Country, to leverage programs and resources that support better outcomes for tribal communities. We fully recognize the trust relationship with the tribes and the need for meaningful consultation. As part of this recognition, former Secretary Sebelius established a new tribal leader advisory committee that continues to meet with our Secretary and senior leadership from around the department on a quarterly basis and provides us with a valuable venue for consultation.

Fundamental to meeting the needs of Indian Country are effective program deployment and financial resources. Under President Obama, with the support of many of you, funding for IHS has increased by 43 percent. The President's Budget for FY 2017 will continue to prioritize IHS and we look forward to continuing to work with you to enact the Budget.

The Administration has also renewed its focus on improving the lives of Native youth through the Generation Indigenous initiative. At HHS, we work with Native

youth through a variety of programs. We have requested additional resources targeted to provide more and better behavioral health for young people and we appreciate your help in securing \$15 million in the recent omnibus for the Native Connections grants I mentioned earlier.

Now I would like to offer an example of our work across HHS on behalf of tribal communities. As a series of tragic suicides began to unfold on the Pine Ridge reservation in South Dakota last winter, we engaged resources from across HHS, and other cabinet agencies, to respond. Within HHS, our Public Health Service Commissioned Corps officers deployed to provide immediate additional behavioral health services. IHS has also added telebehavioral health services to reach the reservation community and we are supporting counselors in schools on the reservation on a weekly basis. IHS has also added case manager positions to the behavioral health department to help follow-up on patients and to be resources for families. And, over the past year, other HHS agencies and programs have provided additional resources and support to the community.

For example, ACF's Administration for Native Americans provided additional funding to help youth with summer jobs and the development of youth councils in the community. HRSA recently awarded the Tribe a telehealth grant that they will use to partner with Avera McKennan Health System to expand access to health and social services through school-based telehealth services. We have partnered with the Department of Education to convene the 17 schools across the reservation to strengthen their existing collaborations to address the needs of school aged youth around critical needs such as nutrition assistance, native language support, and immediate crisis response. Additionally, SAMHSA has worked closely with the Tribe and extended their current suicide prevention grant. The intent is to support suicide prevention efforts, assist with the response to the suicide cluster, and help the Tribe develop comprehensive suicide prevention activities with the goal of minimizing future suicide clusters. A SAMHSA Emergency Response Grant is also being awarded to the Tribe to help meet the continued urgent need to combat suicides. While today's hearing focuses on reviewing care at these Great Plains facilities, we believe it is essential to continue to focus on exploring ways that the Administration, Congress and Tribal Nations can work together to strengthen behavioral health as part of the package of health care services for these tribal communities as well.

And access to behavioral health services is a concern not only for Pine Ridge and other tribal communities served by the Great Plains IHS facilities, it is also a concern for tribal communities across the nation. The FY 2017 President's Budget will continue to prioritize behavior health services and we look forward to discussing these initiatives once the President's Budget is released in early February.

We know that more needs to be done to ensure quality health care is provided by IHS.

In terms of the specific issues that the Committee is reviewing today, it is our intent to further strengthen not only IHS' work, but also the engagement of other parts of the department to assist IHS in improving the quality of care at these facilities. Let me share a couple of examples.

First, CMS is providing both technical assistance to a number of IHS hospitals and regular reviews to monitor the quality of these health care services, as detailed in the statement of Acting Administrator Slavitt. For example, in the past, IHS hospitals have benefitted from technical assistance provided by Quality Improvement Organizations (QIOs) that operate under contract with CMS. Going forward, CMS and IHS are working together to explore ways that the Quality Improvement Program can continue to more directly provide support to the IHS and its hospitals, on a sustained basis, as part of the most recent QIO Scope of Work. Through a strong relationship between CMS and IHS, increased technical support to IHS Area and hospital leadership and by addressing other underlying systemic issues, quality improvements will have a lasting impact, leading to a stronger focus on a culture of patient safety. Secondly, as I think we all recognize, staffing is a perennial challenge for IHS, given that its facilities are often in remote communities with shortages of housing and employment opportunities for spouses, challenges that are similar—and often more acute—than what we see in many other rural remote communities across the United States. Recognizing the staffing needs of hospitals in Indian Country, while I was at HRSA, we expanded the availability of National Health Service Corps-supported providers to IHS by making all IHS facilities eligible NHSC sites. Prior to eliminating the requirement for Tribal sites to apply to be NHSC sites, there were approximately 100 approved sites with about 150 NHSC clinicians working at those sites as of July 2011. Today, there are more than 670 approved Tribal sites and more than 420 NFISC clinicians providing primary health care across Indian Country. Still, we recognize that there is unmet need for clinicians

and more to be done. Looking forward, the President's FY 2017 Budget will continue to prioritize staffing at IHS facilities.

Recognizing the challenges IHS facilities face in the northern plains and elsewhere, and the opportunity to strengthen other efforts, at the Secretary's direction, we recently augmented the senior leadership team at IHS with two additional deputies that bring significant expertise to the Agency. Mary Smith, an enrolled member of the Cherokee Nation, joined IHS a few months ago as Deputy Director and brings an array of experience in Native American policy, including health policy, as well as state-level work in health care policy, implementation, and compliance. A long-time advocate for Indian people, she is already working to further strengthen efforts that cross agency and departmental lines with an eye toward achieving meaningful and lasting impact in many policy and operational priorities at IHS.

We have also recently named Dorothy Dupree as Deputy Director, Quality Health Care. As some of you know, Ms. Dupree, an enrolled member of the Fort Peck Assiniboine Sioux Tribes, was most recently the Area Director for the Phoenix IHS Area and also served as the acting Area Director in Billings, where she focused on improving quality of care concerns. Ms. Dupree's priority was to ensure strong communications with tribal leaders and in using knowledge gained through data analytics to improve quality of care. She too brings substantial expertise in strengthening financial and clinical operations of health care facilities and her responsibilities include working with our direct service facilities to provide higher quality of care, and achieving that aim by working with external partners including tribal, state and other federal agencies. With Ms. Smith, Bob McSwain and the other IHS leaders, Ms. Dupree is mapping a Quality Strategy that includes northern plains facilities with patient safety and the patient experience as central to this strategy. It will include a focus on developing stronger data analytic capacity, improving training, and ensuring that facility governing boards are effectively working to monitor and improve quality of care.

In summary, we recognize there are significant challenges facing hospitals in the Great Plains area that need to be fully addressed. The Secretary had directed actions to be taken, some of which I have outlined, and we will be taking additional actions in our work toward achieving the goal of high quality health care for American Indian and Alaska Native populations. We take the challenges we are here to discuss today very seriously and you have our commitment to work to make meaningful progress.

Thank you. I welcome your questions.

The CHAIRMAN. Thank you.

Mr. SLAVITT.

**STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR,
CENTERS FOR MEDICARE AND MEDICAID SERVICES;
ACCOMPANIED BY THOMAS HAMILTON, DIRECTOR,
SURVEY AND CERTIFICATION GROUP, CENTER FOR
CLINICAL STANDARDS AND QUALITY**

Mr. SLAVITT. Chairman Barrasso, Vice Chairman Tester, and members of the Committee, thank you for the invitation to discuss the quality and safety of health care provided at Indian Health Service facilities in the Great Plains.

At CMS, we work directly with tribal leaders on the important issues which affect health care in the American Indian community, including expanding access to tribally operated behavioral health programs, working with States on waivers to expand Medicaid coverage and as it relates to this hearing, we evaluate and certify the quality and safety of hospitals that serve American Indian populations who are Medicare or Medicaid beneficiaries.

As this Committee well knows and as Senator Dorgan mentioned, healthcare quality for American Indians and Alaska Natives has been a significant concern in this Country. It was highlighted by this Committee's report in 2010 and identified serious, ongoing patient safety issues at several Aberdeen area facilities.

More recently a 2013 Kaiser report found that American Indians and Alaska Natives are disproportionately likely to be in poor or fair health and suffer from serious conditions like diabetes and cardiovascular disease among others.

I mention these reports to acknowledge that providers in the largely remote area of Indian Country face substantial and long-standing challenges. Nonetheless, our role at CMS is to enforce the same high standards of care and safety for the American Indian population as for all others we serve.

I am joined today by Thomas Hamilton who directs CMS's Survey and Certification Group. Thomas and his team are charged with the day-to-day work of holding institutions that participate in the Medicare Program accountable to provide safe medical care no matter who their patients are, and no matter where they live, no matter where they seek medical attention.

To achieve this, CMS requires that all facilities serving Medicare and Medicaid beneficiaries, including Indian Health facilities, comply with health and safety requirements, that we conduct objective on-site assessments to make sure these conditions are being met and to call attention to and take action in situations where they are not.

Since 2010, CMS has conducted 18 separate on-site surveys at three hospitals: Omaha Winnebago, Pine Ridge Hospital and Rosebud Hospital. We identified violations of our safety standards in all three.

Problems have included the hospitals' inability to respond appropriately to emergency situations, perform necessary screenings and diagnostic tests and ensure staff competencies. More details are available in our public survey reports and in our written testimony.

After each survey, we have shared the findings with hospital leadership and required plans of action. After several years of improvement efforts and evaluations, out of concern for patients who were observed at these facilities, last year we terminated one of the hospitals, Omaha Winnebago, from the Medicare program.

Recently, we issued two notices of potential Medicare termination to two other hospitals, Pine Ridge and Rosebud. Management at these facilities is currently in the process of responding to the survey findings.

We appreciate the challenges that operators of these facilities face as the survey findings indicate the need to address serious, longstanding problems to protect the people and their communities.

Given the systematic nature of some of the issues, including the universal challenges often faced by healthcare providers in rural and remote areas, CMS has been trying to do more than just evaluate the problems but provide resources to help the hospitals.

Over the last five years, we have trained over 500 IHS staff in areas of quality and safety and have brought technical resources into three hospitals mentioned here today that specialize in working through root cause issues and improving patient safety.

We know the challenges are significant and that much work remains. As long as patient safety is at risk, we stand ready to work side by side with these hospitals and provide whatever help we can. We are eager to participate actively in the HHS Council on

Quality Care mentioned by Acting Deputy Secretary Wakefield. We believe this can have significant benefits.

While the ultimate responsibility for sustained improvement lies in the hands of the leaders of these facilities and frontline workers, we are committed to doing our part to assist the IHS in raising the quality of care for the American Indian community served in these hospitals.

I appreciate the Committee's attention and interest in these extremely important subjects. We will be pleased to take your questions.

[The prepared statement of Mr. Slavitt follows:]

PREPARED STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR, CENTERS FOR
MEDICARE AND MEDICAID SERVICES

Chairman Barrasso, Vice Chairman Tester, and members of the Committee, thank you for the invitation to discuss the Centers for Medicare and Medicaid Services' (CMS') work to monitor the quality of health care provided at Indian Health Service facilities. CMS is committed to ensuring the safety of the millions of Americans who rely on the U.S. health care system every day. To monitor the safety of care provided throughout the country, CMS requires that all facilities seeking participation in Medicare and Medicaid comply with basic health and safety requirements set forth in the Medicare Conditions of Participation (CoPs). The Survey and Certification process is used by CMS to assess compliance with these requirements. It is CMS' duty to provide objective, onsite assessments of the quality and safety in health care facilities, properly identify any deficiencies, and require that timely corrections are made to any identified deficiencies. We understand that our responsibilities and enforcement requirements may bring challenges to health care facilities, and CMS is committed to working with facilities and providers in good faith as they strive to deliver safe, high quality care.

CMS has fulfilled this role in our work with Indian Health Service (IHS) facilities in the Great Plains area. CMS surveyors have conducted numerous recertification and complaint surveys at IHS facilities, required that corrective action be taken, and monitored their progress in addressing identified deficiencies. Also, in an effort to help IHS hospitals better understand the requirements of the CoPs and address quality deficiencies, CMS has provided considerable technical assistance to a number of IHS hospitals. For example, CMS encouraged administrators at IHS hospitals to participate in compliance training, and has trained 565 IHS staff to date as a part of that effort. CMS also provided onsite technical assistance to staff at the Pine Ridge hospital to help staff understand the quality and safety expectations embodied in CMS regulations. In addition, Quality Improvement Organizations (QIOs), under contract with CMS, provided technical assistance at IHS hospitals (specifically Winnebago) with regard to methods that the hospitals could use to meet Plan of Correction (PoC) requirements. These CMS efforts were intended to support and bolster the IHS' own system-wide efforts to provide technical assistance, training, and personnel actions that might address quality of care issues.

CMS Survey and Certification

CMS maintains oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers (including hospitals, nursing homes, home health agencies, end-stage renal disease facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries). CMS' Medicare CoPs for hospitals set out quality and safety standards on a wide range of topics such as emergency treatment, infection control, medication management, credentialing and privileging of physicians, and responsibilities of the hospital's governing body to ensure safe care.

Generally, State survey agencies (SAs)¹ conduct hospital recertification surveys every three years on behalf of CMS to assess facility compliance with Medicare CoPs and the Emergency Medical Treatment and Labor Act (EMTALA) requirements. However, CMS surveyors may also conduct these surveys, as is the case with IHS facilities. EMTALA requirements impose specific obligations on Medicare-participating hospitals that offer emergency services to screen, treat, or appropriately

¹For IHS facilities, Accrediting Organizations (AOs) or Federal surveyors conduct recertification and complaint reviews. This is due to their status as a federal facility.

transfer patients, regardless of their ability to pay. Surveyors also investigate complaints alleging hospital noncompliance with CoPs. A hospital cannot participate in Medicare unless it meets each and every CoP. As part of the CoPs, surveyors conduct Life Safety Code surveys to ensure the safety of patients from fire, smoke and other environmental hazards. These standards apply to all Medicare hospitals to ensure basic health and safety standards. Under section 1865 of the Social Security Act, CMS has also approved four accrediting organizations (AOs) for hospitals whose standards and survey processes are determined to be equivalent to those of CMS. CMS deems a hospital's accreditation by an approved AO to be sufficient for Medicare certification. The AOs conduct recertification surveys at least once every three years for hospitals. CMS retains the right to conduct complaint investigations of accredited facilities, and remove a provider's deemed status if CMS finds serious deficiencies. CMS also conducts validation surveys of a sample of accredited hospitals to check on the adequacy of the AO surveys.

The survey and certification process includes, but is not limited to, conducting surveys to determine whether health care entities comply with Medicare CoPs or requirements; and conducting enforcement actions when these entities are found to be out of compliance with the Medicare CoPs. For example, during a hospital survey, the surveyors examine the hospital's health records, interview staff and patients and observe the processes of care. This includes observing doctors and nurses as they provide emergency services to assess the facility's ability to adequately provide emergency screenings and services.

As a result of the survey, the SA or CMS may find the hospital in violation of Medicare's CoPs, EMTALA, or find that the hospital has deficiencies so serious that they constitute an immediate and serious threat to the health and safety of patients, referred to as immediate jeopardy (IJ). Hospitals have 23 days to correct IJ violations and 90 days to correct other CoP and EMTALA violations to avoid termination from the Medicare program.

If Deficiencies are Found

If any deficiencies are found during the survey, the SA certifies that the facility is non-compliant and recommends termination to the CMS Regional Office (RO). The RO then sends the institution a "Statement of Deficiencies" outlining deficiencies that were identified during the survey. CMS follows a specific timeline for every hospital where deficiencies are found.² First, the institution is given five calendar days to respond to deficiencies at the IJ level or 10 calendar days in which to respond to less serious CoP or EMTALA deficiencies. The response must include a PoC for each cited deficiency, which is included on the form containing the statement of deficiencies. Once a facility has made a credible allegation of compliance,³ surveyors conduct a revisit to determine whether compliance with the CoP or acceptable progress towards compliance has been achieved. Only two revisits are generally permitted in the hospital setting; one within 45 calendar days and one between the 46th and 90th calendar days. If compliance is achieved, the facility goes back to the regular certification schedule.

If compliance has not been achieved, the SA certifies that the facility remains non-compliant. Within 65 calendar days following the date of survey, the RO determines whether survey findings continue to support a determination of noncompliance. If all requirements are met by the hospital, the hospital returns to its normal recertification schedule.

If the determination of noncompliance continues, the RO sends an official termination notice by the 70th calendar day to the facility, the public, and the State Medicaid Agency if the facility also participates in Medicaid. The termination generally takes effect by the 90th calendar day if compliance has not been achieved. Termination can take effect in fewer than 90 days if all required procedures are completed. CMS sometimes extends the prospectively scheduled termination date if CMS requires more time to schedule or complete a revisit survey that is necessary to confirm that corrective action has restored the hospital to compliance with the CoPs, or if there are very unusual circumstances such as the need to make alternate arrangements for care of patients in remote areas.

If an adverse action, such as a termination, is likely to be initiated against a Medicare participating provider or supplier, the CMS RO follows procedures out-

² https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Downloads/Schedule_of_Termination_Procedures.pdf

³ Credible allegations of compliance include, a statement or documentation that is realistic in terms of the possibility of the corrective action being accomplished, and that indicates resolution of the problem.

lined in the State Operations Manual.⁴ We note that every facility faced with termination from Medicare participation is provided with a full opportunity to take necessary remedial action and demonstrate compliance with the CoPs before the prospectively-scheduled Medicare termination date. In addition, if the institution disagrees with the finding of noncompliance, it may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board within 60 calendar days of the final CMS notice of termination. Finally, any provider that CMS has involuntarily terminated from Medicare participation has the right to apply for reinstatement at any time. To be reinstated, subsequent onsite surveys must confirm not only that the provider has restored its services to compliance with the CoPs, but that the provider demonstrates reasonable assurance that the deficiencies which led to involuntary termination are not likely to recur.

We appreciate that, in some circumstances, Medicare termination of a provider may cause or increase access to care problems for beneficiaries. While such considerations do not influence in any way the proper identification of quality or safety deficiencies, we can consider such factors in the selection of enforcement methods. In an effort to balance patient access to care while ensuring high quality health care, CMS considers factors such as patient driving times to the next nearest facility, specialized services provided at the nearest facility, and the identified facility's ability to achieve and maintain substantial compliance with CoPs. If patient access to care may be greatly affected, CMS may look into additional options to help preserve beneficiary access to care and help the hospital meet CoP and EMTALA requirements. An example that CMS has used in rare but serious access to care situations is a Systems Improvement Agreement (SIA). An SIA is an agreement, voluntarily entered into by CMS and a hospital that obliges the hospital to engage in a specified regimen of quality improvement, and make significant investments in improving the quality of care, in exchange for more time to make needed systemic improvements before Medicare termination would take effect. All of these requirements and timelines are available for public review in the State Operations Manual and in CMS regulations.⁵ CMS, SA, and AO conduct CoP and EMTALA education and outreach to hospitals through Open Door Forums, and additional assistance is also provided to facilities from Quality Improvement Organizations (QIOs).

Both private and IHS hospitals in the Great Plains area face a number of challenges including their location in rural areas and difficulty attracting qualified administrators and physicians to work in their facility. Due to these and numerous other factors, three IHS hospitals, as described below, have had challenges meeting CoP and EMTALA requirements in recent years.

Issues Identified at the Winnebago Indian Health Service Hospital

CMS surveyors have been investigating and monitoring complaints made regarding Winnebago Indian Health Service Hospital. CMS conducted a complaint survey of the hospital on April 8, 2011 and found the hospital to be in violation of various Medicare CoPs. The deficiencies included failure to ensure there were systems in place to inform patients of their rights, to promptly investigate and respond to patient grievances, to ensure patients have information necessary to make informed consent regarding their care, and to investigate allegations of patient abuse to assure patients are protected. Due to the importance of these findings, the hospital was notified that a Medicare survey would be conducted to assess compliance with all CoPs, not just those that had been the subject of the complaint.

CMS subsequently conducted a full recertification survey on October 14, 2011 and found the hospital to be out of compliance with nine CoPs: compliance with Governing Body responsibilities, Patients' Rights, Quality Assessment and Performance Improvement, Medical Staff, Nursing Services, Radiological Services, Infection Control, Organ/Tissue/Eye, and Emergency Services. The hospital was notified of CMS' intention to terminate the hospital's Medicare agreement on January 16, 2012 if it did not correct these violations. A variety of plans of correction and improvement efforts ensued, including extensive direct assistance from the Nebraska QIO, under contract with CMS, throughout 2013 and 2014.

In a response to another complaint filed, the hospital was surveyed on April 25, 2014, and found to be out of compliance with CoPs concerning Nursing Services, specifically related to failure to assure the nursing staff were adequately trained

⁴<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c03.pdf>

⁵<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html>. The SIA content for organ transplant programs may be found at 42 CFR 488.61(h).

and possessed the necessary knowledge and skills to ensure patients were provided safe and appropriate care. Surveyors determined that this noncompliance placed patients in IJ. CMS provided Winnebago with a termination date of May 18, 2014. Surveyors conducted a revisit survey on May 15, 2014 that found Nursing Services remained out of compliance. In response to IHS requests for additional time, CMS conducted additional surveys and extended the Medicare termination date.

An additional revisit survey, conducted on July 17, 2014, found the hospital remained noncompliant concerning Nursing Services and found that Emergency Services were also out of compliance. These concerns still constituted an IJ due to the survey's findings that the hospital failed to provide services, equipment, personnel and resources within timeframes that protect the health and safety of patient receiving medical care in the emergency department (ED); and that the hospital failed to maintain policies and procedures for emergency medical services provided to all patients who receive medical care in the ED.

An additional survey conducted on August 27, 2014 found the hospital to be out of compliance with EMTALA requirements. CMS determined that the EMTALA violation constituted an IJ, and also found continuing noncompliance with the CoP of Nursing Services and Emergency Services. Of the 25 medical records randomly selected from the ED log from March 2014 to August 2014, the hospital failed to provide adequate medical screening examinations to three patients and failed to provide stabilizing treatment within its capabilities to one patient. Winnebago submitted a performance plan to stay the termination. As part of our responsibilities, CMS scheduled a full Medicare survey before the hospital was scheduled to be terminated from Medicare on November 6, 2014. The termination date was later extended to December 5, 2014 to allow surveyors time to complete a survey report.

On November 6, 2014, CMS surveyors conducted the full Medicare survey at the hospital to assess compliance with all the applicable Medicare CoPs and to assess that status of the noncompliance findings of the previous surveys. During this survey, the IJ findings cited in previous surveys were deemed removed and the previous noncompliance findings were determined to have been corrected. However, the hospital was found to be out of compliance with other Conditions concerning their Governing Body, Nursing Services, Food and Dietetic Services and Emergency Services. Although the deficiencies cited were serious, they did not constitute an IJ to the health and safety of patients. On November 21, 2014, CMS notified the hospital of these changes and extended the termination date to April 30, 2015 to allow a revisit survey. On April 23, 2015, the termination date was extended to June 15, 2015, to allow the revisit to occur.

CMS Federal surveyors then conducted revisit and complaint surveys on May 14, 2015 and found that the hospital was noncompliant with seven CoPs including: Governing Body, Nursing Services, Outpatient Services, Emergency Services, Appropriate Medical Screening Examination, Stabilizing Treatment, and Appropriate Transfer. The noncompliance was found to constitute an IJ. Because of ongoing non-compliance since 2011 and repeated IJ citations, despite technical assistance from CMS and the Nebraska QIO and repeated PoCs prepared by the hospital, it was determined no further extensions would be granted and that the hospital would be terminated July 23, 2015. On July 8, 2015, CMS issued notice of final termination of Medicare participation to the hospital, effective July 23, 2015, with concurrent newspaper notice. The hospital has appealed the termination. The IHS has continued to work with the hospital and Tribal officials, and has engaged a consultant firm to assist the hospital and facilitate resolution of the problems. CMS stands ready to respond to a request from the hospital for a survey that might start a reinstatement process if the hospital is found to be in compliance with the CoPs.

Issues Identified at the Rosebud Indian Health Service Hospital

To investigate an EMTALA violation complaint, Federal surveyors conducted a recertification survey at Rosebud Indian Health Service Hospital on November 16–19, 2015 and a Life Safety Code Recertification Survey on November 17–18, 2015. Based on the survey findings, it was found that the hospital was not in compliance with all of the Medicare CoPs for hospitals and that deficiencies put patients in IJ, particularly related to risk of inappropriate care in the ED. As a result, CMS notified the hospital of the intent to terminate on December 12, 2015 if the hospital did not prepare a PoC and correct these violations. The hospital placed its ED on diversion. IHS later notified CMS that it would temporarily close the ED and CMS then removed the IJ. Following this closure, the IJ was removed, giving the facility until February 17, 2016 to address its remaining ED and CoP compliance issues. The hospital has agreed not to reopen the ED without seven days prior notice to CMS to allow CMS time to conduct an onsite survey of the ED. CMS will also reschedule a revisit survey once the ED has reopened.

On January 5, 2016, CMS also found that Rosebud Hospital was in violation of EMTALA requirements, specifically, failure to provide appropriate medical screenings and stabilizing treatment to patients presenting to the emergency department. On January 6, 2016, CMS sent the hospital a notice of intent to terminate Medicare participation due to the EMTALA deficiency. The hospital's PoC for the EMTALA violation is due to CMS on March 15, 2016 to avoid a termination date of May 19, 2016.

Issues Identified at the PHS Indian Hospital at Pine Ridge

On October 29, 2015, following a complaint survey of PHS Indian Hospital at Pine Ridge, federal surveyors identified that the hospital was out of compliance with three CoPs and was in violation of EMTALA. CMS identified concerns with the hospital's Quality Assessment and Performance Improvement program, which is the hospital's system for tracking, analyzing and developing plans to address significant issues. As a result, CMS gave the hospital until January 27, 2016 to correct these violations to avoid termination. CMS received and approved the hospital's PoC.

On January 14, 2016, federal surveyors completed a revisit of this hospital. They found the hospital in compliance with the CoPs, but still in violation of EMTALA. CMS issued a termination date of February 23, 2016 for the EMTALA violation. The hospital will have one more opportunity to demonstrate compliance with the EMTALA requirements prior to this date. CMS expects the hospital to submit a PoC prior to February 23, 2016. If the PoC is accepted, another revisit would occur.

Conclusion

CMS remains diligent in our duties to monitor every hospital participating in Medicare to help ensure patient safety and access to care across the country. CMS surveyors have relied on longstanding policies when engaging with IHS facilities in the Great Plains area. It is our obligation to ensure all health care facilities are safe and can meet patient needs. CMS and QIOs have provided numerous hours of technical assistance to IHS facilities regarding quality improvements and deficiencies. We will continue to work with IHS as these hospitals strive to make improvements and to make sure patients are receiving quality health care services. We are hopeful that these hospitals will soon be able to come in to compliance with all relevant requirements and continue to provide much-needed care to patients in the Great Plains area. We appreciate the Committee's interest, and I would be pleased to address any questions you may have.

The CHAIRMAN. Thank you, Mr. Slavitt.
Mr. McSwain.

STATEMENT OF ROBERT G. MCSWAIN, PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MCSWAIN. Chairman Barrasso, Vice Chairman Tester, and members of the Committee, I was reflecting back on previous events.

I first came to the Indian Health Service in 1976. I am a proud member of the North Folk Rancheria of Mono Indians of California and personally understand the important work of the Indian Health Service and its mission.

I recognize the frustration amongst the tribes and members of this Committee. I have worked the past 40 years to improve the health of our people. Providing access to quality medical care is a top priority for the Indian Health Service.

When issues do arise, as regrettably has been the case in the Great Plains area, IHS is committed to taking immediate action which we can discuss later but to preserve patient safety above all.

We are also working to make the improvements more lasting. We will talk about that in a moment.

Despite these efforts, challenges remain. Some of the biggest challenges we face in the Great Plains area are associated with providing health care in rural, geographically isolated communities.

You all are aware of the isolation and the difficulty with staffing, housing and what have you.

Three hospitals at issue today, Omaha Winnebago, Pine Ridge and Rosebud, have faced additional challenges. From July to October, as Mr. Slavitt mentioned, they received non-compliance notifications from the Center for Medicare and Medicaid Services.

IHS understands and accepts the severity of the CMS findings and has taken immediate steps and measures to correct them and implement safeguards to prevent recurrence. In addition, I know we have gone beyond just the CMS review and the area has contracted with a firm to take a wider look at the facility, not only in terms of the things CMS looks at but the things we need to look at as a comprehensive healthcare system.

We have done that. We completed the assessment at Omaha Winnebago and are doing a similar analysis at Pine Ridge and Rosebud. Throughout we are communicating regularly with the tribes. In the case of Omaha Winnebago, we communicate weekly with them as we progress through the process.

We believe these actions will address the concerns and issues in the immediate term and we also recognize the need for the long-term solutions. In that regard, you heard Acting Deputy Secretary Wakefield talk about Dorothy Dupree being added to our staff. Senator Tester if you are wondering where she wound up, she is now working for us. Her title is Deputy Director for Healthcare Quality.

We have converted our hospital consortium established a few years ago to a quality consortium. We are working off Ms. Dupree's actual work plan. Working with Dorothy will be Mary Smith, an enrolled member of the Cherokee Nation as mentioned earlier. Mary has extensive background in advocating for Indian people and is steeped in health policy.

In conclusion, the IHS is committed to working to improve the quality of healthcare services received by our patients. We are also committed to working in a transparent partnership with Rosebud, Pine Ridge and Omaha Winnebago hospital leadership and their four respective tribes.

Mr. Chairman, thank you for your longstanding commitment to improving Indian health in the Great Plains area and throughout the Indian Health Service, and for the opportunity to testify today.

I would be happy to answer any questions you may have.

[The prepared statement of Mr. McSwain follows:]

PREPARED STATEMENT OF ROBERT G. MCSWAIN, PRINCIPAL DEPUTY DIRECTOR,
INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman and Members of the Committee:

Good Afternoon. I am Robert G. McSwain, the Principal Deputy Director for the Indian Health Service (IHS) and accompanying me is Dr. Susan Karol, the Chief Medical Officer for IHS. I am pleased to have the opportunity to testify before the Senate Committee on Indian Affairs regarding operations of the Great Plains Area IHS Hospitals.

I first came to IHS in 1976 and have held positions throughout IHS since then. I am a proud member of the North Fork Rancheria of Mono Indians of California and personally understand the importance of the work that IHS does and I recognize the frustration among tribes and the members of this committee. I have worked over the past 40 years to improve the health of our people, and providing access to quality medical care is a top priority for IHS. When issues do arise, as regrettably has been the case in the Great Plains Area, IHS is committed to taking immediate actions to preserve patient safety above all else. We are also working to make a more lasting improvement in the quality of the care we provide and are committed to demonstrating lasting change.

Since 2010, IHS has been working to address quality issues in the Great Plains Area. We have worked to improve appropriate credentialing and privileging of providers, implement policies surrounding pharmacy controls and security, and implement financial management controls. The changes made in 2010 resulted in substantial reductions in discrepancies of unit counts for controlled substances, from approximately 3,600 in 2010 to only 81 in 2015. Additionally, financial management improvements have led to increased third party collections and more timely outside provider payments through the Purchased/Referred Care system.

We have also conducted focused management oversight reviews in all 12 IHS Areas to examine policies and practices related to hiring and human resources, funds management, Purchased/Referred Care, pharmacy controls, health professional licensure, and facility accreditation. IHS submitted a report to this Committee in July 2013 that summarized the review process, findings, corrective actions, and ongoing work at the agency. We made a commitment in the July 2013 Report to Congress to continue monitoring these functional areas in its annual assessment of high-risk functions in ongoing internal management control work under the Federal Managers Financial Integrity Act and related testing under OMB Circular A-123 Appendix A. Performance measures related to the findings are in all senior leadership performance plans, and accountability for implementation of appropriate corrective actions cascades down to all responsible employees.

In early 2015, IHS initiated a new Enterprise Risk Management Program (ERM) that linked this effort to ongoing management control activities under "A-123", and added a new element to focus oversight of remediation of management control findings such as those found in the Committee's 2010 investigation. A multi-year comprehensive contract was awarded to provide expert management support in a variety of health specialty areas that will begin its second year of performance in 2016. A comprehensive view of risk, or ERM will enable IHS management to identify, prioritize, and mitigate a variety of risks that will serve to inform strategic decisions. ERM will facilitate management decisions including: allocation of resources to mitigate risk in mission-critical areas; ensure program integrity goals are met; and to prioritize remediation efforts for deficiencies in both internal and external audits.

Despite these efforts, challenges remain. Some of the biggest challenges we face in the Great Plains are associated with providing health care in rural geographically isolated communities. These include recruiting and retaining qualified healthcare staff, providing competitive salaries, and the availability of suitable housing, schools and community resources for staff. The Great Plains Area currently has over 250 vacancies for healthcare professionals and, specifically, a physician vacancy rate of 37 percent. As you can imagine, this number of vacancies hinders the delivery of safe, efficient, and quality health care. In addition, the relatively low inpatient volume and complexity of cases at some facilities does not support maintenance of clinical competencies while the geographic remoteness reduces access to training resources. These challenges are seen in most of the AI/AN communities served by the Great Plains Area, including the three of particular interest today.

The three hospitals at issue today, Omaha-Winnebago, Pine Ridge and Rosebud, have faced additional challenges, and, from October 2011 to January 2016, received non-compliance notifications from Centers for Medicare & Medicaid Services (CMS) regarding their Medicare Conditions of Participation, the specifics of which my CMS colleagues will address. IHS understands the severity of the CMS findings and has taken immediate measures to correct them and to implement safeguards to prevent recurrence. We are developing a comprehensive plan to ensure the safe delivery of care for all patients and to ensure full Medicare and Medicaid billing and payment for care at the three hospitals identified by CMS.

Since receiving the notices of non-compliance, the Great Plains Area has contracted with the Critical Management Solutions and Krasker Healthcare Consulting. They developed a comprehensive gap analysis and Corrective Action Plan for Omaha-Winnebago to correct the deficiencies CMS identified. A similar analysis is being completed for Pine Ridge and Rosebud. Corrective Action Plans are being implemented for Omaha-Winnebago, Pine Ridge and Rosebud Hospitals. We are also working to better our communication with the tribes served by these facilities as we address specific shortcomings cited.

In response to various issues at the Great Plains hospitals, a review of the Great Plains Area Office (GPAO) was conducted October 6-8, 2015 in Aberdeen, SD, by senior IHS leaders from other areas and from headquarters. The purpose of the review was to assess the GPAO level of support provided to Service Units (SU) and healthcare facilities throughout the Great Plains Area (GPA). This internal review team identified a number of challenges and made a number of recommendations for improvement. These recommendations have been shared with the staff at the GPAO. A number of these recommendations have already been implemented, including the following: a centralized Governing Board process has been instituted to make the governance process more efficient and effective by GPA; additional clinical support for the service units by adding more clinical specialists in the GPA office is being pursued. Continued implementation of recommendations made by the October 2015 GPA Office review by IHS Headquarters is underway and, most importantly, GPA executive leadership will be held accountable for continued progress through the annual performance review. The GP Area Director has been charged with implementing all 29 recommendations from the report and is currently on schedule to complete all of them during 2016. This critical directive will be included, monitored and evaluated as part of performance management plans for 2016.

IHS will implement a Quality Improvement Division within the Great Plains Area office to ensure a continued quality effort is employed throughout GPA in response to identified areas for quality improvement.

While we believe these actions will address the concerns at issue in the immediate-term, we also recognize the need for longer term solutions. IHS is addressing issues such as recruitment and retention in innovative ways, such as utilizing telemedicine, including tele-radiology, and tele-behavioral health, which has already increased the hours of available service for these specialties. At Pine Ridge, specifically, tele-behavioral health providers are seeing patients at three reservation locations, resulting in 46 hours of new services provided per month since June 2015. Pine Ridge has received equipment for a tele-health program to provide assessments of crisis patients with suicidal behavior in the emergency department. Additionally, there has been a high rate of patients who did not show up for their scheduled appointment, partially due to the lack of transportation. To address this issue, two new emergency case managers were hired and will be used to help contact patients regarding appointments and offer transportation to patients.

We have also worked across IHS to address some of the challenges we face. SAMHSA is working with Pine Ridge to provide additional resources to assist with combatting the rise in suicides, including helping the tribe secure a no cost extension for the tribe's FY 2015 Garrett Lee Smith grant, totaling approximately \$165,000. SAMHSA is also working with the tribe to secure additional funding through an emergency, non-competitive grant to fund additional services. And, the Administration for Children and Families has awarded the Oglala Sioux a grant for \$800,000 for the "Empowering the Youth Project." The goal of this project is to empower youth ages 8 to 24 to make changes in their communities, to be proud of their heritage, inspire them to celebrate life and see there is a positive future for them. We have also deployed additional Commissioned Corps officers to IHS facilities to provide extra emergency behavioral health assistance.

At a more systemic level, this year IHS is transforming its Hospital Consortium into the Quality Consortium. It coordinates activities aimed at improving the quality of care and enhancing patient safety. This level of oversight will lead to the development of the IHS as a high-reliability organization, meaning that it actively learns and adopts evidence based practices. The Quality Consortium is taking a system-wide approach to standardize and improve performance in certification, accreditation and governing body function to promote quality of health care delivery at federal health care sites.

In partnership with the Tribes and Great Plains Area Office, IHS will develop a Strategic Framework (Framework) and Sustainability Plan (Plan) to address management, quality, and business process improvements, which will include development of preliminary goals and objectives to promote sustainable practices for the Great Plains Area Office and Hospitals. Sustainability of improvement is the goal we must aim for. In collaboration with the tribes, the Framework will identify top priorities and strategies and the Plan will define and monitor targeted improvement over the next year, including strengthening the Governing Board oversight, one of the primary findings identified by CMS. The Plan will address deficient service delivery and administrative oversight as well as establish new policies, practices, and processes to support future compliance and continued performance improvement. IHS will also use lessons learned from the Great Plains Area to develop a national quality strategic plan for FY 2018-2022.

As part of overall management and accountability reforms, IHS will also implement a quarterly performance review process. The quarterly performance reviews will promote the discussion of performance measures and achievement of milestones among multiple levels of the organization and will be chaired by IHS senior staff. Discussion will include ongoing evaluation of program performance and milestone achievement as a means for informing management decision-making and resource allocation. This Strategic Framework and Sustainability Plan will foster a culture of accountability and quality improvement, by 1) clearly communicating strategic goals, 2) identifying and monitoring metrics to indicate goal progress, and 3) promoting sustainable corrective actions to improve the quality of health care services delivered.

And, at headquarters, I have recently established a new Deputy Director position to oversee and focus the agency on improving quality improvement practices across IHS. Dorothy Dupree, our new Deputy Director for Quality Health Care, has the responsibility to ensure that, in our direct service facilities, such as the three of particular interest today, provide a higher quality of care, including working with external partners like states and other federal agencies. She has first-hand knowledge of managing an IHS area and will be looking for ways to sustain quality of care throughout our system at all times, not just when CMS identifies a facility with an issue. Ms. Dupree is an enrolled member of the Assiniboine & Sioux Tribe of Ft. Peck, MT.

Working with Dorothy will be Mary Smith, an enrolled member of the Cherokee Nation, who joined IHS a few months ago as Deputy Director. Mary has an extensive background advocating for Indian people and is steeped in health policy knowledge. Mary also has extensive management experience from her time in the private sector and state government.

Conclusion

IHS is committed to working towards improved customer service and ethical behavior, fairness and accountability in performance management, stronger financial management, and an improved Tribal consultation process, to improve the quality of health care services received by our patients. We are also committed to working in a transparent partnership with the Rosebud, Pine Ridge and Omaha-Winnebagos. IHS Hospital leadership and their four respective Tribes' leadership.

Mr. Chairman, thank you again for your long-standing commitment to improve Indian health in the Great Plains Area and throughout Indian Health Service and for the opportunity to testify today. I will be happy to answer any questions you may have.

The CHAIRMAN. Thank you very much, Mr. McSwain.

Dr. Karol, I know you do not have an official statement and are here to answer questions. I do not know if you want to make any statement at this time or just wait for specific questions?

STATEMENT OF SUSAN V. KAROL, M.D., CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. KAROL. Just to let the Committee know who I am. Thank you for the opportunity to present.

My name is Dr. Susan Karol. I am a Captain in the U.S. Public Health Service. I am the Chief Medical Officer for the Indian Health Service.

I am an enrolled member of the Tuscarora Indian Nation which is in upstate New York. I graduated from Dartmouth College and the Medical College of Wisconsin. For the past 32 years, I have been a practicing general surgeon.

My role at IHS Headquarters in Rockville is as the Chief Medical Officer. I advise the director and our senior leadership of the Indian Health Service. I assist in formulating and implementing those national policies adopted by the director.

I have direct responsibility in oversight of the Office of Clinical and Preventative Service, the Office of Information Technology, the Office of Public Health Support and External Affairs for the Indian Health Service.

I work with each of the 12 IHS Area Chief Medical Officers who provide direct oversight of the quality programs and work with hospital leadership and providers at our IHS service units, military clinics and health stops.

Mr. McSwain provided our opening testimony. I stand ready to answer questions.

The CHAIRMAN. Thank you very much, Dr. Karol. We appreciate your being here and joining us today.

Dr. Wakefield, we are dealing with severe, long term problems, a pattern of healthcare facilities that are so substantial in terms of the failures that CMS and another agency in your department have actually terminated its provider agreement with one of the IHS facilities. Other facilities are in jeopardy as well.

You are a registered nurse, a Fellow of the American Academy of Nursing, Dean of the School of Rural Health at the University of North Dakota, and you were part of the Administration when Senator Dorgan had the first hearing on this. I just wonder what we can do to fix this problem in the Great Plains area, both short term and long term. What assurances can you give us that in five years we are not going to be in the same situation with the same problems identified again?

Dr. WAKEFIELD. Thank you for that question, Senator. I would say a couple of things.

First of all, in terms of short term strategies, Mr. McSwain and the IHS team are working now, immediately with assistance from our Commissioned Corps to turn around the circumstances in those three hospitals. It is our expectation that work is done as effectively and efficiently as possible. It is underway now. That is short term.

Longer term, we have two strategies we are implementing. One, we have already started implementing which is to markedly strengthen the priority focus on quality in the IHS beginning with the leadership of IHS.

You heard me talk about the expertise brought into that part of the agency at the helm of the agency on the executive team with specific priority, as I mentioned, placed on quality improvement and with expertise and with a plan to do that work that has been informed by consultation with tribes and also informed by features of that plan having already been implemented in the Phoenix area as well as in the Billings area.

Secondly, we are also convening an executive council at the HHS at the request of Secretary Burwell to focus our assets across HHS from parts of the agency that have resources devoted to this particular population to drive and leverage an agenda on quality improvement forward.

Andy mentioned CMS's role briefly in that effort. That is the second part of our strategy. First is to strengthen IHS and second, to advance this agenda with the assets across HHS.

The CHAIRMAN. We had listening sessions with tribal members in the region on the ground, visiting with people specifically. We got an earful. Tribal members have told Committee staff there is pervasive employee intimidation, retaliation, nepotism at every level of the Indian Health Service, that the employees are afraid to report their concerns, afraid to be honest and forthcoming when surveyors visit, are told not to speak with members of Congress, their staff or anyone else who might be able to help improve the conditions.

Doctors and nurses, they tell us, are afraid because they are threatened repeatedly and directly and even openly. It was astonishing the sort of things they came back and said, this is what we

heard on the ground. Their families were denied health care, reputations were dragged through the mud. They try to do something right to protect patients and report criminal activity and feel they are ostracized and pushed out.

I just want to make sure that you are completely aware of that and what we are going to do about this culture of harassment that seems to exist in the Indian Health Service.

Dr. WAKEFIELD. Our goal is to deliver high quality, consistent care. We have to have providers that are on the front lines, administrators on the front lines that share that commitment. Most of the providers in the field are absolutely committed to delivering high quality care as are the administrators.

We have bright spots in the Great Plains area. We do. We have great providers in the Great Plains area.

We also need to strengthen our management along the lines of what you just indicated. As I mentioned, Mary Smith has joined us. That is one of her priorities on the executive team of HHS. She brings experience in that area, in management and operations and it is a focus for us.

The CHAIRMAN. Mr. Slavitt, first we were told the situation at Winnebago was unique. As time went on, we heard from other tribes that they were experiencing similar problems impacting patient safety and patient care. Still the Administration claimed the issues facing Winnebago were an exception to the rule.

Then CMS sent notices of intent to Rosebud and the Pine Ridge hospitals indicating that their provider status was at risk as well. Based on the information we received, I suspect the "immediate jeopardy conditions" found at these three facilities also exists at other hospitals in the Great Plains and beyond.

I am asking how many IHS facilities have been issued this immediate jeopardy finding since 2010? Why does the problem seem to be so concentrated in the Great Plains area?

Mr. SLAVITT. As you stated, we have issued in one situation termination of our participation in Medicare and Medicaid and in two situations late last year where there is similar potential. The management of the hospitals is in the process of giving us a response to those areas.

I suggest I allow my colleague, Thomas Hamilton, to speak more specifically as it relates to the breadth of the work we are seeing across the Indian Health Service.

The CHAIRMAN. Mr. Hamilton, welcome to the Committee.

Mr. HAMILTON. Thank you. Thank you for the invitation.

As Administrator Slavitt indicated, since 2010, we have had 18 site visits on these three facilities alone. All of our survey reports are matters of public record. We appreciate the Committee had requested a number of those and carefully examined those for the results.

When we find there are serious deficiencies, then we issue a notice to the hospital scheduling a prospectively scheduled termination date which communicates a message that there will be no discussion about whether or not problems are fixed but rather, how quickly and how well. That is the situation playing out at these three facilities.

The CHAIRMAN. If I could, Winnebago's first citation after the 2010 report Senator Dorgan came out with occurred in April 2011. But CMS did not terminate the provider agreement until four years later in July 2015. Extensions have consequences. At Winnebago between 2011 and 2015, there were five extensions granted by CMS.

I wonder if standard termination procedures and timelines were followed if it might have been different in terms of patient lives possibly being saved. I wonder why it takes so long for CMS to act on its own findings and what led the agency to finally make the decision to terminate the provider agreement at Winnebago?

Mr. HAMILTON. Simply because termination occurred later does not mean that there was no activity. In fact, there was a great deal of activity. My colleagues in the Quality Improvement Group were enlisted. They got four quality improvement organizations under contract to provide direct on-site technical assistance between 2012 and 2014 to Pine Ridge, Winnebago and Rosebud facilities.

We were hoping at that point in time that a regimen of intense, technical assistance would do the job. When we went back out in April 2014, unfortunately, we found the problems had not been remedied to the extent necessary. At that time, we issued a termination notice again.

The director of the Indian Health Service at that time personally became involved. Dr. Roubideaux went out to the facility, there was a change in the executive officer, a variety of other more intensive changes were put in place. For six months quality did improve.

However, when we went back out in 2015, again, we found the gains had not been sustained and we reluctantly issued the final terminal notice from Medicare.

The CHAIRMAN. Thank you, Mr. Hamilton and Mr. Slavitt.

Senator Tester?

Senator TESTER. Thank you, Mr. Chairman. Thank you all for your testimony.

I will get right to it. Senator Dorgan brought up the point of incompetency and made a solid point. If you have someone incompetent, fire them; do not move them. Mary, do you have the capacity to fire folks in a timely manner for incompetence?

Dr. WAKEFIELD. We follow performance, government-wide standards associated with performance reviews. I have used those standards in my position as the Administrator of Health Resources and Services Administration. Yes, staff can be terminated.

Senator TESTER. This is also an argument heard a lot in Veterans Affairs healthcare that Senator Moran knows about. Is it standard operating procedure to move them around or get rid of them if they are incompetent? I am talking about employees who do not cut the mustard.

Dr. WAKEFIELD. Senator, speaking for myself, when I have had staff that have not fulfilled their responsibilities, I have applied the opportunities that I have to help relieve them of their responsibilities, yes.

Senator TESTER. Music to my ears.

Now I want to talk about recruitment and retention which is exactly opposite of what I was saying. If you have someone that is

good or someone you are trying to recruit, what parameters do you have to bring them on?

We are talking about areas, by the way, that are not like areas where I live. We do not have a doctor where I live either. We are talking about places that do not have housing, police protection is poor and Senator Heitkamp talked about it. Police protection is poor, schools are not top notch, you have no place to live and the list goes on.

What can you do to help recruit doctors into areas that are one, frontier, and two, do not have places to live?

Dr. WAKEFIELD. One of our most effective strategies as I have looked across our workforce programs deployed by HHS is the National Health Service Corps Program. That is a scholarship loan repayment program that is extremely effective in helping to pay loans for physicians, nurse practitioners, psychologists and others. In exchange, they work for a minimum of two years in an underserved area.

We have markedly expanded that program in the last five years, as I mentioned earlier. We now have 420 of those clinicians working in Indian Country with Indian populations. That is a big boost from the just over 100 that we had back in 2008. We are also focusing on retention, Senator Tester. It is recruitment but also retention.

Senator TESTER. Do you have the capacity to incentivize these folks with additional wages? For example, Customs Border Protection, there are certain areas on the northern border where they cannot get people to serve there. They gave them a quarter boost right off the top on their salary if they served in certain areas. Do you have that capacity?

Dr. WAKEFIELD. Yes, we do. We actually changed the program about five years ago to incentivize and provide more resources in terms of loan repayment and scholarship to individuals willing to serve in our greatest need areas.

I could not speak for the scholarship program out of IHS, but I can speak to the National Health Service Corps. Yes, we have done that.

Senator TESTER. Bob, can you incentivize their salary in IHS?

Mr. MCSWAIN. We do. In fact, we offer pay packages based upon what is available. If it is a scholarship recipient or if it is loan repayment, we have a loan repayment program as well.

Senator TESTER. What about salaries?

Mr. MCSWAIN. We have the authority for physicians and dentists under Title 38.

Senator TESTER. How much can you bump their salary?

Mr. MCSWAIN. I think it is close to \$300,000.

Senator TESTER. Can you get back to me with the figures?

Mr. MCSWAIN. Yes, I will.

Senator TESTER. I will have a lot of questions for the record because time is wasting. There is about a 37 percent vacancy rate in the Great Plains area for physicians. Is that comparable with other IHS regions or is that high?

Mr. MCSWAIN. I would say it is high for that area.

Senator TESTER. Can you tell me why it is high?

Mr. MCSWAIN. It is those isolated, remote locations primarily and the housing issues.

Senator TESTER. I am going to put some questions into the record because we have other folks who want to ask questions. I do want to close with one point. It is the point Senator Heitkamp brought up talking about what we pay for Medicare spending for beneficiaries, veterans and what we pay for IHS.

Senator Dorgan said it also. He said we are 50 percent. The National Congress of American Indians said IHS is about 59 percent underfunded. I want to tell you if I was a farmer and this was my board of directors and you underfunded me by half, that means I would only be able to put 30 pounds of seed down in the spring and only be able to till my land two and a half times and at harvest time, there would not be any money to cut the crop. You would ask me how come we failed.

We can put forth the best words we want in this Committee but unless we back it up with money, it is just that. It is baloney. Some of the same folks that talk about the problem with IHS vote against the budget. They vote against IHS funding.

I am telling you guys, we can point the finger at these guys but there are three of them pointing right back at us. We can talk about the challenges out there with people harassing and nepotism. We should not stand for that. The folks who are not doing their job, we should fire them.

In the end, we are never going to be successful if we do not deal with what it cost to treat people in medicine. You cannot do it with half. We can talk about what it takes to have good schools and good housing and good water because you will never get people to live there.

It is a big issue. We can talk about it and say, damned that IHS, these guys just are not doing their job and by the way, there are cases where you are not doing your job and you need to clean it up. We need to clean up our act too.

The CHAIRMAN. Thank you, Senator Tester.

Senator Hoeven?

Senator HOEVEN. Thank you, Mr. Chairman.

Again, I would like to thank Secretary Wakefield for being here as well as the rest of the witnesses.

Across the Country on and off reservation, there is a shortage of healthcare providers. Senator Tester asked about the shortage of doctors. There is a shortage of doctors just about everywhere. The reality is we do need more resources on the reservation but we also have to figure out how we leverage our resources.

I am going to start with Secretary Wakefield. In drawing on your experience at the University of North Dakota, the rural health center there which you ran and is a tremendous operation, how do you create a culture of accountability and empower people, make sure people are accountable but also empower them?

I would like for you to touch on what we are trying to do in the VA which is to create that culture of accountability and empowerment but also this concept of leveraging resources. We not only are striving to make sure that veterans can get good care directly through the Veterans Administration but also that they have vet-

erans' choice so that where you have issues of distance or time delay, they can get services from local healthcare providers.

How do you create that culture of accountability, empowerment and leverage your resources for example, like this veterans' choice concept? I am going to ask both Administrator Slavitt and Mr. McSwain that question as well.

Dr. WAKEFIELD. In terms of leveraging resources, I think we have to be real smart about what we are doing with regard to deploying our resources as efficiently as possible. I talked a couple of times about the National Health Service Corps Program. This puts primary care providers in the field.

Most of the National Service Corps providers go to rural areas. From my vantage point coming out of the Great Plains, that is a good thing because we have such significant shortages there. As we leverage them to provide primary care, that frees up resources to staff out the acute care facilities we are even talking about here today. To your point, it really is about ensuring that we are not creating redundancies but are establishing systems that are working together collaboratively among the programs that play out on the front lines.

In terms of accountability and supporting recruitment, we recently have spent more time focusing on retention, recruitment and retention and not just trying to retain an individual in a location based on what we are doing at the Federal level, but we are working with the local community.

Quentin Burdick Hospital in Belcourt is a good example of that. We have a core of clinicians working together. It is that core nucleus and looks a lot like Hettinger, North Dakota, Senator Hoeven. You will know that experience of creating a local culture within the community that is supportive of that set of clinicians and clinicians supportive of each other in terms of the delivery of high quality care. We have bright spots.

Senator HOEVEN. Those are great models. If you can help your team replicate those, you will go a long way to solving these problems. Those are great models.

Dr. WAKEFIELD. They are great models. The Quentin Burdick model at the Quentin Burdick Hospital is a direct service hospital. It is the type of hospital we are talking about here today.

Our aim is to achieve consistent, sustained quality care across our direct service facilities. We have those models in hospitals that already exist. It is a lot about focusing on the individual provider, but it is the community as well and helping communities establish a culture of support for those clinicians.

Senator HOEVEN. I like your giving those concrete examples. That is very helpful.

I would ask Administrator Slavitt the same question, particularly leveraging resources. Across the Country, nobody is providing adequate health care without leveraging resources because of the tremendous demand.

Mr. SLAVITT. Thank you, Senator.

There are three things in our experience that are important here. The first is transparency from the bottom to the top. Unless problems can be identified, they cannot be fixed. Obviously, that is critical.

Second is the leadership and engagement and the culture that my colleague, Deputy Secretary Wakefield, pointed to. The tone has to be set that it is okay to share these problems and people have to get engaged in those details.

Third is accountability and resources. People need to feel like they can succeed, we need to know who is held accountable and as those things come in place, as my colleague Mr. Hamilton said and as Mr. McSwain said, there has been good leadership that has moved into these hospitals. When that has happened, we have seen progress. That should encourage us that we need to keep moving in that direction.

Senator HOEVEN. Director McSwain.

Mr. McSWAIN. That is absolutely correct. I want to second Dr. Wakefield's notion about Quentin Burdick. There is a model that has good leadership. We are finding if we can get good leadership, they can recruit people.

The other part of it too is they do not have as many contractor physicians who rotate out. Their vacancy rate is 12 percent. You heard about the total vacancy rate for the whole area is 37 percent. They are at 12 percent. Why is that? It is leadership. It is the core staff. That is the model.

To leverage that, I read your question a little more insofar as we are reaching out to other people, the VA, to pay for Indian vets, reimbursements. We are reaching out and leveraging our resources which are limited to other resources that might be available that would treat our population.

As Dr. Wakefield said, in working with the rest of the department, there may be other opportunities that exist in the department that will come to bear on our problems.

Senator HOEVEN. The leadership, the leveraging and then metrics, if you install metrics and can come back to us with metrics to show progress and deficiencies, it is very important and really helpful in what we are trying to do here.

Thank you.

The CHAIRMAN. Thank you, Senator Hoeven.

Senator Heitkamp?

Senator HEITKAMP. Thank you, Mr. Chairman.

I have a couple quick questions. Mr. Slavitt, when did CMS actually notify not just the hospitals but the leadership of Indian Health and potentially the Secretary's office about these deficiencies?

Mr. SLAVITT. I am going to ask my colleague to walk through the specifics and the timeline but our process is as soon as we are aware, we make the local representatives on the ground aware. In this particular case, Mr. McSwain and I spoke immediately upon the determination. I called him and we had a very direct conversation.

Senator HEITKAMP. Are we talking about immediately upon the determination of deficiency or immediately upon the determination that you were no longer going to certify an IHS hospital?

Mr. SLAVITT. Talking about both. In the case of the deficiencies, those were communicated as reports are completed at the local level. In the case of my conversation with Mr. McSwain, that hap-

pened in the case where we were going to notify they that were terminating.

Senator HEITKAMP. I might suggest that in the future you not leave it up to just notifying the local people at the hospital. Obviously, we had an information gap here where people who should have been responsible immediately for change were not notified. That concerns me.

Deputy Secretary Wakefield, when did the Secretary's office become aware of the problems in these hospitals?

Dr. WAKEFIELD. Senator Heitkamp, I will have to get back to you with an answer to that question. I would be happy to do that. I am sorry I could not speak to it specifically. I know that is what you are asking for, a specific date.

Senator HEITKAMP. The point I am trying to make is that you all work under the same umbrella. We can talk about miscommunication and talk about metrics, but you have to all be communicating with each other.

The other point I want to make is the extraordinary difficulty of serving a population with chronic disease, with a lot of history of trauma, a lot of history of challenges, both behavioral and mental health.

We see it in the substance abuse. We see it in high rates of suicide. We see it in chronic disease being reflected from these conditions.

I am a big believer, as a lot of people at SAMHSA, a lot of people working on this, that we can do better in terms of treating the whole person so we continue to treat chronic disease and never really get to the problem.

I am wondering what IHS is doing and what HHS is doing to begin to address things like trauma informed treatment, begin to address merging this curative medicine model with behavioral and mental health model so that we can treat the whole patient.

Deputy Secretary Wakefield?

Dr. WAKEFIELD. Secretary Burwell asked the Administrator for Native Americans at the Administration for Children and Families to lead our HHS-wide effort on exactly this area. That is to develop what would be a comprehensive, integrated department-wide approach that stems from an understanding and the evidence based around historical trauma. That is department-wide. That is under-way.

We are looking forward to consulting closely with any member of this Committee who is interested in tracking against that work as it pushes forward.

Senator HEITKAMP. I hope as we are looking at recruitment and retention, we are looking at recruiting a new kind of physician, people who actually have received this type of training because I think it is critical if we are going to have long term better outcomes that we change the dynamic of how we deliver the service.

Finally, I want to make the point that no one here should be happy with this outcome. My frustration always is that there is almost a culture of failure. What can we do? There is nothing we can do.

Yes, we have an obligation to fund but you have an obligation to come with the plan that changes outcomes. You have an obliga-

tion to tell us what you need. My frustration always is we are going to rearrange and I am not saying that is the response we are getting, but rearrange the deck chairs on the Titanic because it is going to go down anyway.

Let us not have this hearing again in five years. Let us come back, have constant communication about what we are doing, how we are changing outcomes and make sure whatever you do that this is done in consultation with the tribes because the people who are most concerned about these outcomes are the tribal elders, the tribal leaders, the mothers and fathers and people who see the core of the lack of delivery of health care every day.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Heitkamp.
Senator Daines.

**STATEMENT OF HON. STEVE DAINES,
U.S. SENATOR FROM MONTANA**

Senator DAINES. Thank you, Mr. Chairman.

I first want to give a warm welcome to Jace KILLSBACK, the Executive Health Manager of the Northern Cheyenne from Lame Deer, Montana. It is great to have you, Jace. Thank you for appearing on this next panel.

I would like to begin by noting that on top of facing the bureaucracy of the Indian Health Service, which we have discussed at length today, tribes are being hit with massive fines under Obamacare which is why we have introduced the Tribal Employment and Jobs Protection Act.

It exempts tribal employers from Obamacare's employer mandate. I am hearing about this from virtually all of my tribes back home in Montana. I hope through efforts like this with this legislation, we as a Committee and as a greater body, must continue working to uphold the United States' trust responsibility to Indian tribes while honoring this very important government to government relationship.

I recently heard from a constituent of mine, in fact I have the email here, who was a member of the Assiniboine Tribe of Fort Belknap who contacted me to voice the hardships she has faced in seeking treatment through IHS. Listen to this story.

She drove 35 miles to the closest IHS facility, spent four hours there waiting for medication and then drove all the way home to find out she had been administered the wrong medication. This is all contained in the same email from one of my constituents.

She described the way the IHS had treated her on multiple occasions as with extreme negligence. In fact, when she called and told them she had the wrong medicine, they told her to flush it down the toilet. This is in the context of where we have certainly abuse of prescription drugs and sometimes a lack of control.

Problems like this have been happening for decades. The fact they are happening today is unacceptable.

I want to point out something else. As Al Franken said back in 2010 when this was first discussed, "We cannot keep throwing good money after bad." In fact, in your testimony, you stated that under this Administration, funding for IHS has increased by 43 percent.

However, the issues we are addressing today are not the result of underfunding. Plain and simple, this is an issue of oversight, an issue of accountability, an issue of failing to follow through on promises and basic responsibilities to Indian Country.

I do not think this is a healthcare system. I think this is a healthcare tragedy. I spend a lot of time with the families in Indian Country and seeing the outcomes of a system that is very, very broken. It is a real tragedy. We are dealing with the lives of real people, grandmas and grandpas, children and moms and dads suffering and dying prematurely.

Mr. MCSWAIN. Dr. Wakefield states that the challenges facing hospitals in Indian Country and those IHS is responsible for helping address include difficulties in recruiting and retaining qualified healthcare providers. What specifically have you done and what are you doing administratively to address the difficulties of retaining as well as recruiting qualified healthcare providers, as well as the low volume of these providers?

Mr. MCSWAIN. We are using all the mechanisms available to us by existing authorities and requesting additional authorities, but a lot of it has to do with pay because we need to be competitive and be able to get them onboard. That is a big issue as you can well imagine.

There have to be enough incentives to go to an isolated location. Those are the incentives that we are working on. We have requested to expand some of our pay authorities. The other has to do with working more closely with the tribes on what is needed in the community. That is another area we are working on.

I know Dr. Karol has been working heavily on that. If you do not mind, I would like to have her respond as well.

Dr. KAROL. I think a big part of our recruitment and retention package is also the work we have been doing with our scholarship program. I am a good example of that. I am an IHS 437 scholar. Basically it puts Native students into medical school, nursing school, dental school to get them educated and brought back either to their home tribes or to others.

We have a loan repayment program. We are working with the United States university health systems, USUHS, in Rockville to educate at least two students a year who come back to our areas. Previously, they have been assigned to return to the Great Plains area so there are a number of students over the last few years that did come to the Great Plains area. We can give you more information.

Senator DAINES. On the pay gap, how much is enough? What are the gaps approximately in percentage that we need to address the recruiting and retention issue? How far apart are we?

Dr. KAROL. One example is emergency room physicians across the Country make about \$350,000. Our Title 38 brings them in at about \$220,000 to \$240,000 so there is a gap there.

Senator DAINES. Thank you. I am out of time.

I know the Committee staff has been provided examples of where additional dollars have been put in but unfortunately were consumed on the administrative side of this instead of going to paying for providers actually on the front lines treating people and patients. That is another discussion to have.

Mr. Chairman, I am out of time.

The CHAIRMAN. Thank you very much, Senator Daines.

Senator Udall?

Senator UDALL. Thank you, Mr. Chairman.

Director McSwain, I understand the IHS is working to get emergency resources for the NCI Detox Center in Gallup. As I mentioned in my opening statement, I believe there is a real public health crisis going on there. There is a real risk this center may close in a matter of weeks.

The community is alarmed. We alerted you to this. When critical public health facilities close, people are going to die. That is what is going to happen.

How can the IHS plan to work collaboratively and creatively with tribes and local officials in Gallup to fund a long term solution to this funding issue? How can the agency better leverage its resources to help address crisis situations like the one in Gallup, New Mexico?

Mr. MCSWAIN. Senator Udall, as you know, we actually have identified resources that we are sending out. We are moving it through the Navajo Nation. That is the vehicle. Our relationship is with the Navajo Nation. We are going to be moving on a short gap and then we are having conversations with others like our partners at SAMHSA about long term strategies to maintain that program. It is a vital program certainly for the Gallup community. That is one we desperately need to complete. That is what we are doing right now both short term and long term.

Senator UDALL. Thank you very much for that work.

As we have heard today, IHS facilities across the Country experience interruptions in service due to staffing issues, poor facility conditions, and deficient patient care. I mentioned Crownpoint as the recent glaring example in New Mexico.

The emergency room in a rural area closed for over a month. Thankfully the situation has improved but I remain very concerned about the long term success there and at other New Mexico IHS facilities and as we have heard, facilities across the Country.

What is HHS's plan to address these serious, ongoing staffing issues at IHS facilities and then the bigger issue we are talking about which is this whole issue of 50 percent under funding? Senators Tester and Heitkamp mentioned it. The National Congress of American Indians talks about 59 percent.

Normally what has happened in these kinds of situations that I have seen in the past is an Administration steps forward. You know you cannot do it in a year but you step forward with a plan, a five year plan and we are going to wipe out this under funding.

I hope with this hearing and the attention given to this that President Obama and your agency will step forward and give us a plan so we can get people to see here is the plan and who will vote for and support it because that is what is really needed here. Please go ahead.

Dr. WAKEFIELD. We agree that there absolutely is a need to fill the gap, not just to recruit into underserved areas in Indian Country but also to retain those clinicians. There will not be just one strategy to accomplish that, it is going to be a set of strategies.

We have already been talking inside the agency. You talked specifically about emergency departments. One of the strategies we have focused on, and Mary Smith, the individual I mentioned who has been brought into the leadership of IHS, is focusing on, is a much more comprehensive approach to thinking about deploying telehealth technology.

I am from a rural area. I know the difference that can make. We have in Montana and also out of Arizona associated with our direct service facilities, direct service hospitals, the application of telehealth technology.

In Pine Ridge, for example, we have telebehavioral health. We have tele-ED out of Montana. That is one strategy but again, it will take a number of strategies. That is one strategy that I do not think we are leveraging as comprehensively as we could.

It is important to back up those frontline providers and emergency departments that may see infrequently a particular case come in with special healthcare challenges. It is also an appropriate technology to use in connecting to specialty services, sort of a backup of primary care providers on the front end and also to deliver specialty services into particular areas.

I mention that because you mentioned emergency departments specifically. We have some resources going into telehealth technology applications. We will continue to look at that and push the boundaries of that in our planning going forward.

Telehealth does not solve it all. That is simply one strategy. Another strategy is also to make sure that we are investing in primary care providers to free up providers to provide care in acute care settings.

I talked already about National Health Service Corps clinicians but should have also mentioned we have markedly expanded over the last five years our community health centers. As a result, today, our community health centers probably since about 2009 are seeing 30 percent more American Indian, Alaska Natives than they did four or five years ago.

That is good news because that allows us to free up resources and personnel to be able to provide other non-primary care services, a set of strategies from expanding technology but also expanding the provider pool in a more comprehensive way rather than looking at this specialist by specialist, and rather leveraging those assets together.

Senator UDALL. Thank you very much for that answer and for looking at this in terms of strategies. I am a big supporter of telehealth and many of the other strategies you mentioned. If you put them forward, you will get a lot of support from this Committee and in the Congress.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Udall.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman, again for the opportunity to ask some questions and participate in the hearing.

I too want to echo what was said. One of the things I hope comes out of this is better use of telehealth and telemedicine. We have three regional health systems in South Dakota, all of whom have done some pioneering work in the area of telehealth technologies.

That is a way, I believe, that we can do a better job of delivering healthcare services not just in our tribal communities but in rural areas of the Country. I would encourage you to carry on with that.

Secretary Wakefield, in your oral testimony you noted the hiring of additional administrative staff, two new deputy directors and created executive level working groups, is that correct?

Dr. WAKEFIELD. Yes.

Senator THUNE. Did IHS consider using that funding at the local level to invest in additional providers, those that directly serve patients or to address the emerging situation in Rosebud and Pine Ridge?

Dr. WAKEFIELD. I would ask Mr. McSwain to speak to additional clinicians and administrators that have been or are being seeded into those three facilities.

I would say the resources that we have committed at the local level from HHS, not from IHS, into that region are additional Public Health Service Corps clinicians, physicians, nurse, quality improvement experts into the Great Plains area to focus very sharply on the current challenges we have right now. They are there on the ground, have been on the ground and will continue to stay there as we work to stabilize and strengthen those three facilities and more broadly the area.

With regard to the two positions I mentioned, I think these two positions are absolutely critical. We have to have a much sharper focus on quality improvement if we are going to sustain and strengthen the quality of care that IHS is responsible for delivering. That starts at the top.

We have a tremendous expert we have brought to the table and were fortunate to get her. She has a plan that can be operationalized. It is concrete. I am not talking about it in the abstract. There are very specific strategies. I have looked at that plan. I have had people from CMS and the Federal Office of Rural Health Policy look at that plan.

Her expertise at this level and that priority for that agency is one of our major strategies to begin to do the work, not just in the Great Plains area, but across Indian Health. This is a reset. This is a reengineering of how we are doing our work and our focus on quality.

I think those two positions at the executive level set the tone for what we need to be focusing on, making this a top priority. It is for us.

Senator THUNE. I guess I would say in addressing the situation, I am glad you are putting that kind of spotlight on it and focus, but I think it is important to remember that the solution to every problem is not growing the administrative size of the agency. We want to get people on the ground delivering healthcare services, doctors and nurses inasmuch as you need somebody that is going to do this.

I hope that this time it gets done because after the 2010 report, there was a paper put out that had a strategy that was going to be implemented in the Aberdeen area. The Aberdeen area responded to that report with their own report about all the things they were going to do. In 2013, we had another report about all the

things that were going to be done and none of the stuff gets implemented.

I guess my point is that when you look at these issues, clearly there are problems up the food chain and there is not the efficient oversight, follow through and implementation and all that. I am glad you are rightly focused on that.

I think it is really critical that we get the help to people on the ground where we have the needs not being met and the conditions that have been so well documented.

Mr. McSwain, I want to follow up with that because there was a lot of work done in 2010. The Committee report created this program integrity coordinating council that was to make recommendations for changes within IHS. As I said, they reported and the Aberdeen area responded with specific plans to better the region.

Who was responsible at that time for compliance with the July 2011 plan?

Mr. MCSWAIN. You are testing my memory but let me answer the other question you had about staffing at the local level. Bear in mind we are talking about a 37 percent vacancy rate. How are we actually filling those positions? We are dealing with contractors. We would like to get away from the contractors because the contractors are costing us at least triple. That is another point.

Getting back to your question about the program integrity coordinating council oversight and the actual work group that went into that, during that time, actually I may have been that in my previous job. I may have been the Deputy Director for Management Operations and therefore was actually overseeing the activities going on out there until I was changed out.

That particular report focused on helping the agency move ahead with addressing the report itself, the report findings, some 19 findings. We walked through all of those items. We actually made very good progress on some of those items. Some of them are still very challenging.

Senator THUNE. To your knowledge, are the reports submitted on the 30th of each month, something called for by each hospital outlining the level of compliance with the CMS conditions of participation, a requirement of the July 2011 plan, are those reports submitted, to your knowledge?

Mr. MCSWAIN. Yes.

Senator THUNE. On the 30th of each month?

Mr. MCSWAIN. Yes.

Senator THUNE. How is it possible that three hospitals in the Great Plains area have failed to satisfy the conditions of participation? Were IHS officials in the Great Plains area just rubber stamping these documents? How did this happen?

Mr. MCSWAIN. They were not rubber stamping so much, Senator. They were taking and processing them through. What happened on the surveys is, and I will defer to Mr. Slavitt and Mr. Hamilton, but there were times where we actually achieved satisfaction on the surveys.

Then, as I think Mr. Hamilton mentioned, we failed again. We fell back, so that was a year later. We achieve and then we fail. That has been the cycle. I think Dr. Wakefield is saying we want to sustain while we are up there and continue to move forward.

Senator THUNE. My time has expired, Mr. Chairman. There are some questions I would like to submit for the record.

I would say in closing that in response to Secretary Wakefield's comments about creating a structure or model, that this time it has to work. Mr. McSwain, even in response to the 2010 report, we are not sure exactly who was responsible.

I am saying there has to be accountability. There has to be a chain of command, the buck has to stop somewhere to prevent these sorts of things from happening and to ensure that the conditions we have been finding and that CMS is responding to just do not happen again. That will take a lot of work on the part of a lot of people.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Thune.
Senator Franken.

**STATEMENT OF HON. AL FRANKEN,
U.S. SENATOR FROM MINNESOTA**

Senator FRANKEN. Thank you, Mr. Chairman, for holding this hearing.

I want to thank Senators Thune, Heitkamp and Rounds for requesting this hearing and Senator Tester as well.

I want to clarify something. What I said in 2010, I do not know if I necessarily said you cannot throw good money after bad. That might be a paraphrase of something I was saying. We did a word search for that and we do not quite have that.

What I was saying was that we kind of a catch 22. We have members who do not want to increase funding because the bureaucracy is dysfunctional but you have a situation where the system is dysfunctional because it does not get enough funding.

I think that is the nub here. I do not want to be taken out of context.

Senator Heitkamp brought this to the Committee, to the hearing today. She has gone over it, Senator Tester has referred to it. Average spending per capita in the United States on healthcare is \$8,097 as of 2014. The average for IHS per user is \$3,600, less than half.

Add to that everything we have talked about in this Committee in terms of housing, in terms of education. When you are attracting a healthcare provider to a hospital or clinic, if they are married, you are also recruiting their wife or their husband and their kids. It matters to that spouse what the schools are like.

How much do we spend on the schools? How much is spent on law enforcement considering that we have the levels of violence that we have? When I am quoted as saying, you cannot throw good money after bad, that is not what I was saying.

We had a hearing on suicide a few months ago. We have an epidemic of suicide in Indian Country. Senator Heitkamp talks about this all the time, talks about trauma, cultural trauma, but there is individual trauma. If you are living with another family, the chances are exponentially higher that you are going to see violence or domestic abuse or drug addiction.

Though we spend less than half per American Indian on health care, we have heard in the testimony that the health condition of

the average Indian Native American is not as good as the average non-Indian American.

We have to get real about this. I tried to get an \$11 million loan guarantee for energy projects in the last omnibus bill. After we had that hearing on suicide, I asked for that member's support and that member said, is there a paid for.

When we did the doc fix, \$120 billion was not paid for but I could not get a member here on Indian Affairs after a suicide hearing where we know that unemployment on Pine Ridge must be 75 percent, I could not get \$11 million for economic development so people could have jobs. Please staff, "in context."

Let me ask about telehealth. I know I am over my time. Is there a problem with broadband in Indian Country because we are talking about telehealth? I think telehealth is great. I am co-chair of the Rural Health Caucus. I know the importance of broadband for telehealth.

Dr. WAKEFIELD. I cannot speak specifically to broadband in Indian Country but I assume that it is going to be very similar to what I am going to say in terms of rural areas at large, so we do not have access to broadband across rural America but probably the bigger challenge in some respects or an additional challenge, I should say, is the cost associated with broadband.

You are right, that can be a rate limiting factor to implementing telemedicine, yes.

Senator FRANKEN. Mr. McSwain?

Mr. MCSWAIN. Agreed. I agree with Dr. Wakefield. It is the cost of the broadband. We have had examples of challenges in Alaska, for example, where they have to rely on broadband. I heard of a case where the person was going to send an x-ray result and had to send it tonight so they can get it tomorrow. That is how long it took to get there.

There are challenges about telehealth but I think more importantly, it is the staff support for telehealth on both ends.

Senator FRANKEN. I think everyone on this Committee agrees with that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Franken.

Director McSwain, you have been around from previous Administrations and spent decades doing this. You know the agency well.

I have a number of tribal resolutions and letters addressed to you and others seeking the removal of some specific IHS employees. I know Senator Heitkamp you asked a specific question during this.

The joint resolution was adopted by the Omaha and Winnebago Tribes on August 12, 2015. It specifically identifies a number of underperforming IHS managers. As far as we can tell, these people have been shifted around the Great Plains area, in many cases given pay raises and promotions, not fired even though most of these people seemed to be directly responsible for the violations that were cited in the CMS surveys we are talking about today.

I would like you to explain to the Committee why these people are still employed by the IHS?

Mr. MCSWAIN. I would be happy to speak with you not in this public setting only because of personnel issues and privacy issues

with the employees and perhaps provide a full response to that question.

It is a good one and I appreciate the question, Mr. Chairman, but we would need another forum to provide the response.

The CHAIRMAN. I appreciate that and the confidentiality of workers and those issues but it does highlight the concerns that all of us on the Committee have about the ability to deal with problems when they exist. If they cannot be dealt with, how do we solve the problem?

We have heard from some of our colleagues money is an issue. We also hear about lavish expenses, that so much of the money ends up at headquarters rather than being spent to actually take care of people.

You would be astonished how many heads in the audience are shaking yes as I say that, Director McSwain and the smiles that coming to the faces because they know that is the case. There are huge concerns about that.

Dr. Karol, I wanted to visit with you about one other thing. There was a December 4, 2015 conference call with congressional staff and HHS officials. My report is you almost brushed off concerns raised by the congressional staff about an incident described in one of those CMS surveys saying "If you only had two babies hit the bathroom floor in eight years, that is pretty good."

I want to be absolutely clear. You and I both took the same Hippocratic oath, we are both physicians. You have a professional duty, a trust responsibility, a moral responsibility to our patients seeking care. I just wonder if you would like to say anything about that and perhaps straighten out the record, clarify or say things to the folks here including the young mothers who you referenced on the call and the tribes actually impacted by this?

Dr. KAROL. Thank you, Chairman Barrasso.

Yes, I would like to say something. I am the Chief Medical Officer for the Indian Health Service. I am a Native and I am 100 percent committed to the Indian Health Service.

Those comments are totally unacceptable, were really made after a long day. You know we all work very hard. I really am sorry that I made any reference to any negativity to patient care. My 100 percent priority is improving patient care, providing quality is my highest priority.

Thank you.

The CHAIRMAN. Thank you.

Senator Thune, I know you had a question?

Senator THUNE. I have just one question, Mr. Chairman, for Mr. McSwain because this came up earlier and was in sort of a passing sense.

I want to ask the question, to your knowledge is IHS still discouraging IHS employees from communicating with Congress and tribal governments?

Mr. MCSWAIN. No. We actually have a process whereby if they are going to make a statement to folks that we know what they are going to be saying, that it is accurate and correct. Aside from that, there is no prohibition at all.

Senator THUNE. I would just say I hope you will revisit this with your department because I will tell you personally from my staff's

experience, we continuously have issues gaining information from IHS employees who observe some of these incidents but are fearful to step forward.

It was an issue identified in the 2010 Committee report. I would like to remind you and your entire staff that it is against Federal law to interfere with an employee's right to speak with Congress. I think if some of these employees had been able to come earlier, we might be having a different hearing today.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Thune.

Senator Heitkamp.

Senator HEITKAMP. Mr. Chairman, I have just one point.

I almost got jealous listening to Senator Udall. Do you know why? We do not have any place for detox in North Dakota. It is a desperately needed service. In a recent visit with a tribal chairman, he told a story about tribal police being called. A woman high on methamphetamine was coming down and they had no place to take her. As they left, she walked to the church, sat on the steps of the church and froze to death.

It is not just about the quality of care. It is access to care. If we do not build access to detox, substance abuse, rehabilitation, we will always fail. Those conditions add to and exacerbate chronic disease.

We have record amounts of smoking. The highest rates of smoking in this Country occur among Indian people. We know what that means in terms of diabetes and chronic heart conditions.

We not only need to look at how we do better with the services we provide but we need to think about new services. I asked Senator Barrasso if he had detox. I do not know if South Dakota has any detox but let me tell you, this is a desperately needed service in the Great Plains region.

The CHAIRMAN. I want to thank all of the members of the panel for being here. I would remind the Administration our work is not complete. I look forward to continuing dialog including Committee briefings, listening sessions and more hearings.

We do expect prompt, thorough and accurate responses. Some members may have some written questions as well. I hope that you would get back to us on those.

This concludes our second panel. Thank you for being here.

We will now hear from our third panel of witnesses who have traveled a long way to be here today. We welcome each of you to the panel. I will remind the witnesses your full testimony will be made a part of the official hearing record.

Before we move forward with the testimony, I want to thank Sunny Colombe for her efforts to be here today. Unfortunately, due to weather, she was not able to be here to testify. We are very fortunate to have the Honorable William Bear Shield here today to provide testimony to the Committee. He is the Rosebud Sioux Tribe Council representative and sits on the tribe's health boards. We thank you for being here.

I also ask all of the members to please try to keep their statements to five minutes so that we have time for questions. I look forward to hearing testimony from each and every one of you.

As the panel takes their seats, I would like to turn to Senator Thune to introduce a special guest from South Dakota.

Senator THUNE. Thank you, Mr. Chairman.

I would like to introduce Sonia Weston who was mentioned earlier from the Oglala Sioux Tribe. Sonia is an enrolled member of the Oglala Sioux Tribe as well as a four time elected member of the Oglala Tribal Council.

She graduated from Oglala Lakota College in 1996 with a Bachelor of Arts in Business Administration. She served two terms on the Pine Ridge High School Board and currently serves on the Tribal Public Safety Review Board, Personnel Board and as the Chairwoman of the Health and Human Services Committee.

Sonia has been a longtime advocate for improving health care for Lakota people. I have enjoyed working with Sonia and her insight and expertise is greatly appreciated. I want to thank her for being here today and look forward to gaining her insights.

I will also mention Mr. Willie Bear Shield who is an enrolled member of the Rosebud Sioux Tribe. He received an honorable discharge from the United States Army in 1991 where he was a combat veteran in Desert Storm.

He returned home and shortly after was elected to the tribal council on which he currently serves. Willie is also the chairman of the Tribal Health Board and is a member of the Great Plains Tribal Chairmen's Association and the Unified Tribal Health Board.

I have the deepest admiration for Willie's dedication to his country and the people he represents. As you will see and hear, Willie is passionate about what he believes in and fights for.

Thank you, Mr. Bear Shield for being here today. Thank you for your service to this great Country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Thune.

With that, we will start in order with the Honorable Victoria Kitcheyan, Treasurer, Tribal Council, Winnebago Tribe of Nebraska.

STATEMENT OF VICTORIA KITCHEYAN, TREASURER, WINNEBAGO TRIBAL COUNCIL

Ms. KITCHEYAN. Good afternoon, Mr. Chairman and members of the Committee. My name is Victoria Kitcheyan, an enrolled member of the Winnebago Tribe, currently serving as Treasurer of the Tribal Council. I thank you all for holding this very important meeting.

I want to thank all those who have taken a personal interest in our crisis and have done things to elevate our concerns.

I am here today with a heavy heart. I carry the burden of the countless tribal members who have been harmed at the IHS, including the five defined in the CMS survey who died unnecessarily.

I carry the burden of the mourners and the concerns of the tribal members who are afraid to go to the Winnebago Hospital as we speak. It has been said in my community that the Winnebago Hospital is the only place you can legally kill an Indian. It is 2016 and our people are still suffering at the hands of the Federal Government. Kill the Indian, save the IHS sounds appropriate.

It is terrible what is going on at Winnebago. For decades and generations, IHS has had a notorious reputation in Indian country but it is all we have to count on. We do not go there because they have superior health care; we go there because it is our treaty right and we go there because many of us lack the resources to go elsewhere. We are literally at the mercy of IHS.

Since 2007, there have been documented deficiencies at the Winnebago Hospital. My community believes that it is the dumping ground for poor administrators and unskilled providers.

The back to back CMS findings have given our concerns some credibility. It took the loss of our CMS certification to finally bring light to the real issues going on. We thank you CMS for highlighting that and bringing us to this point.

The Winnebago Hospital has a variety of issues from mismanagement to collusion, waste, fraud and abuse but most importantly, we are at the hands of a dated bureaucratic system that is not offering quality health care to many of the deserving Native patients it serves.

We have a nurse who cannot properly administer a dopamine drip. We have an ER where nobody can find a defibrillator as a patient lies dying. We have a nurse who does not know how to call a Code Blue. All these things happened and are noted in the CMS report. It sounds ridiculous but it is true and our people have experienced this.

Mr. Chairman and members of the Committee, I know you all have families and close friends you love and we have all lost someone at some point. It is painful and even more heartbreaking to learn that your family member died at the hands of a Federal employee at a Federal facility.

The hospital is supposed to be a place of healing, yet our people go there and are leaving in worse condition or not at all. God rest those souls.

Our relatives do not have to die in vain. If you take a look at page four, there are some details in my testimony. Our relatives also do not have to be minimized to a patient number. Our relatives have names, Debbie, Shayna, Paulie, to name a few. I could go on and on but the point here is that these people had a role in our community and a place in our hearts.

My Auntie Debbie was cited in the 2011 CMS report. She was overly medicated and left unsupervised. Even though the nursing staff was aware of this, they neglected her, she fell and it was undocumented. When we requested the chart, we met resistance. My other aunt was retaliated against when she was a nurse at the hospital because of our inquiries.

Bad decisions continue to happen. Just yesterday, our hospital was closed down due to the blizzard and patients were being diverted to Sioux City, 20 miles away. It took an hour and a half to drive there. Our EMTs, our crews and patients were put at risk while a doctor and nurses sat collecting a paycheck in the ER. This is unacceptable.

A corrective action plan is in place but it is useless to us when, excuse me, but stupid decisions are being made on a daily basis that affect our tribal members and the many other tribal members that facility serves.

The Winnebago Tribe is fed up. We have had enough. We have lost all confidence in the IHS. We have begun a draft planning phase to assume control of that facility through the PL 93-638 compact but it cannot happen soon enough.

As I stated, just yesterday, these things were happening. Someone could have died. Someone could have wrecked or died of exposure. It was that bad, yet these decisions are being made on behalf of Native people.

Mr. Chairman, the Winnebago Tribe truly appreciates all you have done. We have some solutions we would like to offer in the listening session. We stand willing and anxious to work with you, members of the Committee and our fellow tribes in the Great Plains region.

We cannot stand by and let this happen to any other tribe. IHS is killing our tribal members, patient by patient. This tragedy cannot continue.

We thank you.

[The prepared statement of Ms. Kitcheyan follows:]

PREPARED STATEMENT OF VICTORIA KITCHHEYAN, TREASURER, WINNEBAGO TRIBAL COUNCIL

Good afternoon Mr. Chairman and Members of the Committee:

My name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska and I am currently serving as Treasurer of the Winnebago Tribal Council. Thank you for holding this very important hearing. Your Committee's interest and your personal involvement in this matter is encouraging as we work collaboratively to improve the health care provided to our people. I would also like to thank the Members of our Nebraska and Iowa Congressional delegations, who have given us a great deal of support in these past few months, as well as the Members of the South Dakota and North Dakota Congressional delegations and the House and Senate Appropriations Committees. Without all of this support, none of the preliminary improvements that we have seen in these past few months would have happened. We also appreciate the work of the other Tribes in Nebraska and the Tribal leaders and staff of the Great Plains Tribal Chairmen's Association, the Great Plains Tribal Health Board and the National Indian Health Board, all of whom have gone out of their way to assist.

The Winnebago Tribe is located in rural northeast Nebraska. We are served by a small thirteen (13) bed Indian Health Service (IHS) operated hospital, clinic and emergency room located on our Reservation. This hospital provides services to members of the Winnebago, Omaha, Ponca and Santee Sioux Tribes. It also provides services to a sizable number of individual Indians from other tribes who reside in the area. Collectively, the hospital has a current service population of approximately 10,000 people.

The Winnebago Tribe has already provided the Committee staff with a number of documents, including numerous independent reports from the Centers for Medicare and Medicaid Services (CMS) and a report from the independent contractor hired by IHS last fall to evaluate the facility. These materials document in great detail the appalling conditions which exist at the IHS hospital in Winnebago. I would ask that these materials all be incorporated into the record of this hearing.

It would be impossible to cover everything contained in those hundreds of pages, so I will summarize a few of the very disturbing problems that these outside investigators uncovered. Many of these are problems that the Winnebago Tribe has been pointing out for years, but which have remained unaddressed. Many of these issues were also documented in this Committee's 2010 Report "In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area", which is now known as the Great Plains Area. Since 2010, the situation has moved from bad to worse and we are anxious to work with you and the other Members of Congress to find real concrete solutions. This is imperative because people's lives are literally at stake.

Because my testimony will be highly critical of the IHS, I would like to note that there are a number of fine and talented people who work for that Agency. Many of these individuals are as appalled as we are about what has happened at the Win-

nebago Hospital and are working hard to find solutions. Some are even risking their careers to accomplish this goal and have had to seek whistleblower protection for choosing to report incidents at an IHS facility. We thank each and every one of those fine IHS employees who perform a difficult job correctly under difficult conditions. We therefore call upon this Committee to protect every federal employee who stands up and does what is right.

Before I provide you with the history of the CMS findings at the Winnebago Hospital, I would like to ask you to think about one thing. When a person suffers a medical emergency, we all do the same thing: We try to get to the place that displays the big bright sign "Hospital." We learn as children that a hospital is a place where we will be assisted by highly trained professionals who have the skills and the desire to make us better. We are taught that we can trust a doctor and a nurse. When they tell us to take the blue pill twice a day for ten days and we will be fine, we believe them. Unfortunately, too many of our tribal people have not found these things to be true at this IHS Hospital.

Since at least 2007, this IHS facility has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. I am not talking about unpainted walls or equipment that is outdated. I am talking about a facility which employs emergency room nurses who do not know how to administer such basic drugs as dopamine; employees who did not know how to call a Code Blue; an emergency room where defibrillators could not be found or utilized when a human life was at stake; and a facility which has a track record of sending patients home with aspirin and other over-the-counter drugs, only to have them airlifted out from our Reservation in a life threatening state. I am also talking about a Hospital which had at least five documented "unnecessary deaths," including the death of a child under the age of three. These are not just our findings, they are the findings of the Federal Government's own agency, CMS.

In fact, the CMS uncovered deficiencies which were so numerous and so life threatening that this last July 2015, the IHS operated Winnebago Hospital became what is, to the best of our knowledge, the only federally operated hospital ever to lose its Medicare/Medicaid Certification. Because this Committee's 2010 Report was fairly comprehensive, please allow me to pick up where that report left off.

In 2011 CMS conducted a re-certification survey of our hospital and detailed serious deficiencies in nine areas, including Nursing and Emergency Services. My wonderful Aunt, Debra Free, was one of the victims of those deficiencies. She died in the Winnebago Hospital in 2011. According to what our family learned, Debra was overmedicated and left unsupervised, even though the nursing staff at the Hospital knew that she was dizzy and hallucinating from the drugs and should be watched closely. After her death, a nurse at the hospital told my family that Debra had fallen during the night. She said that that nurses from the emergency room had to be called to the inpatient ward to get Debra back into bed because there was inadequate staff and inadequate equipment on the inpatient floor to address that emergency.

While the hospital insisted that they did everything possible to revive her and save her life, we question just how long she remained on the floor and what actually happened. Among those doing the questioning was Debra's sister, Shelly, who was a nurse at the hospital during that period. Unfortunately, Aunt Shelly was not on duty when this occurred, but she did know enough from her professional training to question why the body temperature and reported time of death did not appear to match up. The body was still warm when the family arrived after receiving the call.

When my Aunt Shelly and the family requested to see the charts to determine what actually happened, we were met with immediate resistance. First, my mother, also Debra's sister, was told she was not authorized to request the chart. Then my grandmother, Aunt Debra's own mother, Lydia Whitebeaver, submitted a request and was denied the information. In fact, the whole family and the Attorney that we were forced to hire were all told that the chart was "in the hands of the Aberdeen Area Office's attorneys" and was not available to us.

Because she demanded answers to our very reasonable questions, my Aunt Shelly was retaliated against in the worst way. As an IHS employed nurse at the Hospital she was regularly intimidated by her supervisors and colleagues, and generally treated in the most horrific way by the Director of Nursing and her cronies. One of those nurses even reported Shelly to the State Licensing Board. Thank goodness the State Licensing Board's Members saw that report for what it was and dismissed the inquiry almost immediately, but this is a prime example of why we have been unable to get the proof that this Committee has been asking for, before the CMS Reports were released. Fear of retaliation within the IHS system is real and as your Committee's 2010 Report document, such retaliation has been present at the Winne-

bago Hospital since well before 2010. One former IHS employee of our Hospital even told your own Committee Staff that those employees who threaten to speak out are regularly reminded to “remember who you work for.” Another employee told your staff that Hospital employees, at least for a period of time, were told not to report incidents of improper care on the Webcident system. This, as you may know, this is the federally established system for reporting improper care in all federally funded facilities.

When the CMS was finally able to obtain the records that we were denied, there was no record whatsoever of the fall that my Aunt Debra suffered. A fall which a nurse told us about in some detail. It is common knowledge in our area that the then Director of Nursing and the two other nurses involved in Debra’s care are close friends. It is regularly asserted by other IHS hospital staff that they have been known to cover up events which might get one of them in trouble.

My Aunt Debra Free left behind a nine year old daughter and a loving family. She should not have been allowed to die like this. Her story and those of countless others need to be told. This example of substandard care and the numerous other examples documented by the CMS Reports are indicative of the federal government’s loose commitment to upholding its federal trust responsibility. The Great Plains Service Area is in a state of emergency and the patients who seek care at the Winnebago Service Unit are in jeopardy as we speak!

My ancestors made many sacrifices so that our people’s livelihood would continue. As a tribal member and tribal leader, it is my responsibility to carry their efforts forward to protect my people. Neither the Winnebago Tribe, nor I, will stand idle as Indian Health Service kills our people, patient by patient.

In addition to my Aunt’s case, the 2011 CMS Report also found that during that year: patients who were suicidal were released without adequate protection; that a number of patients who sought care were sent home without being seen, or with just a nurse’s visit, were never documented in any electronic medical records; that out of twenty-two (22) patient files surveyed by CMS, four (4) of those patients were not provided with an examination which was sufficient enough to determine if an emergency existed, and that at least one of those patients was sent home from the emergency room. The staff failed to diagnose that he had suffered a stroke.

When some of the findings of the CMS 2011 Report became public, in early 2012, former IHS Director Roubideaux publically promised improvements. While some minor issues were addressed, many other things got worse.

In just the past 2 years, four additional patient deaths and numerous additional deficiencies have been cited and documented by CMS. These incidents and reports include:

- April 2014. A 35 year old male tribal member died of cardiac arrest. CMS investigated this incident and found that the Winnebago Hospital’s lack of equipment, staff knowledge, staff supervision and training contributed to his death. Specifically, the nursing staff did not know how to call a Code Blue, were unfamiliar with and unable to operate the crash cart equipment, and failed to assure the cart contained all the necessary equipment. CMS concluded in its report that conditions at the hospital “pose an immediate and serious threat” mandating a termination of the Hospital’s CMS certification unless they were corrected immediately.
- May 2014. A second CMS survey conducted a month later found that a number of the conditions which pose immediate jeopardy to patients had not been corrected, and that the Hospital was out of compliance with CMS Conditions of Participation for Nursing Service.
- June 2014. A female patient died from cardiac arrest while in the care of the hospital. This time the death occurred when the staff was unable to correctly board her on the medivac helicopter. This is documented in the July 2014 CMS report. This young woman was employed by the Tribe’s Health Department and played an active role in the lives of many youth, who often referred to her as “mother goose.”
- July 2014. A 17 year old female patient died from cardiac arrest because the nursing staff did not know how to administer a dopamine drip ordered by the doctor. CMS also documented this event in detail in its July 2014 report and found that numerous nursing deficiencies remained uncorrected at the hospital. This resulted in the issuance of a continuing Immediate Jeopardy citation for the hospital on the Condition of Participation for Nursing Services.
- August 2014. In its fourth survey conducted this year, CMS concluded that failure to provide appropriate medical screening or stabilizing treatment “had

caused actual harm and is likely to cause harm to all individuals that come to the hospital for examination and/or treatment of a medical condition.”

- September 2014. CMS survey jurisdiction of this hospital was transferred from the Kansas City regional office to Region VI in Dallas, TX.
- November 2014. Just four months later, CMS returned again for another survey. This report again identified more than 25 deficiencies.
- January 2015. Another death occurred when a man was sent home from the Emergency Department with severe back pain. A practitioner later left him a voicemail after discovering his lab reports showed critical lab values telling him to return in 2 days. The patient died at home from renal failure. This situation is documented in the May 2015 CMS report.
- May 2015. CMS conducted another follow up survey. In addition to documenting the January 2015 death noted above, the report states that seven CMS Conditions of Participation and EMTALA requirements were found out of compliance at the hospital.
- July 2015. CMS terminated the Winnebago IHS Hospital provider agreement. CMS stated that the hospital “no longer meets the requirements for participation in the Medicare program because of deficiencies that represent an immediate jeopardy to patient health and safety.”

Mr. Chairman and Members of the Committee, I know that each of you have families and close friends, and I assume that most of you have also suffered a loss or know someone who has. It is a profoundly painful experience. Now, imagine going through that pain only to learn a year or more later, through some government report, that the death might have, or even should have, been avoided. Keep in mind that the deaths and findings cited here are only the ones that have been documented by CMS. When CMS conducts a survey, only a small sampling of patient records are reviewed. We have no way of knowing how many more unnecessary deaths and misdiagnosis have occurred at the hands of IHS personnel. There is also no way that we can portray the tremendous pain and loss that has been suffered by our families and our community in these few pages. Our people are devastated, angry and demanding change. Given what has happened, and been allowed to continue to happen, I respectfully submit that we have every right to those feelings.

As the CMS reports piled up, we have started to see less Hospital admissions and less care being provided in the Emergency Room. We believe this is due, at least in part, to hospital staff fearing on-going CMS oversight of their lack of training and skills. We have actually been told this by some of our members who work at the facility. This is possibly contributed to the most recent documented death in January 2015 (noted above).

The totality of these circumstances finally led CMS to notify the Indian Health Service in April of 2015 that it was pulling its CMS Certification of the Winnebago Hospital, unless substantial changes were made. Changes were not made and CMS terminated that certification on July 23, 2015.

I wish to note for the record that throughout this period the IHS assured the Winnebago Tribal Council that the CMS findings, most of which were never provided to the Winnebago Tribe at least in their totality, were being addressed. In fact, less than two weeks before CMS actually pulled the Certification, the IHS Regional Director was still telling the Tribal Council that the threatened CMS decertification would not happen because IHS was talking to its lawyers and planning an appeal.

When the termination happened, the Winnebago Tribe and its attorneys asked to see a copy of the latest CMS report. We were told by the IHS Regional office that it needed to be reviewed for privacy concerns before it could be released to us. We finally obtained a copy and also learned that the CMS oversight of Winnebago IHS Hospital was transferred from Kansas City to the Dallas Office. When we asked one CMS employee why this transfer had occurred, he was fairly quick to suggest that, in his opinion, this was forum shopping. Whether there is any truth to this or not, this transfer of CMS oversight certainly raises questions. Perhaps this Committee can get the answers that we cannot.

Immediately after the hospital lost its CMS Certification, the Winnebago Tribal Council got on a plane and came here to this Committee and to its Congressional delegation for help. You responded. Thank you!

While the Winnebago Tribe had heard and reported stories of these atrocities for years, the CMS reports have provided independent verifiable documentation of what was really going on. What we have learned since then is equally disturbing.

When we asked Acting Director McSwain about the professional medical review that the IHS had engaged in after each of these five deaths occurred, and what role the Central Office played in those reviews, we were shocked to learn that the IHS

does not appear to have an established procedure for dealing with questionable deaths or other unusual events that occur in its hospital. In fact, if there was ever a professional peer review of any of those five incidents of questionable death, we can't find it! When we pushed harder on this issue we were told that this review should have been conducted by the "Governing Body" of the hospital. This basically means that a body, composed largely of other IHS employees who are not doctors or other medical professionals, were supposed to review the actions of the physicians, nurses and anesthesiologists in the emergency room. I can assure you that this would not happen at the Georgetown Medical Center or Med Star Hospital in Washington, D.C. The end result, however, is that—to the best of our knowledge—no one was fired, no one was reprimanded, no one was suspended pending a medical investigation and no one was reported to the licensing board. This is outrageous!

Again, many people have asked us why the families of these individuals did not sue. The answer is simple: Most Indian people do not place a dollar value on human life. Others, who might be willing to sue, either did not know that they could, did not know how, or could not afford it. Medical malpractice cases are complicated and expensive. You need expert witnesses who are willing and able to testify, and we have trouble getting federal employees to answer questions about CMS findings. A litigant also needs access to medical records which are not easy to get from the federal government, and they need a lawyer who has the financial means to front the costs for a family with few financial resources. These types of lawyers are not plentiful in our area. So yes, our people have rights under the Federal Tort Claims Act, but taking on an federal agency which has all of its own experts on salary is not as easy as it appears.

It is also important to note that the Winnebago IHS Hospital has become a short term stop for a number of IHS contractors. Many of the doctors who take care of our needs are not federal employees, they are private contractors who rotate in and out of the facility. This forces even the best of those physicians to rely heavily on the nursing staff who remain at the facility, many of whom have been found by CMS to be serious undertrained. The negative media coverage of our hospital over the past six years has made recruiting all the more difficult. Would you want to see your daughter, fresh out of medical school, step into a mess like this in a hospital managed by a dentist or pharmacist?

After the Tribe met with Secretary Burwell's legal counsel in August of 2015, the IHS finally hired an outside consultant to perform its own review of the facility. This review was conducted applying standard federal and state medical standards. During this review, this independent consultant found 97 deficiencies, many of which were never uncovered, or at least never reported, by CMS.

The IHS also employed that consultant to develop a corrective action plan for the Winnebago facility. This is clearly a step in the right direction. At the same time, I, and the other Members of our Tribal Council, will not be satisfied, until one of our members comes up to me and says "I was just at the emergency room with my mom—what a difference." I am not going to trust that simply checking an item of a list is getting us the real change that we need to see or that those changes will be sustained.

To this day, when we pressure the IHS on the big issues, we get the same excuses:

- "Employees are protected by the Federal Employee Regulations". In fact, it seems all but impossible to fire a federal employee. In conversations with your own Committee staff, Winnebago hospital employees reported that some of their colleagues believe that their job can never be put in jeopardy because they are protected by the Civil Service System. When did there become two standards of care- one for the private sector on one for federally operated hospitals?
- "We wished that we could hire people more quickly but the OPM system has to be followed." How many professional people can wait months for an OPM approval? We have lost a number of good candidates who refuse to wait six months or more to be hired. You simply cannot recruit under these circumstances.
- "IHS lacks the resources to recruit the best people." There is truth to this and we encourage the committee to look into this problem. At the same time, while we hear about recruiting problems, we have seen no real effort to recruit from our local Nebraska, Iowa and South Dakota Medical Colleges. In any event, we will never agree that inadequate resources justifies the continued employment of an undertrained or incompetent individual. It seems like the IHS position has, over time, evolved into "even a poor doctor is better than none at all."

The IHS hospital management has also been an on-going problem. Even though CMS has documented countless problems in the emergency care division, we have had a pharmacist and a dentist as acting CEO's, and I have to ask you what training a dentist, even one of the top dentists in the country, has in dealing with issues like renal failure, cardiac arrest and overdoses.

So what should be done?

First, we ask the Committee to examine the role that Federal Employment Policies and Regulations are playing in allowing incompetent and undertrained employees to continue to work in the Indian Health Service. Employees need to be held accountable for their actions. No longer can IHS continue to protect, cover up, shuffle, transfer, or perpetuate incompetency.

Second, we recommend that the IHS be mandated to institute a formal process for investigating any report of a questionable death or other unusual medical incident in any of its facilities. If problems are identified, immediate action must be taken to correct the problem, including disciplinary action against any employee who has failed to do their job.

Third, we recommend that the IHS mandate, *as a condition of on-going employment*, that its employees report any improper care or mismanagement that they observe, and that those reports be sent directly to Central Office. The standard of care must be raised and every IHS employee should feel responsible for helping to fix this problem.

Fourth, we recommend that IHS be authorized and directed to immediately terminate any employee who retaliates or threatens to retaliate against a person who files such a report. The culture must change. Employees should be encouraged to make improvements and find better ways of doing things, not intimidated into maintaining the status quo.

Fifth, we feel strongly that each of the tribes who are served by a direct care facility should be given full and immediate access to any CMS, Accreditation or other third party reports or studies performed on that facility. We further recommend that all negative reports should be shared with this Committee and its counterpart in the House. IHS needs to stop hiding the ball.

Sixth, we recommend that the IHS be directed to insure that no tribe suffers the loss of services or resources because of IHS mismanagement. The third party billing from Medicare and Medicaid represented a sizable percentage of the Winnebago IHS Hospital's operating budget.

Seventh, we insist that IHS mismanagement should not be used as an excuse for eliminating or cutting back on services. Already, IHS is discussing how the underutilization of our facility makes it difficult to seek the funding necessary to fix its problems. It like a death spiral—IHS creates an environment that people do not want to go to. They refuse to admit patients because they fear further scrutiny. Then they conclude that the hospital is too underutilized, so maybe they should shut down some services. This is a totally unacceptable. It is a flagrant violation of the Federal Government's treaty and trust obligations, and someone should be fired for even raising this as a possibility.

Eighth, tribes should be given a real role to play on the governing bodies of IHS operated facilities, not just a token attendance right. Let me give you an example. The IHS will tell you that since the "corrective action plan" has been implemented, our tribal Chairwoman has been invited to participate in the final interview process for key positions at the hospital. This is true. What they do not tell you is that she only received the resume just before the meeting and she was never told how many others applied for the job, who they were, what the differences were in their credentials, or even how many candidates there were.

The bottom line, Mr. Chairman, is that things need to change and they need to change now. We have just heard that both the Pine Ridge and Rosebud Hospitals are now threatened with a loss of CMS certification and we also know that many of the things that CMS has documented at Winnebago are happening at other hospitals throughout the Great Plains and Billings Regions. These are our families, many of our people are veterans, and they all deserve better.

Two of your own Committee Staff Members were at Winnebago earlier this month. Would any of you want to see one of them to end up in an emergency room with IHS Winnebago's reputation, if they were involved in an automobile accident?

The Winnebago Tribe has already begun developing a draft plan to assume control of this hospital under a P.L. 93-638 compact. For years we have trusted the IHS to do its job. Over and over again, the IHS has failed. At this point, the Tribe feels that it has no alternative. Contracting is a great thing, and our tribe already operates a number of programs under P.L. 93-638. At the same time, contracting or compacting should be a tribal choice, not something forced upon us by circumstances

like this. We know that if we move forward with this effort, we are taking on a highly troubled enterprise. That is very concerning to us, and to our members.

Mr. Chairman, the Winnebago Tribe truly appreciates your efforts to date and stands ready, willing and anxious to work with you, the Members of this Committee and our fellow tribes to insure that our members receive the health care that they deserve and that no other tribe suffers these same tragedies.

The CHAIRMAN. Thank you so much for your compelling and heartfelt testimony. We are very grateful that you have come to share that with us.

I will let you know that the prior panel has all stayed. They are here in the audience in the room and are hearing every word that all of you are saying, just so you know that your words are being heard by them as well as by the Committee members.

I would like to turn to the Honorable Sonia Little Hawk-Weston. Thank you for being with us.

**STATEMENT OF SONIA LITTLE HAWK-WESTON, CHAIRWOMAN,
HEALTH AND HUMAN SERVICES COMMITTEE, OGLALA
SIOUX TRIBAL COUNCIL**

Ms. LITTLE HAWK-WESTON. Thank you. Good afternoon, Mr. Chairman and members of the Committee. Thank you for holding this important hearing. Thank you, Senator Thune for your help in requesting this hearing.

My name is Sonia Little Hawk-Weston. I am the Chairwoman of the Oglala Sioux Tribal Council's Health and Human Services Committee.

First, I would like to thank Senator Dorgan for the 2010 report. The lack of adequate health care is one of the greatest challenges facing our reservation and community. Clearly not enough progress has been made since the 2010 hearing and Senator Dorgan's report.

Just last November, CMS cited the Pine Ridge Hospital for several EMTALA and certification violations. This put the hospital at risk of losing its right to participate in the Medicare program. This would pose serious financial problems for the Pine Ridge service unit which is underfunded as it is.

It is more than the funding issue we are worried about. The CMS finding shows that the hospital failed to meet basic Federal standards for quality of care. CMS accepted IHS's corrective plans but the tribe is wary that this will result in a temporary fix. We want to work with this Committee and the IHS towards true lasting reform.

The tribal council hears ongoing complaints from our members about the quality of health care on our reservation. In one case, a tribal member with severe back pain was told several times that a complete hysterectomy was needed. Thankfully, prior to the surgery this member was seen at a non-IHS hospital off the reservation where the member was diagnosed with a herniated disk in the spine and advised that no hysterectomy was needed.

Another tribal member went to the hospital complaining of chest pains and was diagnosed and treated for acid reflux. Hours later at home, this member suffered a massive heart attack and passed away.

Access to care is also a serious problem for our members. Often the IHS cannot provide the kind of services that tribal patients need. Due to limited funding for purchase of referred care, IHS often refuses to pay when patient are referred to non-IHS providers unless the issue is life threatening.

For example, IHS referred a tribal member to a specialist for an assessment. The specialist said surgery was needed but IHS refused to cover the cost of the surgery. What good is an assessment if the patient cannot pursue the recommended treatment?

Those who do go to appointments often cannot pay when IHS denies the service. Members have shared with the council stacks of IHS denial letters and bills for medical services they have received. Many tribal members cannot bring on lawyers to deal with the situation. Instead, they are plagued by debt collection actions and credit score downgrades.

One member told us he is being pursued by a collection agency for \$72,000 for medical services. Our members cannot pay that. Many of our members who are referred to Rapid City or elsewhere for treatment do not have the means to cover the transportation cost.

For on-reservation access to care, our hospital lacks the staff, space and equipment to meet demand. The service unit estimates it operates at 50 percent of need. Patients endure long wait times to be seen by medical staff. Seriously ill patients cannot withstand these wait times. Nobody should have to.

Further, we truly appreciate the efforts to address suicide prevention but more is needed. Recently, a clinical psychologist brought in to help a suicide prevention worked for one day before quitting. Providers usually only stay as long as their contract term.

We need permanent physicians who will stay and become a part of the community and get to know their patients. The area needs to recruit, hire and retain skilled medical staff. That is not happening for several reasons.

One major factor is the critical shortage of housing for medical staff. Limited funding for facilities and equipment is another challenge. Work environment is also a key factor in recruitment and retention. Medical personnel want to work in a well managed facility where high quality patient care is a priority.

We have heard that the practices of recycling problem employees through reassignment or administrative leave cited in the Dorgan report continues in our area. We would like this issue looked into.

We want greater transparency in the allocation of funding for the Pine Ridge service unit. We cannot make sure the area is maintaining its funds to ensure that the greatest amount of funds possible are used for direct patient services.

We hope this hearing will spur further reform but we are wary of a temporary fix. We need to make sure that the Great Plains area is managed in a way that patient care comes first, noncompliance issues are nonexistent and our service unit is an attractive place to work. All we want is quality health care for our people without the struggles we currently endure to receive any health care at all.

This should not be unachievable in the United States of America, especially when the United States of America bears treaty and trust responsibilities to our people.

Mr. Chairman and Committee members, thank you for the opportunity to testify. I am happy to answer questions.

[The prepared statement of Ms. Weston follows:]

PREPARED STATEMENT OF SONIA LITTLE HAWK-WESTON, CHAIRWOMAN, HEALTH AND HUMAN SERVICES COMMITTEE, OGLALA SIOUX TRIBAL COUNCIL

Good afternoon, Mr. Chairman and Members of the Committee. My name is Sonia Little Hawk-Weston, and I serve as the Chairwoman of the Tribal Council's Health and Human Services Committee for the Oglala Sioux Tribe. The Oglala Sioux Tribe is the largest tribe of the Great Sioux Nation, with more than 47,000 tribal members. Our Reservation, the Pine Ridge Reservation, spans more than 2.8 million acres, making it larger than the States of Delaware and Rhode Island combined.

I am pleased to be here today to testify on the state of Indian health care in the Great Plains Area, and specifically on the Pine Ridge Reservation, as the lack of adequate health care is one of the greatest challenges facing our Reservation community. It is also an issue requiring federal attention and action on behalf of the United States. In the Sioux Treaty of 1868 (known as the Fort Laramie Treaty) the Great Sioux Nation and the United States agreed on a *quid pro quo*; by terms of the Treaty, the United States promised to provide certain benefits and annuities to the Sioux Bands each year, including health care services, in exchange for the right to occupy vast areas of Sioux territory. Accordingly, it is our position that the obligation of the federal government to provide adequate health care services to the Oglala Sioux people, who are some of the poorest and most disenfranchised in the Nation, is not only a moral responsibility, but a legal one.

In 2010, this body held a similar hearing, exploring the urgent need to reform the Indian Health Service in what was then referred to as the Aberdeen Area, prompted by years of complaints of mismanagement and substandard care. The hearing followed up on a formal investigation of the Aberdeen Area, which resulted in a Report of Committee Chairman Byron Dorgan confirming and documenting the deplorable condition of the Area's health care services to Indians.¹

I am here today to testify that, while some efforts have been made to improve the administration and delivery of health care in the Great Plains Region, much work remains. The Oglala Sioux Tribe is concerned that the IHS Great Plains Area still struggles with poor management and lack of accountability, and that many of the problems identified in the 2010 Hearing and Report continue, to a greater or lesser extent, today.

We need administrators in the Great Plains Area to focus on ensuring patient care, a stable, well-managed work environment and recruitment of permanent medical staff. The IHS also needs to bring on more staff for third party collections and for paying referred claims in a timely manner. In 2013, the GAO disagreed with IHS's position that it could not divert resources to hire more contract health services (now called purchased and referred care) staff. We need to be far-sighted, not short-sighted in the approach to fix the problems in health care delivery in the Great Plains Area. We look forward to working with this Committee and the Administration to make sure this happens.

This testimony discusses some of the specific ongoing problems we face.

¹ In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area, Report of Chairman Byron L. Dorgan to the Committee on Indian Affairs, 111th Cong. (Dec. 28, 2010) ("2010 Report").

Quality of Care and Accreditation/Certification

Substandard quality of care and the resulting threat of loss of accreditation and certification are ongoing issues for the IHS facilities at Pine Ridge. Chairman Dorgan's 2010 Report concluded that the Pine Ridge Service Unit Hospital was one of six facilities in the Great Plains Area experiencing accreditation problems and/or Emergency Medical Treatment and Labor Act (EMTALA) violations. The Report specifically cited a 2010 the Centers for Medicare and Medicaid Services (CMS) report finding that Pine Ridge Hospital "received a number of EMTALA complaints in 2009 and 2010, which centered on insufficient care in its Emergency Department."²

Clearly, insufficient progress has been made over the last five years to address these violations. In letters dated November 24th and 25th, 2015, the CMS stated that based on recent surveys the Pine Ridge Hospital is in violation of several Medicare Conditions of Participation for Hospitals and the EMTALA. As a result, the Hospital is at risk of termination of its provider agreement and loss of its right to participate in the Medicare program. The loss of Medicare reimbursements would have significant financial consequences for the Pine Ridge Service Unit, which takes in substantial amounts in third party collections. The Service Unit's third party collections for FY2015, as of December 2015, were approximately \$8.4 million, with about \$6.5 million at Pine Ridge Hospital. The Service Unit's hospital and clinics federal appropriations amount was just over \$15 million for FY2015. If the Service Unit lost its ability to participate in the Medicare program, it would be forced to operate on base funding alone. This would pose drastic budget problems to an already woefully underfunded facility; the Hospital simply *could not operate* on its base budget alone.

Of course, apart from the funding issues, the survey findings underscore that the Hospital continues to fail to meet basic federal standards for competency and quality of care. CMS uncovered numerous violations in its surveys, conducted last October, including but not limited to the following:

- The Hospital's governing body "failed to ensure that medical staff was accountable for the quality of care provided to patients" and abided by Hospital policies and regulatory requirements, resulting in the Hospital's "inability to ensure the provision of quality health care in a safe environment."
- The Hospital failed to ensure that patient privacy and safety requirements were met. Among other things, the survey team discovered unsecured scalpels, needles, and syringes readily accessible to patients, including prisoners, and visitors in the Hospital, including an unlocked syringe cart near a patient entrance and unlocked cupboards in exam rooms where patients and family members were left alone. The survey also found that the Hospital left prisoners and individuals at risk for suicide unattended, contrary to Hospital policy, thus endangering staff, patients, and visitors in the Hospital.
- The Hospital failed to ensure confidentiality of patient records, as computer monitors with patient data were visible to patients and visitors, and medical records were found left on the countertop in an unsecured room.
- The Hospital has "failed to develop, implement, and maintain an effective, ongoing, hospital wide [Quality Assessment and Performance Improvement] program" with "plans of action and measurable goals" as required by the Conditions of Participation. The Hospital has no plan in place to address patient complaints and grievances or patient pain management. Members of the Hospital's Quality Management Oversight Committee do not consistently show up for Committee meetings, and several meetings have been cancelled altogether due to poor attendance. In short, the Hospital is failing to adequately monitor quality of care and implement performance improvement measures.

² 2010 Report at 23.

- Medical records were found to be incomplete or inaccurate, and many contained information on the wrong patient. In one case, a female patient was informed that she had multiple illnesses, including liver disease and hepatitis C, which she did not in fact have. That information related to a male patient, and was wrongfully included in the female patient's chart. Hospital staff admitted this was a common problem. The survey also revealed instances of "pre-signed" records, later filled out by Hospital staff.
- Hospital failed to provide medical screening exam that was, within reasonable clinical confidence, sufficient to determine whether an Emergency Medical Condition existed. The survey cited that the Hospital discharged a person with a displaced fracture in the head after the preliminary report of the CT scan was read as negative. The CT scan report, however, was timed after the patient was discharged. This patient was ultimately retrieved after discharge and airlifted to an off-Reservation facility for treatment. This patient's care was not presented for review through the Quality Assessment Performance and Improvement Committee.
- Certain drugs were found to be stored in an improper environment, and expired infant formula was kept in supply and not discarded. In addition, the Hospital "failed to ensure all drugs and biologicals were kept in a secure and locked area."
- Among other broken equipment, the dish machine in the hospital kitchen, used to wash and sanitize cookware, has been broken since 2013.
- The Hospital has "failed to ensure that there was an active infection control program that monitored, investigated, controlled, and/or prevented or decreased the opportunities for the spread of infections." The hospital also failed to "ensure adequate processing of contaminated reusable medical instruments and the proper use of mechanical sterilizers," several of which were broken. In some instances, dirty instruments were found sitting uncovered at various locations throughout the Hospital. There were no gowns or masks readily available in the isolation room in the ER. The survey thus concluded that the Hospital "failed to ensure infection control policies specific to each department... This included the training [for] and monitoring [of] the procedure for handling of dirty or soiled reusable instruments and the use of sterilizers to ensure those infection control measures were being followed to prevent or decrease the opportunities for the spread of infections."

The survey also revealed that the Hospital had failed to implement an earlier Plan of Correction submitted to CMS after a July 16, 2015 survey that discovered EMTALA deficiencies. In fact, the EMTALA survey conducted in October was a follow-up to the July 16 survey, and revealed ongoing deficiencies even though the Hospital had alleged compliance as of August 26, 2015. The October survey found that the Hospital did not have a functioning and effective Quality Assessment and Performance Improvement committee, which the Hospital had represented would be utilized to implement its Plan of Correction, and that no committee meeting had been held since April, 2015.

Though CMS has accepted new Plans of Correction submitted by IHS following the November 24th and November 25th letters, past experience gives the Tribe little reason to believe that these plans will be fully and competently implemented or will result in lasting, meaningful reform. For example, we understand that the Service Unit has made the decision to borrow over \$1 million from the Kyle Health Center to pay for contracts for outpatient and ER providers at the Hospital in order to comply with the Plans of Correction. Now that these violations have been uncovered, the solution must not be to divert funding from one under-resourced part of the Service Unit to another in a last-ditch effort to avoid de-certification. We never should have arrived at this point. Simply put, the IHS should not be operating the Pine Ridge Hospital in a manner that threatens its accreditation or CMS certification.

Unfortunately, the Oglala Sioux people do not need CMS to tell them that IHS is operating the Pine Ridge Hospital in an unsatisfactory—even dangerous—manner. The Oglala Sioux Tribal Council and the Office of the President have heard ongoing complaints from tribal members about the quality of care on our Reservation, including frequent complaints of misdiagnosis and mis-prescribed medications. In one case, a tribal member suffering severe back pain was told several times that a complete hysterectomy was needed and the member was preparing for the procedure. In the meantime, the member was seen at a non-IHS hospital off the Reservation, where the member was diagnosed with a herniated disc in the spine and advised that in fact no hysterectomy was needed and that it would have been malpractice for any doctor to perform one. Another tribal member went to the Hospital complaining of chest pains, and was diagnosed and treated for acid reflux. Hours later, at home, this tribal member suffered a massive heart attack and passed away. Another tribal member visited the hospital repeatedly complaining of health problems, and was repeatedly told nothing was wrong, until the person was finally diagnosed with cancer. A few weeks later, this tribal member passed away. Stories like these undermine our confidence that the IHS is able to provide competent, quality care to our tribal members on our Reservation.

Access to Care Issues

Access to necessary medical services is also a serious problem for Oglala Sioux tribal members. Oftentimes, the IHS cannot or does not provide the kinds of services that tribal patients need. But because of limited funding for purchased and referred care, previously referred to as contract health services, IHS often refuses to pay when patients are referred to non-IHS providers unless the issue is life-threatening. Those that do go to these referred appointments oftentimes cannot pay and they end up looking to the Tribe for financial help. We have stacks of IHS denial letters and bills for medical services that our tribal members have received and shared with the Tribal Council. In one collection, we have files shared with us by our members that contain approximately 212 claims submitted by 147 different claimants and worth over \$1.2 million. Several IHS denials state that although the care is a Priority 1 due to lack of contract health funds IHS is unable to approve the referral. IHS's numbers show that it has denied 4,830 referrals since April 2015. In December 2015, IHS reports 539 referrals denied.

Many patients simply choose not to go to their medical appointments when they know the IHS will not pay. As a result, these patients ultimately do not receive the medical care they need. This pattern leads to a lack of preventive care, the development of chronic conditions, and the overall deterioration of health on our Reservation.

We hear from our tribal members on a regular basis about their access to care problems and the impact of receiving IHS denials of referred care. Many times if only the person received preventive care, the needed specialized treatment or necessary medications, health conditions would not have progressed to a chronic or catastrophic state. In one instance, a tribal member with a painful joint problem was referred to a specialist in Rapid City for an assessment. The specialist told the tribal member that surgery was needed to alleviate the pain. When the tribal member attempted to schedule the surgery, the IHS refused to cover it, saying they had agreed to cover an assessment but not a surgery. But what good is an assessment if the patient cannot pursue the recommended course of treatment? In another instance, a tribal member fell and called the Hospital Emergency Room but was told it was full. At a service clinic, this patient was advised that a bone was broken and was referred to a specialist in Rapid City. The specialist notified this member that surgery was needed, but the IHS would not pay for the surgery or the visits to the specialist, so the member could not return for the surgery. Consequently, this tribal member suffered with severe pain.

Another tribal member who did undergo critical surgeries following a car accident, and was later hit with bills totaling approximately \$250,000 because the IHS refused to pay. Fortunately, this tribal member was able to hire a lawyer to help deal with the situation. However, many tribal members, who receive direct bills often for staggering amounts, cannot bring on lawyers, and are plagued by debt collection actions and credit score downgrades. IHS regularly denies purchased and referred care based on procedural requirements even though IHS does not provide education to members about what those requirements are. As just one example, a member recently shared a collection agency letter with our Council showing that the member is being pursued for payment of more than \$72,000 in medical bills. Our members cannot pay that amount.

The costs of transportation to referred care is also a very serious problem for our tribal members and the Tribe, itself. Many tribal members who are referred to Rapid City or elsewhere for medical treatment simply do not have the means to cover the costs of transportation, even if the services would be covered by the IHS or other insurance. When these patients are minors or need to be accompanied by family or caregivers for other reasons, the costs of travel are even more prohibitive.

The Tribe supplements transportation costs out of its general fund when it can. In the past decade, the Tribe has spent just short of \$3.5 million in medical emergency assistance for its tribal members. About \$2.9 million was spent from 2010 through 2015. These transportation costs are a significant amount of money that the Tribe badly needs for other initiatives such as community development, economic development, and other projects for improving Reservation life, all of which are needed in our efforts to overcome our poverty conditions and poor health outcomes on our Reservation. In Oglala Lakota County, on the western side of the Pine Ridge Reservation, more than 52% of our people live below the poverty line and the average per capita income is only \$9,226. According to the U.S. Census Bureau, Oglala Lakota County is the third poorest county in the United States. The unemployment rate on our Reservation is well over 70% and our high school dropout rate exceeds 60%. These statistics directly impact the health of our tribal members and need to be addressed. Last year, upon tribal request, the IHS reimbursed a portion of the funding the Tribe diverted to cover medical transportation costs for our members. Nevertheless, the Tribe should not have to front these costs and lose the ability to use its general fund monies for other purposes to benefit the Tribe. Unfortunately, the portion of monies that was reimbursed went right back out the door to cover costs of additional medical emergency assistance needs.

We are also concerned with the costs incurred by the frequent use of airlifts or life-flights to facilities off the Reservation for specialized care. Since the Pine Ridge Hospital often lacks the care needed, airlifts to other facilities are not unusual. The IHS covers the cost of the airlift if the patient is determined to be Priority 1. Airlifts can cost approximately \$20,000 per trip. Clearly, these trips result in a significant amount of money being paid out from the Pine Ridge Service Unit's already strapped budget. Furthermore and significantly, if it is determined that the patient is not Priority 1, the patient, ultimately, is billed for the airlift, and if the patient does not have Medicaid, Medicare or private insurance to look to, this massive bill falls to the patient.

In terms of on-Reservation access to care, the Pine Ridge Hospital lacks the space, staff, and equipment to meet demand. The Pine Ridge Service Unit had documented a need for fetal monitoring systems, telemetry systems, surgery lights, a nurse call system, and dental chairs and equipment, among other equipment needs estimated to cost approximately \$5.5 million for FY 2016. In fact, the equipment needs are so dire that the Hospital waits for one of its IV Service Unit Pumps to finally stop working so they can take parts from it to fix another one. There are not enough supplies for the IV pumps, and new ones that are needed would cost an estimated \$677,790. This is a critical piece of equipment that could mean the difference between life or death in a patient emergency.

These unmet needs lead to an inability of our local facilities to address a variety of illnesses locally, and contribute to backlog and long wait times for medical staff to see patients. The Pine Ridge Hospital is notorious for its long wait times, and it is generally understood that if you need to see a doctor at a Reservation facility you should clear your schedule for the day, as your minimum wait time is likely to be five hours or more. One tribal member waited five hours at the Emergency Room without being seen by medical staff even though the member presented with severe pain. Ultimately, this member left unseen and went to an emergency room off the Reservation where the member was told surgery was needed the next day due to a protruding broken bone. Seriously ill patients cannot withstand these wait times, and nobody should have to. Some have remarked of the Reservation clinics that, "if you are not sick when you go in, you are when you leave" because of the wait times. Additionally, the Emergency Room is backlogged with patients coming to receive primary care services because there is such a long wait time to see outpatient providers.

Our Tribal Council pushed hard to have a Tribal Liaison position created between the Tribal Council and the Pine Ridge Service Unit so that there would be an open line of communication between the two entities. The position was to provide an avenue for our efforts as Tribal Council to promote the interests and welfare of our members when they receive health care from the Pine Ridge Service Unit. There is a grievance process at the Hospital for patients to file complaints about their care. The Tribal Liaison reports to our Council's Health and Human Services Committee. However, when we ask questions to determine if grievances and complaints are being addressed, we are told that because of HIPAA they cannot answer our questions. We are, therefore, left in the dark about whether our members' grievances are in fact being addressed. Our tribal members, however, rely on our Health and Human Services Committee and the Council overall to get answers and ensure all is functioning as it should at the Service Unit. We, of course, want strict adherence to HIPAA, but we want to make sure it is not used as a general shield to not answer any questions about the grievance process. We need to develop a plan to ensure our Tribal Liaison position is being as effective as it should be and was envisioned to be; such plan should include HIPAA training on what information can and cannot be shared.

Inadequate Facilities

As I have mentioned, the Pine Ridge Hospital struggles with inadequate space to serve its user population. The IHS Service Unit profile states that the active user population exceeded the designed user population in 2000, and that the Service Unit currently services a user population

of 51,227, in a space that is already undersized to serve the Health Systems Planning estimated user population of 22,000 patients.

The Hospital has used curtains and ad-hoc partial walls to improvise exam space, but this approach obviously risks breach of patient confidentiality. The single trauma room is inadequate and the Service Unit reports a need for additional space for the emergency department, outpatient, behavioral health, contracted specialty services, physical therapy, occupational therapy, respiratory therapy, dental, administration, and support services.

Further, the Hospital has no psychiatric unit, and lacks any appropriate facilities to handle psychiatric patients. The Hospital employs one psychiatrist and one psychiatric nurse. Yet, multiple individuals with immediate psychiatric needs—some of them suicidal or homicidal—come into the hospital on a daily basis. Medical staff on duty, who are not necessarily trained in psychiatric medicine, must be diverted from their assigned duties to supervise these patients until they can be transferred to an appropriate facility off-Reservation. This disrupts services to other patients in the Hospital and puts Hospital staff, patients, and visitors at risk of harm.

Need to Recruit, Retain, and House Qualified Staff

I recently heard of a clinical psychologist, brought in to help with suicide prevention and other behavioral health issues, who worked for *one day* before quitting. It is common for providers to only stay as long as the duration of their temporary contract. Once their contract is up, they move on. As a result, there is a lack of trust between patients and providers, and patients constantly have to start over from square one as new physicians cycle through. Further, the position vacancy rates at our facilities hover around twenty percent.

If we want to have any hope of a positive outcome in the Indian health care system, we need permanent physicians who will stay, become part of the community, and get to know their patients. The Pine Ridge Hospital Unit needs to recruit, hire and retain skilled medical staff. That is not happening, for several reasons.

One major factor is the critical shortage of housing in Pine Ridge and the surrounding areas. Medical and Hospital staff simply have nowhere to live. The housing shortage affects every facility in the Pine Ridge Service Unit:

- The Pine Ridge Hospital has 450 positions, but only 104 housing units.
- The Kyle Health Center has 86 positions, but only 20 housing units.
- The Wanblee Health Center has 35 positions, but only 5 housing units.
- The LaCreek District Clinic has 6 positions, but 0 housing units.

There are very limited housing options available within 60 miles of the Hospital or within a reasonable distance of our other facilities, due to our isolated location. Pine Ridge also lacks a local motel or other temporary housing for contracted providers and visiting professionals.

Limited funding for medical staff, facilities, and equipment is, of course, another challenge in recruitment and retention. In addition to an overall lack of funds for competitive salaries, IHS employees are impacted by the uncertainty of continuing resolutions and the threat

of government shutdowns when Congress fails to enact a timely budget. The lack of funding for basic and necessary equipment and the inadequate facilities are also unappealing to prospective medical staff, as these inadequacies make their jobs much harder.

Significantly, however, work environment is also related to recruitment and retention. Competent, professional medical personnel want to work in a well-managed facility where high-quality patient care is a priority and where staff are rewarded for good performance. The CMS survey findings clearly demonstrate, at the very least, that the Pine Ridge Hospital is not being effectively managed and is not prioritizing improvement in patient care. This kind of environment is demoralizing and discourages the kind of professionals we need to address our urgent health care needs from applying or remaining on the Reservation.

In addition to qualified medical staff, we need trained, expert hospital administrators and administrative staff. Administrators must prioritize recruitment and a stable, well-managed work environment. Further, the administrative staff should be trained and proficient in third party billing to enable aggressive pursuit of third party collections, so no available health care funding is left on the table. We were told that for the past three months, third party collections are only at 25% of the goals for our hospitals and clinics.

Administrative Leave

Senator Dorgan's 2010 Report found that the IHS used transfers, reassignments, details or lengthy administrative leave to deal with employees who had a record of misconduct or poor performance. We have heard that these practices, and the "recycling" of problem employees, continue to persist throughout the Great Plains Area. We remain concerned about the use of these practices and would like this issue to be examined and analyzed for its effect on the provision of quality health care for our members.

Administration and Accountability

The Great Plains Area Office should be accountable to, and work in partnership with, the Tribes it serves. The Oglala Sioux Tribe would like information clearly detailing the budget received by the Area Office and how that budget is then allocated and spent. It is clear that the levels of funding actually reaching our local facilities are grossly inadequate; the Pine Ridge Service Unit estimates it operates at 50% of need. But the Tribe lacks the information necessary to evaluate whether the Area Office is appropriately managing its funding to ensure that the greatest amount of funds possible are used for direct patient services. The Tribe would like to see greater transparency, accountability, meaningful partnership and consultation in the allocation of funding for the Pine Ridge Service Unit. In addition, when the Area Office is listing and filling job vacancies, the Tribe would like to be notified and involved with candidate selection and interviews. Finally, the Tribe would like statistics and information about patient lawsuits against the IHS, including the cost to the IHS of defending and settling such lawsuits.

Use of Third Party Revenues

Third party resources are an increasingly important component of IHS funding, but the Oglala Sioux Tribe is concerned that these resources are not being effectively managed or utilized by the IHS to improve patient care.

In August of 2015, the IHS used third party collections to pay an administrative settlement of a union grievance in arbitration. The settlement had two categories: \$60 million for back pay and back pay-related costs (such as payroll taxes), and \$20 million for administrative costs and attorneys' fees. Fifty million of the \$60 million amount was paid from third party collections and \$10 million from expired appropriations. The \$20 million was paid from then current FY 2015 appropriations.

Under federal law, third party collections are primarily to be used "to achieve or maintain compliance with applicable conditions and requirements" of the Medicaid and Medicare programs. If there are amounts collected in excess of what is needed for this purpose, such collections shall be used "subject to consultation with the Indian tribes being served by the service unit . . . , for reducing the health resource deficiencies (as determined in section 1621(c) of this title) of such Indian tribes."³ We are, therefore, greatly concerned by the fact that there was such a large amount of third party collections readily available to the IHS that was not being used for maintaining compliance or for reducing health resource deficiencies. We request that Congress look into this matter.

Use of Telehealth

Efforts are currently underway to utilize telehealth capabilities for behavioral health on the Pine Ridge Reservation pursuant to a Health Resources and Services Administration (HRSA) grant, but the Oglala Sioux Tribe believes that this technology should be used in a wider variety of circumstances by the IHS. The use of telehealth technology could be a powerful tool in addressing some of our most pressing concerns related to the prohibitive cost and other burdens of patient travel, as well as misdiagnosis and improper treatment, resulting from our remote location and the lack of certain medical services and expertise at the Pine Ridge Service Unit. Telehealth would provide access to experts while saving unnecessary patient travel costs to Rapid City and elsewhere.

Importantly, we understand for telehealth to work in all aspects of the Hospital, the Hospital needs to be completely wired. At present, we do not have the technological capabilities as only 50% of the Hospital is wired. For technology purposes, we also need one central system. Presently, we have three systems which causes problems in communications within the Hospital.

Respiratory Health Services

We need accessible respiratory care services on the Reservation. Currently, our members who need respiratory care services are sent to Minneapolis, Denver or Omaha. If those members are able to be weaned off of such care, they return home. However, if they are not able to be

³ 25 U.S.C. § 1641(c)(1)(B).

weaned off the care, they stay far from home and often end up passing away in these unfamiliar locales. The CMS survey discovered that the Pine Ridge Hospital had contracted a single respiratory therapist to provide respiratory services, but had failed to approve respiratory care policies and procedures for the Hospital. The Tribe would like these services available on the Reservation so our members can stay near their homes and their family members can have them nearby.

Youth Suicide Crisis

On February 17, 2015, the Tribal President issued a proclamation declaring a state of emergency on the Pine Ridge Reservation due to the high incidence of youth suicide. This is a critical problem that continues to plague our Tribe. According to IHS's numbers, an average of 30 persons with suicidal ideation with plan and intent visit the Pine Ridge Emergency Room per month, with one month recording as high as 58 persons.

We appreciate the help of this Committee in highlighting this most important issue. Our Tribe testified at the Committee's June 2015 hearing. We are grateful that Congress provided additional appropriations for methamphetamine and suicide prevention and treatment in the Omnibus. We also appreciate the attention of the Administration toward combating youth suicide on our Reservation and its focus on Native youth. Federal agencies came together to focus on this epidemic. We, however, need a sustained, intense effort.

Our mission has to be to provide our youth with hope and this can only happen by improving the quality of life on our Reservation and raising our people out of the oppressive poverty conditions they currently endure. This requires a comprehensive approach. Behavioral and mental health care must be a priority as well as education and youth engagement. But we also must address housing conditions, community infrastructure and economic development. It is only then that hope will not be elusive when our youth contemplate their futures.

An immediate need is to address the lack of adequate psychiatric care at the Pine Ridge Hospital. As stated above, the Hospital has no psychiatric unit, and lacks any appropriate facilities to handle psychiatric patients. These patients require specialized care for their own safety and the safety of others, but as it stands, they are forced to wait hours just to be seen by the one psychiatrist or by other hospital staff who may not have the specialized training to help them. In the past, the IHS permitted volunteers to come into the Service Unit facilities to sit with psychiatric patients, so at least they would not be left alone; however, the IHS has been forced to disallow that practice unless specifically requested by family members. Oftentimes, however, the families of these patients have limited means of transportation to even visit their loved ones in the Hospital and cannot get to the Hospital to provide the required request. As mentioned above, the Hospital currently diverts staff to supervise these patients which takes staff away from their other duties. We need to quickly implement a plan to address this issue.

Another immediate need is to get our safe houses operational. We have three existing safe houses that provide safe spaces where youth can be secure outside of their homes, but they are currently not running due to lack of funding for staffing and operations.

Dental Care Services Needs

We need more dentists to adequately provide dental care for our members. We also need capability for specialized dental care on our Reservation to avoid members having to travel to Rapid City or elsewhere for specialty services such as oral surgery. Finally, we need improved dental care. The general practice our members receive is to have their teeth pulled rather than treatments and procedures to save the tooth.

Conclusion

The recent CMS survey findings confirm the experience of our tribal members that not enough progress has been made by the IHS to improve Indian health care service delivery on the Pine Ridge Reservation. We hope that the survey findings and this hearing will pressure further reform, but we remain wary of a temporary fix. It would not be acceptable for the IHS to shore up the deficiencies identified by CMS only by diverting resources or attention to the detriment of other areas of the Pine Ridge Service Unit in a desperate attempt to maintain certification. Rather, in light of the longstanding and pervasive nature of IHS substandard quality of health care in the Great Plains Area, a root and branch approach is needed to achieve lasting reform.

Clearly, additional funding is needed. We need to make sure our Service Unit is fully funded. However, we need more than dollars. We also need to make sure that the Pine Ridge Service Unit is managed in such a way that patient care undoubtedly comes first, noncompliance issues are non-existent and the Unit is an attractive place to work for the best and brightest in the medical and hospital administration fields. Our facilities also need to have the capability to provide specialty care, at least in some specific areas, to cut down on the excessive and expensive travel our members must endure for health care services. We need to rectify the colossal issue of IHS referral denials and the financial problems associated with them.

All we want is quality health care for our people without the inordinately burdensome and oftentimes horrific struggles they currently suffer to receive any health care at all. Certainly, this should not be an unachievable goal in the United States of America, especially when the United States of America bears treaty and trust responsibilities to our people.

Thank you for the opportunity to testify.

Supplemental Testimony

Thank you Chairman and Members of the Committee for holding this important hearing. The witness testimony and answers from the Administration witnesses to your questions set forth the unfortunate substandard quality of Indian health care in the Great Plains. In addition to the requests in my written and oral testimony, I offer, on behalf of the Oglala Sioux Tribe, certain recommendations for following up on this hearing so that we can be sure concrete steps are being taken to address the many problems with health care delivery in the Great Plains that were identified during the hearing. A comprehensive plan is needed to address the many factors that contribute to the substandard quality of health care in our region. Our initial recommendations are set forth below and should be considered as steps toward the development of a comprehensive plan.

We request that workgroups consisting of Tribal Leaders and tribal health personnel, Administration officials and Congressional staff be formed to tackle the various issues identified during the hearing that need to be addressed for quality health care to be realized in the Great Plains Region. Workgroups on the following issues would be helpful: recruitment and retention of physicians, other medical staff and hospital administrators; housing for such staff; operations; purchased and referred care; facilities and equipment; telehealth and billing. While this is not an exhaustive list, it would be a start and it would continue the focus and efforts in areas we know need improvement. The mission of each workgroup would be to analyze the problems associated with each issue area and develop practical and real solutions to the identified problems. Barriers to quality health care and needs to overcome such barriers, whether they be administrative, lack of adequate funding or other would be analyzed and detailed. It is only by closely examining the root causes of why the Great Plains Area continues to fail to adequately carry out its responsibilities to provide quality health care to our people five years after Senator Dorgan's Report and by casting a wide net of ideas to address those root causes that we can expect to achieve the true reform we need.

We also request that the United States Senate Committee on Indian Affairs require the Indian Health Service to submit a monthly report to Congress which sets forth *at least* the following information about the IHS Great Plains Area: the status of Centers for Medicare and Medicaid Services (CMS) survey findings and IHS correction plans; the efforts of the IHS to recruit and retain medical and hospital administrator staff; the number of referrals denied by the IHS; third party billing statistics; staffing vacancies and staffing needs; statistics regarding staffing reassignments, administrative leave and tele-work; efforts to incorporate telehealth in the Service Units; facilities and equipment needs; efforts to address psychiatric care needs; efforts to address dental care needs; and efforts to address patient wait times to see medical staff. This list of subject matters is not exhaustive. However, we believe that requiring the IHS to provide the Committee this information on a monthly basis will not only help track actions by the IHS and identify ongoing problems with the provision of health care in the Great Plains Area, but it will also instill a greater level of accountability on the IHS as it carries out its duties to provide health care to our people.

The Oglala Sioux Tribe thanks the Committee once again for holding this important hearing. We respectfully request that you keep the issue of the quality of health care in the Great Plains at the forefront of your work. By doing so, the Congress, the Administration and the Tribes will be able to make sure that proper steps are taken toward finally achieving the reform we need to ensure quality health care for native people in the Great Plains Area.

The CHAIRMAN. Thank you very much, Ms. Weston.
If I could ask the Honorable William Bear Shield to testify.

STATEMENT OF HON. WILLIAM BEAR SHIELD, COUNCIL REPRESENTATIVE, ROSEBUD SIOUX TRIBE

Mr. BEAR SHIELD. Honorable Chairman Barrasso, Vice Chairman Tester, members of the Committee, and Senator Thune, good afternoon.

I am William Bear Shield, an enrolled member of the Rosebud Sioux Tribe of South Dakota. My family has served as public servants for generations. My father, William Bear Shield, Sr., was Chief of Police for the City of Gregory, South Dakota and killed in the line of duty on July 26, 1976.

We have served during World Wars I and II as well as in the Korean and Viet Nam Wars and in current wars. I served in the United States Army and was a combat veteran during Desert Storm. I lost my hearing from artillery fire during combat. Since Desert Storm, I have suffered nerve problems, skin irritations, back problems and had cancer surgery.

After receiving an honorable discharge in 1991 from the United States Army, I returned home and was elected to Tribal Council in the fall of 1991 for the first seven terms and served on the Rosebud Tribal Health Board for several terms.

In 2011, I was again elected to Council and I was placed on the Health Board and elected Chairman. I also have been designated by the Tribe to sit on the Great Plains Tribal Chairman's Association and Health Board which covers the States of Nebraska, North Dakota and South Dakota.

Because of health concerns for tribal members being mistreated at the Sioux San Hospital in Rapid City, the tribes created the Unified Tribal Health Board of which I am currently the Chair. This board allows for support and advocacy of our membership in the Rapid City area.

I recently have been nominated to sit on the Health and Human Services Secretary's Tribal Advisory Committee.

I want to start by thanking you and the Committee for sending out your staff to our area last month to gain insight into our concerns. I am here on behalf of President William Kindle and the Sicangu Lakota Oyate.

Our utmost concerns are quality and safety of health care for our people. These concerns have been ongoing for generations and unfortunately for our tribe, continue to get worse. The lack of funding plays a crucial role in our challenges. However, we have witnessed firsthand the level of mismanagement and unethical practices both at the area level as well as at the local level that is completely unacceptable and disrespectful to our ancestors and our treaty with the Federal Government.

The dysfunction of the Great Plains area has only grown in intensity since 2010. Our people continue to pay the price for these atrocities with our lives and health. I would like to take the opportunity to share with you some of these concerns.

Our tribe has organized numerous meetings with IHS leadership nationally, regionally and locally, HHS leadership and congressional leadership over the past 15 months. We have been voicing our concerns and demanding to be involved. We have said that the current situation was going to occur and wanted to prevent it but we went unheard.

HHS acknowledges the trust responsibility and the need for meaningful consultation with the tribes in their testimony today but their actions contradict this. Just this week, the decision was made to remove our current director from the Great Plains area and a replacement was appointed. However, there was no tribal

consultation regarding this. This is only one example but the point is their actions do not align with their words.

We want an explanation as to why the past area director was abruptly detailed somewhere else and is not here today to answer our concerns.

On November 16th, CMS came to our IHS facility for a full hospital recertification survey and to investigate alleged EMTALA complaints. Two days into the survey, they found significant quality and safety issues in the emergency department that posed an immediate and serious threat to any individual seeking care and placed the service in an immediate jeopardy status. This extremely significant finding was not timely addressed by IHS.

At 4:00 p.m. on Friday, December 5th, our tribal health administrator and president were informed that HHS continued to identify significant issues in the ER and they were going to be relieving multiple staff of their duties. Therefore, effective the following day, Saturday, December 6, 2015, the IHS was suspending their designation as a dedicated emergency service.

The tribe was outraged. The lack of planning and communication on the part of IHS caused severe and significant hardships to our communities and surrounding healthcare facilities. In fact the surrounding hospitals, who then became responsible for providing this service to our people, were not contacted by IHS at all.

Furthermore, we were informed this diversion would last about six weeks. We are still on diversion and have been informed it could be another 30 to 60 days.

Another interesting fact is that no employees were relieved of duty. The same staff providing care in the ER is now the same staff providing care in the urgent clinic. To put this in perspective from a patient view, three weeks ago our ambulance was dispatched for a patient having chest pains. They responded within 10 minutes of the call. Immediate CPR was started and the patient was transferred to the nearest ER in Valentine, Nebraska, over 50 miles away. Our hospital was seven miles away.

The staff at Valentine worked on our relative but unfortunately he did not make it. This diversion poses real life or death risk to our people. We cannot predict when an emergency will happen but we are confident that the longer the service is available, the higher the risk to our people. This is unacceptable.

Over the past year, we have had at least five executive level positions filled with acting problematic employees who have been asked to leave other reservations in our region. These employees played a huge role in getting us in the situation we are in today.

We have been informed of recent hiring practices of at least five nurses of whom at least one did not have an active license and three were hired with temporary licenses. Furthermore, the relocation expenses and hiring practices with regard to these nurses was extraordinary.

We have been informed that the interview of one of the nurses was conducted in another language. How is this justifiable when we have elders that only speak Lakota who now are being expected to understand and convey their health issue to these providers.

It is a direct reflection of the severe lack of leadership and oversight of our facility and of the Great Plains area. The disheartening

and traumatic realities described above are the creation of choices to create treaties long ago, choices to dishonor those treaties, budget choices, allocation choices, the choice of professional leadership to act unethically and against the exact mission with which they are tasked and the health and behavioral choices of individual people.

If there is to be meaningful and sustainable change, all of these issues must be explored and addressed. Such public and political education will only occur when the current dangerous status quo is exposed and a mobilization by politicians, native communities and the healthcare community unite for change.

Until then, the premature deaths of our people and this dysfunction we speak of will continue to flourish. We expect change. We are here willing to be an active player to achieve this change we dream of. We will not accept anything less than you or the President of these United States or anyone else expects of your healthcare and needs of your loved ones.

In the next couple of week through written testimony, we will offer solutions to our healthcare woes. We need your help. Address tribal resolutions. Besides addressing the budgetary shortfalls, cut the wasteful spending of the area office. Get rid of the area office. It does us no good. Historically, they work against us.

Help us get funding straight to our service units from HHS where the money will go towards the health care of our people.

I would also like to thank Senators Thune, Rounds, Franken and Heitkamp for their letter to the Committee and asking for this hearing.

It may be too late for many of our members, but it is not too late to make a change for better health care for the Native children that come from the poorest counties in our Nation.

Thank you.

[The prepared statement of Mr. Bear Shield follows:]

PREPARED STATEMENT OF HON. WILLIAM BEAR SHIELD, COUNCIL REPRESENTATIVE,
ROSEBUD SIOUX TRIBE

Good afternoon, Chairman Barrasso, Vice Chairman Tester, and Members of the Committee:

I am William Bear Shield and an enrolled member of the Rosebud Sioux Tribe of South Dakota.

My family has served as public servants for generations, my father William Bear Shield was the Chief of Police for the City of Gregory, South Dakota and was killed in the line of duty on July 26th 1976. We have served during World War I and II as while as the Korean and Viet Nam War. I served in the United States Army and was in combat during Desert Storm. I lost my hearing from artillery fire during combat. Since Desert Storm I have suffered nerve problems, skin irritations, back problems and had cancer surgery.

After receiving an honorable discharge in 1991 from the United States Army, I returned home and was elected to Tribal Council in the fall of 1991 for the first seven terms and served on the Rosebud Tribal Health Board for several terms. In 2011 I was again elected to Council and I was placed on the Health Board and elected Chairman. I also have been designated by the Tribe to sit on the Great Plains Tribal Chairman's Association and Health Board which covers the States of Nebraska, North Dakota and South Dakota. Because of health concerns for Tribal members being mistreated at the Sioux San Hospital in Rapid City the Tribes created the Unified Tribal Health Board which I am the Chair of. This board allows for support and advocacy of our membership in the Rapid City area. I recently have been nominated to sit on the Health and Human Services Secretary's Tribal Advisory Committee.

I want to first start out by thanking you and the committee for sending your staff out to our area last month to gain insight to our concerns.

I am here on behalf of President William Kindle and the Sicangu Lakota Oyate. Our utmost concern is the quality and safety of healthcare for our people. These concerns have been ongoing for generations and unfortunately for our Tribe continue to get worse.

The lack of funding plays a crucial role in our challenges however, we have witnessed firsthand a level of mismanagement and unethical practices both at the Area level as well as the local level that is completely unacceptable and disrespectful to our ancestors and to our treaty with the federal government. The dysfunction of the Great Plains area has only grown in intensity since 2010, our people continued to pay the price of these atrocities with their lives and health.

I would like to take this opportunity to share with you some of our concerns.

Mutliple Attempts for Meaningful Consultation to Prevent the Current Situation

Our tribe has organized numerous meetings with IHS leadership nationally, regionally, and locally, HHS leadership, and congressional leadership over the past 15 months. We have been voicing our concerns and demanding to be involved. We have been saying that the current situation was going to occur and wanted to prevent it. We went unheard.

The HHS acknowledges the trust responsibility and need for meaningful consultation with tribes in their testimony today but their actions contradict this. Just this week the decision was made to remove Ron Cornelius as the Great Plains Area Director and a replacement was appointed however, there was NO tribal consultation regarding this. This is only one example but the point is their actions are not aligned with their words. We want an explanation of Ron Cornelius' abrupt detail and not being here today to answer to our concerns.

Closure of ER Services

On Nov 16th, CMS came to our IHS facility for a full hospital recertification survey and to investigate alleged EMTALA complaints. 2 days into the survey, they found significant quality and safety issues in the Emergency Department that posed an immediate and serious threat to any individual seeking care and placed the service in an Immediate Jeopardy status. This extremely significant finding was not addressed by IHS timely. At 4pm on Friday Dec 5th, our tribal health administrator and President were informed that IHS continued to identify significant issues in the ER and they were going to be relieving multiple staff of their duties and therefore effective the following day, Saturday Dec. 6th the IHS was suspending their designation as a dedicated Emergency Services. The tribe was outraged. The lack of planning and communication of the part of IHS caused severe and significant hardships on our communities and surrounding healthcare facilities. In fact the surrounding hospitals who then became responsible for providing this service to our people, were not contacted by IHS at all. Furthermore, we were informed this diversion would last about 6 weeks, we are still on diversion and have been informed it could be another 30–60 days. Another interesting fact is that no employees was relieved of duty. The same staff providing care in the ER is now the same staff providing care in the Urgent Clinic. To put this in perspective from a patient view, 3 weeks ago our ambulance was dispatched for a patient having chest pain. They responded within 10 mins of the call. Immediate CPR was started and the patients was transferred to the nearest ER in Valentine NE over 50 miles away. Our hospital was 7 miles away. The staff at Valentine worked on our relative but unfortunately he did not make it. This diversion poses real, life or death risk to our people. We cannot predict when an emergency will happen but we are confident that the longer this service is unavailable, the higher the risk to our people. This is UNACCEPTABLE!

Recycling of Problem Employees

Over the past year, we have had at least 5 executive level positions filled with Acting problematic employees that have been asked to leave other reservations in our region. These employees played a huge role to get us in this situation.

Recruitment Practices

We have been informed of recent hiring practices of at least 5 nurses of whom at least 1 did not have an active license and 3 were hired with temporary licenses. Furthermore, the relocation expenses and hiring practices with regard to these nurses was extraordinary. We have been informed that the interview of one of the nurses was conducted in another language. How is this justifiable? When we have elders that only speak Lakota and now are being expected to understand and convey

their health issue to these providers. It isn't, but it is a direct reflection of the severe lack of leadership and oversight of our facility and of the Great Plains Area.

The disheartening and traumatic realities described above are the creation of choices. Choices to create treaties long ago. Choices to dishonor those treaties. Budget choices, allocation choices, the choice of professional leadership to act unethically and against the exact mission they are tasked with and the health and behavioral choices of individual people. If there is to be meaningful and sustainable change here, all of these issues must be explored and addressed. Such public and political education will only occur when the current dangerous status quo is exposed and a mobilization by politicians, native communities and the healthcare community unite for change. Until then, the premature deaths of our people and this dysfunction we speak of will continue to flourish. We expect change. We are here willing to be an active player to achieve this change we dream of. We will not accept anything less than you or the president of these United States expects for your healthcare and that of your loved ones. It may be too late for many of our members, but it is not too late to make a change for better healthcare for the native children that comes from the poorest counties in our nation.

This concludes my testimony and I am happy to answer any questions you may have.

The CHAIRMAN. Thank you for your testimony and thank you also for your service.

Our next witness to testify is Mr. Jace Killback, Executive Health Manager, Northern Cheyenne Tribal Board of Health from Lame Deer, Montana. Thank you so much for joining us today.

STATEMENT OF JACE KILLBACK, EXECUTIVE HEALTH MANAGER, NORTHERN CHEYENNE TRIBAL BOARD OF HEALTH

Mr. KILLBACK. Thank you, Chairman Barrasso and distinguished members of the Committee who are still here with their staffers.

I am submitting written testimony so a lot of the issues that were brought up we share that sentiment with the tribes. I do thank Senator Thune, the non-Committee member, for sticking it out with us.

On behalf of the Northern Cheyenne Tribe and the tribes of Montana and Wyoming, your State, I provide this testimony.

It was my ancestors, my great grandparents, who paid for goods and services in exchange for lands, freedom and peace with their blood. We expect nothing less in return with our treaty rights and our trust responsibilities. That is not being fulfilled by the Federal Government.

It took a lot to come here to the place of power, for my office to come here, getting resources to travel here. I would like the staffers to take these messages to their bosses. It would have been more appropriate for the tribal leaders here to speak first; they have traveled a long way.

I am reiterating the fact that IHS is a broken system, a broken system with no funds. Constantly having to deal with decisions and budget cuts and never being able to recover from sequestration, tribes constantly ask and have in the last few years for advance appropriations and to have our funds protected from discretionary title. We have an entitlement to these funds.

We learned through the Affordable Care Act that IHS is not health insurance. Indian tribes were left in the dark when it rolled out because none of our community members were able to be properly empowered or educated on the importance of having health insurance.

This opportunity is being missed by the IHS as a means to improve or enhance their third party collections. The culture we talked about today, the culture of misdiagnosis, poor customer service, lack of resources, not having proper equipment, losing accreditation, will continue.

I ask the leadership, the Senators and their staffers, do you know the difference between direct service tribes and self governance tribes? Do you know the dichotomy that exists with the budget formulation process tribes currently go through right now?

Do you know that we, the Northern Cheyenne, view this as a tactic of divide and conquer amongst tribes who fight over scraps for IHS funding? Funding is an issue. We know it is the major issue. We wonder why and how these areas, the Great Plains, the Billings area, the Rocky Mountain area, consistently have to deal with IHS's substandard quality of care and the lack of resources. The tribes are labeled the do nothing tribes or the handout tribes.

One of our elders likened it to the old notion of hang around the fort. Which tribes hang around D.C.? In the past, which Indians hung around the fort to receive rations first? Tribes who do not have the resources or the wherewithal, the consultants or the lawyers to travel to this place of power, Washington, D.C., to get help or get your ears, are the ones left out.

Capacity is an issue. Capacity is an issue for tribes in our region because our tribal governments lack those resources. When we try to move forward towards Title V under the 638 law, we are met with red tape and resistance because career and legacy IHS employees do not want to lose their jobs.

It should be the opposite. They should be working themselves out of a job and letting us become more self reliant and self determinant as tribal nations.

The healthcare system and the Federal Government, I want to again reiterate that the bureaucracy is causing these issues we are talking about, that our tribal counterparts are mentioning.

A perfect example was contract support costs. Self governance tribes agreed probably at the detriment of direct service tribes to take funds from the headquarters and tribal shares to pay for fully funding contract support cost claims. That is a perfect example of this divide and conquer tactic.

Other issues I wanted to bring up are in regard to the issue of life or limb. The PRC changed its name to Patient Preferred Care but it is still CHS. Often doctors in our local IHS service units have to game the system to get a CT scan. It may be considered a Level 2 service but they will find a way to game the system and make it a Level 1 so their patient who they care about can get that CT scan.

Yesterday I heard my board member lost his wife to cancer. If she had gotten a colonoscopy sooner, maybe they would have been able to treat the cancer. The issue was the doctor said there was no blood in her stool so they could not refer her out.

That touches home because that is a tribal leader who lost his wife because of this direct care. As direct service tribes, we constantly have to battle funding issues related to the PRC system and the level of care we ask for. This is a trust responsibility and a treaty right.

Solutions I want to recommend in closing are you heard about recruitment and retention. IHS does need to be able to compete with the private sector. There need to be more opportunities than just the loan repayment program.

In Montana, recently the legislature passed the Help Act which provided us with Medicaid expansion. In consultation with the tribes, the State of Montana and the Governor created an Office of American Indian Health to deal with the health disparity that Senator Tester mentioned earlier, that a whole generation of Indian people in Montana is dying before our white counterparts.

We think there should be some facilitation to improve and increase tribal-State relations and also build capacity and in the transition for direct service tribes to self governance. We hope the Committee hears these and we thank the distinguished members of this Committee for allowing me to express the views of the Northern Cheyenne Tribe and the region of the Billings area.

Thank you.

[The prepared statement of Mr. KILLSBACK follows:]

PREPARED STATEMENT OF JACE KILLSBACK, EXECUTIVE HEALTH MANAGER,
NORTHERN CHEYENNE TRIBAL BOARD OF HEALTH

Chairman Barrasso, Vice Chairman Tester, and Members of the Committee, thank you for holding this important hearing on the substandard quality of health care experienced by Indians in the Great Plains and more specifically in my region, the Rocky Mountain Area which includes both the Chair and Vice Chair's home states Montana and Wyoming.

On behalf of the Northern Cheyenne Tribe and the Tribes of Montana and Wyoming, I submit this testimony.

My ancestors, my great grandparents paid for goods and services in exchange for lands, our freedom and peace—with their blood. Their sacrifice was made for me, my grandchildren and their grandchildren into perpetuity. Because of our Treaties with the federal government and your promises to my people there is a trust responsibility for your government to provide health care to my People: Your trust responsibility is not being fulfilled! I come to you revealing a tragic and sad truth: health care is rationed and inadequate for the Northern Cheyenne and surrounding Direct Service Tribes. We are required to utilize this inadequate, hostile system in our isolated and frontier parts of the United States—the places we call home.

IHS: A Broke and Broken System

The Senate Committee on Indian Affairs should be experts now on the funding issues that plague the Indian Health Services (IHS). For years the data show that the IHS has continually operated on a close to 40 percent budget. IHS has never been fully funded based on need. In addition, the IHS Budget has never recovered from budget cuts, recessions and sequestration. We all should know by now that increased funding and advanced appropriations will make a huge and positive impact in the IHS healthcare system. Even more important, Congress needs to protect the IHS budget from discretionary funding and budget cuts. Of course these realities help create and sustain a health care system that the Northern Cheyenne and other DSTs are forced to utilize because it's the only game in town. No matter that it is substandard, lacks any real resources, and is not customer-friendly or culturally appropriate toward its patients. We need to be progressively aggressive in preventing and treating diseases in our communities, to remain eligible and mission driven to meet accreditation standards and to effectively compete with the private sectors. IHS is not a public health system.

IHS is not health insurance. We learned this the hard way with the implementation of the Affordable Care Act in Indian Country. This distinction about insurance was not made clear in our communities and the federal government missed an important opportunity to educate and empower tribes and Indians. Now that tribes have to subsidize the underfunded IHS system with other agency grants, third-party revenue and even Tribal dollars, when possible. Tribes have to be more and more creative in providing support for the direct health care of our tribal citizens. I say direct care because the Tribes in our regions are still a majority direct service tribes.

Direct Service Tribes

How many distinguished members of the committee know the dichotomy of the IHS Tribes? It is Public Law 93-638, the Indian Self-determination and Education Assistance Act of 1975, empowered and created authorities for tribes to be truly sovereign nations in managing and governing federal resources for their people. In healthcare, PL-638 has shown that the levels of tribal government capacity in regard to self-governance varies within the 12 IHS regions. Most commonly, the Tribes in Montana, Wyoming, South Dakota and North Dakota remain Direct Service Tribes. And in the more recent decade, this label has had a negative connotation that is associated with the “do-nothing tribes, hand-out tribes, or the tribes who don’t have stable governments, lack tribal resources to hire consultants and lawyers, who lack funds to lobby and travel to the place of power—Washington DC.” The playing field for tribes is far from level.

Direct Services Tribes receive health care directly from the federal government and these areas that still have direct service tribes tend to be viewed by other Tribes and by IHS as unsophisticated and uneducated governments who lack the understanding to taken advantage of Title 5 of the Indian Self-determination Act. The scrutiny is that if we, the Direct Service Tribes of the Great Plains and Rocky Mountain Area complain so much about IHS, than why don’t we just take over the clinics, hospitals and programs and run them ourselves? First of all, why should we have to? But, it’s just not that easy to do.

Tribes like the Northern Cheyenne still have our language and our ceremonies, we still have customs and traditions that are original to this land and seem foreign to the federal government. The Northern Cheyenne were one of the last tribes to lay down our arms against the US Army. We resisted the longest and now we suffer the most.

Now when Tribe’s in our areas want to contract or compact, we are met with resistance and red tape. Federal employees who work for the IHS would be working themselves out of a job if they help to ensure that the Tribes and Tribal Health Programs can properly manage their own health care functions, the purpose of PL-93-638. In the DST-dominant areas of IHS, our federal Indians are career driven and legacy minded professionals who are quick to hinder our efforts instead of helping our cause to be self-determined in our healthcare. Examples include the contracting of clinics, business office functions and the Patient Referred Care for tribal premium sponsorships programs under the ACA.

The healthcare system under the Federal Government is set-up as a divide and conquer tactic that can be compared to the “hang-around the fort Indians” concept where those who are in Washington, DC (the fort) get the help (the food and health rations) first.

Direct Service Tribes are pitted against the Self-governance Tribes annually when it comes to IHS and HHS Budget Formulation process. Priorities of one group versus another group are discussed and debated on where the already underfunded budget allocation (or increases) for IHS will go. The federal government has us fighting over scrapes again and history is only repeating itself.

The problem with this and the difference between Direct Service Tribes and Self-Governance Tribes is capacity. As a direct service tribe, I know we are still making gains to build our capacity to be able to take over our clinic and run it the way we would like in a culturally significant manner, free of federal bureaucracy. But because we, ourselves, have been given a tribal government system through the Indian Reorganization Act that assures a revolving door of tribal instability, we continually have to start over every two years to make any real progress towards true self-governance. Yes, this portion of the situation is ours and we are moving towards tribal government reform and we will revise our tribal constitutions: we will get there.

Take for example the hot issues of Contract Support Cost (CSC). The fact is the IHS had to eat the cost of fully funding CSC last year and did so mostly at the expense of Direct Service Tribes. Then on May 22, 2015 we learned that the IHS paid out \$68 million to settle overtime disputes with 20,000 IHS employees. \$48 million came from the third party billing revenues Tribes fight to bring in to fund our system. Why was that funding sitting at Area IHS offices, available for re-purposing when our People are desperate for doctors and other health care providers? Again, 11 IHS doctors were sent to Africa to address the Ebola Virus outbreak—when our own People are dying in a health system with nearly 40 percent vacancy rates for physicians in the Great Plains Area, alone. Here we have an already underfunded healthcare system being gouged to take from its coffers money funds and capacities that are supposed to be used to provide direct health care for tribes like the Northern Cheyenne. And now these funds are being used to pay for indirect cost for tribes who are empowered and experts of PL-638 and who provide their own tribal health

care; back pay from a mis-managed personnel system and for Peoples overseas with whom the federal government does not have a trust responsibility!

In the case of the CSC case, the federal government with approval of Tribes (mostly self-governance tribes) agreed to support the taking money from the direct service tribes to pay for the majority of self-governance tribes contract support cost. Sure, the Northern Cheyenne will be settling our CSC claims but it is sad to think that the money is coming from our IT support shares from headquarters or the IHS nurses and doctors salaries in Lama Deer, Montana.

So why doesn't the committee question the system they authorize and fund? This system is still a paternalistic model of colonization. There are tribes at all different levels of success and self-governance. Take a look at the Tribes in the Great Plains and Rocky Mountain areas and see where our capacity is and see how our relationship with the federal government is. It has become normal and "ok" to: be misdiagnosed by locums who are contacted on the weekends to work in our ERs; to wait until you're going to lose a leg or your life in order to be referred out to receive the right healthcare you need; for a baby to be born in a car on the way to the Northern Cheyenne hospital because IHS no longer delivers babies at Crow hospital. If you go out of IHS to make a life decision for your family or yourself that does not meet the IHS standard of "life or limb," you will have to pay for it yourself. Many of my people have been sent to debt collectors or had their fixed incomes compromised because they could not pay for medical care that IHS denied. This protocol has administrators making business decisions over medical providers' medical directions. Now you have doctors at the local level learning ways to game the system in order to ensure that a tribal member receives a CT scan that will eventually save their life versus waiting until one's health erodes into a far more costly and life-threatening condition.

Since we cannot get referred out to for "Level 2 or Level 3" services under the PRC system, tribal members remain in pain or their diseases go undetected and untreated. Most become addicted to pain pills or lose faith altogether and resort to self-medication with alcohol or substance abuse. This vicious cycle, along with the circumstance I mentioned with the funding and capacity issues for Tribes, makes one believe that the Indian Wars are not over and that the treaties continue to be broken and that there is not "trust" worthy of our U.S. Government's responsibility.

In closing I want to point out some positives and solutions that seem to be working in Montana.

1. Montana, Medicaid Expansion and Tribal-State Relations

The Northern Cheyenne has a political and government-to-government relationship with the federal government and yet we are still being classified and grouped into race or ethnicity driven discussions. For example, in Montana, the state issued a report in 2013 identifying the mortality rate of American Indians to be 20 years less than that of our white, non-Indian neighbors. We die a whole generation before our white counterparts. This figure went unmentioned and was not addressed. With an alarming health disparity that is based on a denominator of race/ethnicity, the report and the figure neglected to acknowledge the political status First Montanans have in respect to State-Tribal relations. Montana responded and Governor Steve Bullock met with Tribes to create, by Executive Order, the Office of American Indian Health to address the health disparities Indian people face in the State.

As of January 1st, 2016 some 20,000 American Indians in Montana became eligible for Medicaid Expansion under the HELP Act. With Medicaid Expansion. Tribes and more importantly, IHS facilities are able to increase their billing opportunities for the services they provide to increase revenue that hopefully increases the PRC referrals and direct services. We thank the state for picking up the slack of the federal government.

2. Recruitment and Retention

Recruitment and retention of qualified medical providers is a game changer. For example, the emergency rooms are difficult to staff with permanent ED physicians. Coverage is provided by contract doctors. Primary care doctors then have to cover the ED, which destabilizes the primary care setting and that is our core function. I believe that if IHS fully staffed all the service units with providers many of their issues would disappear. IHS could then focus on optimizing the delivery model and improve access points for the patients. Again, speaking as a Direct Service Tribe, recruitment is more than just pay and with competing against the private sector, IHS should consider their own health care infrastructure (newer equipment, robust EHR, support staff, adequate space etc.), schools, housing, shopping, cell coverage and spouse satisfaction to name a few.

Fill all vacancies and streamline the selection and hiring process for positions. Work with Tribes on fillings positions and remove the PSA requirements for top-level positions. Too often the IHS is burdened with career-oriented and legacy minded individuals who lack any true commitment to the service of tribes and American Indians. Cultural competency should be a standard in recruitment also.

3. Transition Toward Self-governance

Provide better technical assistance and funds for Direct Service Tribes to begin to transition into Self-governance. Begin a pilot project for Tribes in the Great Plains and Rocky Mountain areas to help build capacity and strategize a plan to increase contracting and eventually compacting services and function of the IHS.

4. Allow Tribes to be Voting Members on IHS Governing Boards

Tribal participation on IHS's Clinic/Hospital Governing Boards is limited to ex-officio status. Allow Tribal representatives to have full membership and insurance coverage to make decisions on these boards in a true government-to-government manner. This would also train and prepare Tribes to transition into self-governance.

Thank you for the opportunity to offer this testimony for the committee on this important topic that I am so passionate about. I express the Northern Cheyenne Tribe's support for the work that this Committee has previously done to support the Indian Country and look forward to working with you to find solutions for to achieve excellent health care delivery and status of our indigenous people.

The CHAIRMAN. Thank you very much, Mr. KILLSBACK.

At this time, we will go to questions. Senator Thune.

Senator THUNE. I would direct this to the panel. You obviously heard Mr. McSwain state that the IHS is committed to a transparent working relationship with Rosebud, Oglala and Omaha Winnebago tribal leadership.

To date, how transparent do you feel the IHS has been and what recommendations would you make to improve IHS's transparency with the tribal leadership?

Ms. KITCHEYAN. I would like to address that. I would say we have made great strides from last July when we first learned of our CMS termination through the media. The former area director was in our tribal chambers reassuring us that everything was fine. We have come a long way since that time.

We have weekly calls, a monthly face-to-face but we have begun to feel as if it is just lip service. We are not seeing improvements that we would like to see quick enough, as I mentioned in the blizzard situation.

There is not complete transparency. We ask for things. Some of the questions seem repetitive. We ask for them over and over again. In some sense, we are being entertained but are not getting the solutions our community needs and that we need to provide to assure them that the health care is back on track.

Senator THUNE. Do you feel that IHS is responsive to the concerns of the tribal council and the Tribal Chairman's Health Board when they bring forward issues?

Ms. KITCHEYAN. I think collectively between the Tribal Health Board and IHB, the National Indian Health Board, the tribal councils, it is taking all of us to work together to get to this point. Each individual agency, I do not think, has received answers they deserve or have asked for.

Mr. KILLSBACK. Senator, in the Billings area under Dorothy Dupree as Acting Director, she allowed the tribes to be ex officio on the governing boards for the facilities. In my written testimony, I have asked that they allow tribal representation to be voting members of these governing boards over these facilities so that

they know the ins and outs of the accreditation standards that are needed, the reporting standards that are needed in managing a medical facility.

That was a solution and right now we are asking for full voting authority to be members of these governing boards.

Senator THUNE. Ms. Weston?

Ms. LITTLE HAWK-WESTON. I believe that IHS need to needs to be more I guess based on consultation. I believe they need to do more of the consultation piece to the tribe, especially the tribal leaders.

One of the Senators talked earlier about a communication breakdown between the staff in D.C. and the Aberdeen area down to the local service units. I believe that sometimes communication is not happening between the staff here in the D.C. area and down to our service unit directly at times.

I think there is a communication breakdown but I really believe that the tribal leadership needs to be involved in a lot of these meetings. I know what Mr. Killsback mentioned is the governing body meetings. I know representation from the tribe all the time is the chairman of the tribe or the chair of the Health and Human Services committee.

I believe sometimes we are notified and there are times we are not notified. I really believe the consultation piece needs to be reinforced to make sure that IHS is consulting with tribal leadership, especially when it comes to budgetary or any other important decisions based on our IHS service units. That needs to continue all the time.

Thank you.

Mr. BEAR SHIELD. Senator Thune, I think even since the CMS review and we had a plan of correction in Rosebud that was accepted by CMS, there still continues to be practices that continue that just do not give us any hope that things are being taken seriously.

I feel there needs to be more direction as far as up the chain where they need to be more actively involved and help us work towards getting our ER services reopened. The other day it was supposed to be reviewed to see if we could open the first part of February. From what we are hearing, by no means are we ready for that.

In answer to your question, I feel that there is a lot of work yet to be done. In my testimony when I mentioned our resolutions between the Committee and Congress, besides budgetary woes that we fall on, listen to the tribes.

Your staffers are great. Ms. Hoelyn is a great asset in listening to us and addressing and letting me know how things are. You will be seeing some of the resolutions coming from us. We are addressing some of what we want to see for the future.

Some are short term but there will be long term solutions. We need your help. You will see that in the next ten days or so.

Senator THUNE. My time has expired.

The CHAIRMAN. Go right ahead.

Senator THUNE. Ms. Weston, you mentioned in your testimony air ambulance flights that place a significant burden on the service area's budget. I have recently been told that IHS does not have a flat contract with providers in the area.

Since this is clearly placing a burden on the operating budget, do you know if IHS has been exploring ways to standardize these flights to ensure continuity when it comes to billing?

Ms. LITTLE HAWK-WESTON. I think the area of the air ambulance was a concern a while back with the HHS committee as well as leadership. We only had one air ambulance picking up our patients and taking them either to Rapid City, Sioux Falls or Scotts Bluff, Nebraska.

We had inquired about what was going on, we only had one air ambulance. Come to find out there were other vendors that also transport patients but according to the Acting CEO they call on one air ambulance because they have a contract with that air ambulance according to the way the structure is with the Aberdeen area on how they RFP out vendors to pick up patients within the Indian Health Service.

They utilize only one air ambulance right now. The cost of it we were told was enormous. We did get copies from the Acting CEO on the amount of money we were spending. I will tell you that it is quite high. I think she did mention it does take a lot from the base budget of the Indian Health Service at our service unit.

Senator THUNE. Thank you, Ms. Weston.

Mr. Chairman, thank you so much. Thank you so much for being here today. It has been very, very helpful.

The CHAIRMAN. Ms. Weston, if I could follow up a bit on what Senator Thune was talking about. When these folks are transported for care, families are a long way away. Can you talk about some of the challenges of just getting people back home after they have received their care?

Ms. LITTLE HAWK-WESTON. That is one of the concerns of our tribal membership back home on the Pine Ridge Reservation. One of the things that we as tribal leadership has found is that we are spending quite a bit of money out of our general fund budget within the Oglala Sioux Tribe to transport our families to and from the hospital.

At times, we have to pay for the cost of their transportation, their hotel room, food and whatever else that comes with the time the family has to stay there at the hospital.

On the tribal side, we are spending quite a bit of money. I think I did address that in my testimony, how much we are spending within the Pine Ridge Indian Reservation, the general fund of our tribe.

It is always a concern because we have to send the family when a loved one is in a hospital, whether it be in Rapid City, Sioux Falls, Minneapolis or in one of the Nebraska hospitals. It is a big concern of ours and a big concern of our families back home.

The CHAIRMAN. Ms. Kitcheyan, you talked about CMS's confirmed surveys that a number of tribal members have died unnecessarily due to deficiencies. Can you discuss what impact that had on the community?

Ms. KITCHHEYAN. It has had a horrible impact on the trust. Our people do not want to go to the facility. IHS then tells us that our average daily patient load is down, a means of determining the needs of the hospital. The need is there but our people do not want to go. They look at it as a death trap.

People are suffering at home. They are refusing to seek the care they need. As I mentioned in my testimony, this is our only option. Most of our tribal members do not have insurance or do not even have a vehicle or resources to go somewhere else to maybe an urgent care facility or something like that.

It really has impacted the morale of our community and the morale of the employees at the hospital. They are afraid. We have been told that the nurses were told not to admit because they do not want to be scrutinized and further cited in CMS reports.

In addition, we have many people who have procedures done in Sioux City or other places and they want to come home to recover. They cannot come home because they will not admit them, yet we have vacant beds and patient nurses and staff who refuse to go downstairs and help the clinic.

Who can make these nurses work? These are Federal employees, collecting a paycheck, refusing service. It has had a terrible impact on the trust of the community. They come to the tribal council. We feel helpless. We cannot make those nurses work. We cannot make them admit our people.

Beyond that, sometimes they lack the equipment to even service these patients who want to come home. My Auntie Debbie who I mentioned in this report was one of those people who came home after having an amputation. She died just recovering, over-medicated, did not take the pain patch off and continued to give her medication. She was a dialysis patient. They overdosed her.

There is fear within the community to even go there. It is terrible.

The CHAIRMAN. Would any of the other three of you like to comment on that or give some final thoughts or comments you might have or something else that has come to your mind?

Mr. KILLSBACK. I just want to reiterate the capacity topic I brought up about tribes in our area that want to go to self governance, that there should be some additional resources or a pilot project where we can take on the function of our service units, manage our clinics in a more culturally significant way that benefits our people because we know our people. Let us do the recruitment and retention piece.

Again, with capacity building and self governance tribes are able to be more a lot more flexible, have a lot more billing opportunities that brings in revenue to supplement the underfunding that IHS already receives and would allow us to build better capacity in regard to consultants and having lawyers and experts help us with our governance piece.

The CHAIRMAN. Anyone else?

Mr. BEAR SHIELD. Once again, I would like to thank you for having us today and allowing us to voice our concerns. I think the main thing is we are also here to offer possible solutions. We just need the help of Congress and committees like you.

Thank you.

The CHAIRMAN. Ms. Weston, any final thoughts?

Ms. LITTLE HAWK-WESTON. I also want to say thank you for holding this important hearing today and bringing us all the way from our reservation.

I want to say everything we spoke about in our opening statement is very true to our heart. Also, we need to make improvements within the IHS facilities but we cannot do that unless we have full funding.

Today, I think our service unit only receives 50 percent of base funding. We would like to see one day 100 percent funding so that we can address the adequate space, equipment for our facilities and staffing. We also want to see maybe an increase in our purchased referred care, including our transportation costs.

All of this comes back to how we would like to work with IHS to sit down and look at ways of how we can improve the quality of health care for our people back home. That is what I want to say today, Senator.

With that, I would like to say thank you for bringing us here and giving us time to talk about the many concerns we have about our tribal members back home.

The CHAIRMAN. Thank all of you so much for your testimony. The hearing record will remain open for two weeks. I want to thank you all for being here.

I think you all know that when this oversight hearing concludes in a few moments, we are going to have a very short recess and then follow this with that a listening session called Putting Patients First, Addressing Indian Country's Critical Concerns Regarding the Indian Health Service.

The statements made during that listening session are also going to be included in the record of this hearing for today. Everyone's voice will be heard.

I know numerous tribal leaders and tribal organizations have traveled to Washington to provide their statements at the listening session. It is my hope that hearing directly from these leaders will help guide Health and Human Services and all of its agencies to develop, as you said, answers and lasting solutions for better patient care.

Thank you all very much. The hearing is adjourned.

[Whereupon, at 5:24 p.m., the hearing was adjourned. The Committee proceeded with a listening session.]

LISTENING SESSION ON PUTTING PATIENTS FIRST: ADDRESSING INDIAN COUNTRY'S CRITICAL CONCERNS REGARDING IHS

The Committee and participants met, pursuant to notice, at 5:40 p.m. in room 216, Hart Senate Office Building.

STATEMENT OF T. MICHAEL ANDREWS, MAJORITY STAFF DIRECTOR AND CHIEF COUNSEL

Mr. ANDREWS. I feel like a captain of an airplane here. Can we all take our seats before takeoff, please?

Let me first start and obviously thank everyone for staying through a very important and long hearing. I think overall it was a good dialogue. I think any time you get the diverse witnesses that we had, the Administration, of course, being a central part of that, and then our tribal representatives, I think it's a good recipe for solutions.

Really that's kind of the premise for this listening session. I think Tony Walters and I, who are staff directors on the majority side and on the minority side, when we put this concept together of this hearing, we knew about the outcry and the demand of listening to everybody, giving everybody an opportunity to come before the Committee and telling us your story, telling us areas that you think that we to improve upon as Committee staff who draft the legislation.

So that is our goal here. We want to get to everybody. I think Mr. Killback said it best, about the tribal leaders have an opportunity to speak first. And so I think in terms of that, I think that's probably the correct procedure, how I think we ought to run this listening session. And really not to outweigh one or the other, I think the safest thing to do, without getting in the crosshairs of picking one tribe or the other is really to go by alphabetical order, to hear from the tribes, first, then tribal organizations, and then anybody else. I think that will be kind of in a systematic way. This way we capture everything. And as Chairman Barrasso said, we have a court reporter here. Whatever you say will be part of the record. And it will help drive the discussion with Committee staff.

And in terms of your statement, try as best you can, and I know it's a sensitive topic, if you can, to adhere to a three or five minute rule. Again, it's a sliding scale. We want to capture what you have to say.

And I think in terms of the tribes, obviously the chairmen and the presidents and the elected officials, I will defer to you on who best to represent your tribe coming before us.

With that, Tony, do you have anything you want to add before we kick this off?

**STATEMENT OF ANTHONY WALTERS, MINORITY STAFF
DIRECTOR AND CHIEF COUNSEL**

Mr. WALTERS. Sure, thank you. I'll be pretty brief.

I just want to tell everyone I appreciate their being here and spending this whole evening with us, essentially, afternoon and evening. It's one of the longest hearings we've had on this important topic. I think you can see how the Senators were engaged. Obviously, Senators have to come and go. But clearly, some of them stuck it out. Obviously they know the importance of these issues brought in. Senator Dorgan, who was chair of this Committee five or six years ago, obviously he still understands these issues. And we wanted to even get input from him from having that perspective.

Thanks to all the tribes who have come in today to provide more statements at the listening session. If you have anything in writing, of course, feel free to always send that in to the Committee. Staff is always here to look at anything that comes in. I know Mike's staff and mine as well have regular, constant dialogue with IHS folks here in D.C., in the regions where the tribes are having issues. So we're here to be as helpful as we can, we want to understand as many of the issues that you all have as you can bring forward to us, so we get a better grasp on it and know how we can help the best.

So I'm not sure if we have any overall time constraints, but we're going to be here for as long as we need, I guess.

Mr. ANDREWS. We will be here until we hear from you all. In terms of the listening session, the microphones are up front here on the side. So looking at alphabetical order, Cheyenne River Sioux Tribe, Chairman Frazier, if you want to address us first.

Chairman, thanks.

**STATEMENT OF HON. HAROLD FRAZIER, CHAIRMAN,
CHEYENNE RIVER SIOUX TRIBE**

Mr. FRAZIER. I'm Harold Frazier. I'm Chairman of the Cheyenne River Sioux Tribe in South Dakota.

As I was back here and I was listening, I felt like grabbing my papers and throwing them away. Because everybody knows the problems. Everybody knows the solutions. I can't understand why we're not fixing them, or addressing them. We know about recruitment and retention. We know the barriers. We know the weaknesses. We all know that. But nobody's doing anything about it.

I got elected in 1988 on tribal council, four years, and I served another four years as tribal chairman. Health care was a priority back then and it still is. One of the things is that presently, when there's something wrong with the Indian Health Service, we get rid of the service unit director. Since 1998, on the Cheyenne River Service Unit, I think we've gotten rid of about 10, 12 of them. And I'll guarantee the problems are still there.

Even today, with our area director getting rid of Cornelius, I guarantee you tomorrow the problem is still going to be there. It is a system with regulations.

One of the questions was answered, and you were talking about corruption. A colleague of mine in tribal council says, why do you think that's happening, the corruption? I said, because they think

they're untouchable. When you're a Federal employee, you don't get terminated. You get transferred on or moved on. And that's reality. They're protected by somebody.

To me, when I got in office, just one year ago, I dealt with the Indian Health Service. But to me, the solution is, the only way I see for Cheyenne River is to compact and let some professional company manage it for us like Avera, Sanford Health. Those are the two big health companies back home in South Dakota. I think that's the only way. You can play these games, spend a lot of money on travel, hire experts.

About 10, 12 years ago we did a health care seminar like this, had a court reporter, did testimony, with up to five of our biggest communities. One of the things we found that was common throughout the testimony was our people were upset by having to see a new health physician or health professional every time they went into the IHS. They were tired of telling their health history. And at that time, pharmacy was a big problem on Cheyenne River.

So we looked into it and we found that our service unit, because of the regulations, they could only pay \$45,000 a year. And when we looked into the private sector, they were paying \$100,000 to \$150,000 a year. But I still have to provide that service.

So then they get into a contract with a firm or some company. And that company locates them. That's why our people have seen that.

So I know regulation is a big issue, big problem. I feel that. To me, government is over-regulated itself. And I want to quote Senator Rounds, from about six, seven years ago when he was Governor of South Dakota, VA was having problems, he said, governments cannot run the hospital. I agree with that. Tribes can't, Federal Government can't, you guys can't. It's a proven fact.

Now I'll get to my speech. That was my opening. You guys know all the statistics, you guys know all the concerns. One thing I want to talk about I think is a big issue is suicides. Right now, I think our delegation is looking at building a treatment center or putting a behavioral health center in Pine Ridge. I think, I mean, we would support something like that. Because I want to tell you something, IHS, they refer a lot of our kids to Rapid City Regional West and Rapid City. I get reports back from our tribal staff that the people over there that work at Rapid City Regional West are telling our kids, you tell us you're not going to kill yourself and we'll let you go. And the kids, many times, are not ready to be sent home.

So I did talk to our service unit director, I said, hey, you need to, I hear this is happening, I hear it's happening from reliable sources, you need to sever that contract with Rapid City. I also told him, what you should be doing is interviewing patients. How are you treated out there, good, bad? So then, whenever you do go into contract with whomever, it would be justified, whether we go on with them or we sever ties with them.

Right now, there's no prevention. And that does lead on into higher costs and also a loss of life, as was addressed earlier. Specialty clinics, we don't have them, and we used to have them. It's a hardship for our people to travel to Rapid City. Rapid City from Eagle Butte is 166 miles one way, Sioux Falls probably 300 and some miles. Bismarck, 120 miles.

And we probably live in the top 10 of the poorest counties in the United States and probably in South Dakota, on the reservation. So you can imagine the struggles for many of our people just to go to these places for a clinic. So that's something.

I have also seen too, and studied IHS, like I made a comment earlier about them being over-regulate. Our history is that 1908 Homestead money, we built our hospital. We built it down on our agency along the Missouri River. Then in 1960, the Government built their dam and flooded us out. So the Corps of Engineers replaced our hospital in 1960 in Eagle Butte. They built a 26-bed in-patient facility. Just recently, about four or five years ago, we got a new hospital from IHS.

But one of the things a lot of our elders can tell you, the patient rooms used to be filled up. But before they closed the old facility, many of the patient rooms were turned into offices. So I think when they closed up, there was probably two or four patient rooms. Because IHS is so worried about being in compliance, they are forgetting patient care.

You look in our area, third-party billing, they can do it. It's a proven fact. It's why they closed Rosebud. I'm sure that's the problems in Winnebago.

But I think if Congress really wants to do something, they need to look at the recruitment, the bonuses that should be and can be given out. Money talks. We all know that. And I talked to our service unit director and he said he wished he could offer another \$100,000 a year to recruit doctors. But the regulations prevent him from doing that.

President Steele is here, he was going to mention something to me out there. IHS in their statement and their testimony said they consult with the tribes on everything. Last week, Friday, I found out Ron Cornelius was transferred out, and it was from one of our tribal staff. I had no idea. And it just happened to be, I was meeting with our service unit director. And he didn't know, either.

So why weren't we consulted about him? Was it because this hearing was going to happen and IHS did not want him to testify? That's a question that Congress should ask IHS. Why was he transferred? Was an evaluation done on his performance? Not that I'm sticking up for him, but I think it's important to know why he was transferred out. It should be for Congress as well.

And I liked Senator Tester's comments, that's the bottom line. Find it.

Thank you.

Mr. ANDREWS. Thank you, Chairman. How about the representative for the Crow Creek Sioux Tribe? A couple of councilmen, I believe. President Steele? We can always go back.

**STATEMENT OF HON. JOHN YELLOW BIRD STEELE,
PRESIDENT, OGLALA SIOUX TRIBE**

Mr. STEELE. I think everything has been said. The Senators know everything. I would just like to emphasize that that individual person, the patient, a lot of them get no care at all. They go to the hospital, and the doctor tells them, we don't have any services for you here. I'm sending you to Rapid City. So they go home, not knowing what's wrong with them.

And two weeks later they get a letter, you're declined an appointment in Rapid City, lack of funds. So there is no health care at all. And we jump up and down and say, we have a treaty that promises health care. In 1980, the United States Supreme Court, its words were the most rank and ripe case in the history of the United States to illegal taking of the Black Hills. Why won't the government sit down with us over that? We wouldn't be here today asking you for health care for our people, basic health care.

Gentlemen, they are helpless. They can't do anything about it. We all here feel a responsibility to see that they get any kind of health care. Sometimes when they do, they finally get a second opinion from Gordon, Nebraska, or Rapid City, the doctor there tells them that they were misdiagnosed. You were given the wrong medication, that medication is dangerous.

People have no faith in the Federal Government. They're just caught up in the system, and who cares?

Everything the Senator said today applies. I applaud Senator Thune and his staff for getting that letter signed by four Senators for this hearing. We hope something comes of it. And I think it already has. I talked to one of the IHS staff here after the hearing, and I'm getting some action on some specific points. So I don't need to tell them to you.

I just thank you for having this hearing.

Mr. ANDREWS. Thank you, President Steele. We really appreciate those words.

Chairman Vernon Miller, Omaha Tribe of Nebraska.

**STATEMENT OF HON. VERNON MILLER, CHAIRMAN, OMAHA
TRIBE OF NEBRASKA**

Mr. MILLER. Good evening. My name is Vernon Miller and I'm Chairman of the Omaha Tribe. I want to first of all thank Mr. Andrews and Mr. Waters for providing this opportunity during this listening session to hear the tribal leaders who weren't allowed to provide testimony today to the Committee. It is very important, this hearing that was held today, to specifically address the mismanagement of the health care within our region.

I speak on behalf of the Omaha Tribe, who is a part of the Omaha Winnebago Hospital. Oftentimes it is miscommunicated and not understood that that hospital just isn't for the Winnebago Tribe, it is for the Omaha and Winnebago Tribe. That is historically how the hospital was formulated and how it came about, was because of Winnebago Omaha people. Sometimes that is not often communicated. And both tribes are very separate tribes as well. That is sometimes misinterpreted as well, that because it's Omaha Winnebago Hospital, it's one tribe, but we're very two distinct, separate sovereign nations and we both have our own issues and concerns.

So I want to take this time to express some of my people's concerns with the Omaha Tribe. And I already submitted my written testimony, so I'm going to deviate a little from that so I can address specifically some other concerns that came to my attention as the hearing was transpiring.

The first one is in regard to the inadequate consultation from the tribes in regard to the removal of Ron Cornelius. We're happy that

finally happened. The Winnebago Tribe and Omaha Tribe identified that as one of the most important actions that needed to be taken clear back several months ago. So when we talk about the communication level, it is very indicative if you look at the date on that joint resolution that was displayed. It shows the date on there and how long it took the IHS headquarters to even address that concern.

It is unfortunate now that we have two other hospitals or facilities within the region now who are in the position that the Omaha and Winnebago Tribes are in. When our hospital was put into immediate jeopardy, that was known for two years. You can kind of see how that finally, the CMS finally said, okay, we're going to pull the accreditation. And now the hospital can no longer bill for Medicare and Medicaid now.

And they are maneuvering it somehow, they are able to bill for certain things now, they are telling us, and they cannot bill for this yet. So like I said, communication is kind of spare, I'm going to be honest with you. There isn't adequate consultation when any decisions are made. Like I mentioned earlier, the removal of the area director, we're happy to have it happen, but it would have been nice to have some feedback from us on who was going to be put in that position. Because a lot of us, through our tribal programs as well as our employees, have history with some of the members that are being put in those positions.

I want to further go on and talk about how when people are removed they are placed somewhere else and are transferred to other places. The Omaha Winnebago Hospital is one of those places that a lot of the employees that are sent from other tribal facilities went to. Our hospital was, okay, let's send them to Omaha Winnebago Hospital, we'll get them out of Sisseton Wahpeton's facility and move them down there. We'll get them out of somewhere and send them on over to Winnebago. Let them transfer out there so we can show the tribe, yes, they were removed. But they were given to some other tribe and made somebody else's problem.

As a result of that, you see what happened with our hospital, losing our accreditation, several patients have died, several patients are afraid to go there now. I can honestly tell you as one of the tribes with a dialysis center as well as a nursing home, we divert all of our patients to go to that hospital now, because that health care is not safe. So we take them to other facilities, we utilize our own third party revenue. We never use Medicaid or Medicare. We take them to other facilities to get adequate health care.

So it's truly indicative of how there is no trust in our community for that hospital. And that still hasn't improved. Mentioned yesterday, the hospital emergency room was shut down. There was no tribal consultation in that decision at all, to how can tribes help find a solution to that. That's truly another reason why there's some miscommunication here.

I also wanted to bring up another issue in regard to one of the questions that was asked to the IHS staff was about employees that are working in the facilities, they've been told, do not talk to members of Congress, do not talk to their staff and do not talk to tribal council members. That is true. I can tell you that we have had several of those employees come to us and say, I've been told

if I say anything I'm going to lose my job. We obviously respect their confidentiality. We're not going to go that.

But I can give you specific names. I'm not going to give them here now because there are personnel issues that are going on, of which employees do tell our tribal members that and tell employees of those hospitals, if you want those. So that is another whole section and even hearing on that.

I also want to talk about the consultation process a little bit further. We have a DDU within our area, the Omaha Tribe and Winnebago Tribe. I can tell you another example of how there was no adequate consultation, because when I first got elected chairman, not even three days later, I was informed through one of CMS's reviews that they were going to pull, after a survey was done, the DDU was found not in compliance because our policies were not consistent with the actual hospital. Well, they are two separate entities. Because there's a hallway that connects those two buildings, they considered it one building. As a result of that, I got a phone call on a Saturday morning, said, Chairman Miller, I just want to let you know, it was one of the acting CEOs saying, we're going to have to close down the DDU. We were just starting a cycle of treatment and our patients that were there, we're going to have to send all the patients home that are there for treatment because you don't have enough adequate nurses and doctors on staff according to what CMS is requiring. So we need you to say that's okay, that area takes over this now. And obviously I don't want to see anybody who's going through treatment process to be sent home and to now be able to utilize services that are supposed to be guaranteed to them.

So I and the other chairman of the other tribe, obviously we don't want to see those patients go home, said okay, do what you have to do to make sure that facility can stay open. Like I said, that adequate consultation wasn't there and as a result, that DDU's now sitting in area's hands, not tribal control which it was before.

So that's a concern of adequate consultation that's not happening. That's a good example of how we need to really think about how that consultation process is occurring.

Another issue I want to talk about is echoing the issue of the governing board. Apparently the tribes, the chairmen are sitting as ex officious on the board. The rest of the board is all area staff, who aren't even at the hospital, who aren't there in the field at the actual hospital level, hearing these concerns and hearing directly what's happening, the level of inadequate health care that's being delivered to them. So we really need to reconsider how we're even providing the governing process for those hospitals. I know Chairman Frazier mentioned earlier, maybe I should be privatized. That's something I would like to consider talking a little bit further about before we take those steps. But the governing process is definitely an issue. That corrective action plan which we've had from the Omaha Winnebago Hospital, they've identified as an issue is the governing process.

So I've brought that up numerous times already, but I want to make sure you are aware of that, that issue, and that we brought that up.

I also just want to talk about patient advocacy. That's a huge portion of why the hospitals are the way they are. At our hospital, we did have a patient advocate, but unfortunately, because of the structure of the hospital, my tribal members' needs weren't being adequately addressed when they were receiving this inadequate health care, when our go in and work, didn't feel safe there, they had no one to turn to. I want to thank the area office for identifying that after we brought that to their attention.

So what they've done, just so you're aware, is they allocated specific funding for the Omaha Tribe to have an advocate there. Because they recognized that they weren't receiving advocacy and they weren't being made aware of those mistreatments and misdiagnoses as well as inadequate health care. So that's indicative of how if you communicate with the tribes, it's something that we can do.

We also just want to make sure that we're maintaining a level of communication that's necessary. We do have weekly phone calls, but they're really short. And I think they're almost just there as an obligatory action, it has to happen. We are really concerned, because since we lost accreditation in July, it's almost about into the third quarter now, when we're going to start into the funding, or half of the second third quarter of the funding mechanisms, for no longer being able to rely on that Medicaid or Medicare as a revenue source to operate that hospital. So we're really concerned what services are going to be cut. Is our emergency room going to get shut down? Are they going to have to lay off employees? We're already standing at 60 to 70 percent rate of not having enough employees to even staff. We've had a turnover almost every 30 days of a new CEO.

So when we talk about trying to have management there, leadership there to help get the hospital there to a level of performance, when you have a new CEO coming in, all that work that was done in that 30 days gets kind of thrown to the back again and restarted over. So it's a cycle that's completely starting over and over again.

So I wanted to make sure you are aware of that, as we just had another acting CEO who was just now cycled out again and now we have another one. I'm not even sure who it is, Seneca Smith? Maybe somebody else. But just one of those things, that's kind of what we're dealing with. We can't hire a CEO there for some reason. We're not able to, I guess, get a correct panel that can get adequate support to move along the process.

I just want to relay those issues to you. I know we've had other side conversations. I want you also to remember that it is the Omaha Winnebago Hospital. We recognize that the Committee wanted to come to the region. We were left out of those conversations, and so we made a special time two weeks ago when our tribe was in town for the Supreme Court case, to let you know, hey, it's also the Omaha Tribe, here's our concerns as to what's going on. I just want to remind everyone that we are here too, we are here to make sure that our tribal members' needs are being met as well.

Thanks to the Committee, and thanks, everyone else, for listening.

Mr. ANDREWS. Thank you, Chairman.

Is there a representative from Three Affiliated? How about a representative from the Rosebud Sioux Tribe that would like to address us?

**STATEMENT OF EVELYN ESPINOZA, HEALTH ADMINISTRATOR,
ROSEBUD SIOUX TRIBE**

Ms. ESPINOZA. Good afternoon. My name is Evelyn Espinoza. I'm an enrolled member of the Rosebud Sioux Tribe. I'm also a registered nurse. I'm currently the health administrator for our tribe.

Who am I speaking to? Who's represented here? I see a lot of tribal representation. But who else is represented here. I may have missed the introduction. I apologize for that.

Mr. ANDREWS. We opened this up to really any tribal organization that would like to talk about—oh, are you talking about staff?

Ms. ESPINOZA. No, is this Congressional folks, is this HHS?

Mr. ANDREWS. These are all Congressional staff.

Ms. ESPINOZA. Okay. Well, the reason why I asked is it's very disappointing that we're here talking about such an important issue that is devastating lives and spirits of our tribal members and everybody gets up and leaves. We have made the trip to come out here and talk to people and have our voices be heard and our stories be heard. And everybody left. And I'm very disappointed by that.

Mr. ANDREWS. I did want to say, I do see—thank you—that other Congressional folks and HHS, IHS, is here as well.

Ms. ESPINOZA. Thank you. I do see Mr. Grinnell, and I was really intending, he said he wasn't going to be here, so I'm really happy that you did decide to stay.

This is very, very frustrating. I'm sure you can tell by my tone. But we're talking about entire communities being destroyed. We are talking about families being affected for generations. And we see here, it's almost like we have to prove these awful things are happening, when they're documented things happening. It's so frustrating to be on this side and to be a person that has a responsibility to advocate and protect our tribal people. You feel helpless. It's like hopeless. You get stuck in this, the sense of gloom, like it's never going to change.

How many people have to die? There are babies that have lost their lives because of this.

We talk about suicide rates, we talk about alcohol and substance abuse, we talk about all this. But this situation that we're in is completely unhealthy. We're talking about the health care of our people. The way things are practiced, the way medicine is being delivered, the way communication is between these agencies and our tribes is unhealthy. It's creating the same exact challenges that we're here trying to fight against.

Until we can come together and respect one another and acknowledge that things have to change, it's going to continue to go on. People are going to continue to lose their lives. Our parents are going to continue to lose their children and our children are going to continue to lose their parents. This directly affects us. The majority of the people in this room, you have no idea the level to which this affects us. Our whole being as tribal people, we're very spiritual people. Our spirit is very sacred to us. And this current

situation and the way health care is provided to our people completely goes against our beliefs.

We at one time had a very solid foundation, a very solid understanding of who we were and what we believed in. And that was taken from us. A hundred and fifty years of history created the situation that we're in. We have tribes fighting against tribes over scraps. We have other relatives being left out, their voices not being heard. We have tribes that are in better condition, IHS's that are in better condition than the Great Plains area and the Billings area, that don't have the problems. But they're the ones that continue to get the improvements, while us that struggle and have these challenges, we continue to go down.

We've had multiple meetings, multiple opportunities to share concerns, asked to be involved, we want to be involved, we want to be an active player in this game. We want you to take our suggestions and take action on them. We sit in situations like this and we end up with this afterwards, okay, maybe finally something will happen. And nothing happens. No follow-through. We have a beautiful report Senator Dorgan initiated six years ago. And it's only gotten worse.

No follow-through. No expectation. It's like we're not being treated as human beings. We have blood vessels, structures, anatomy the same as anybody else. We're no less than anybody else.

I'll give you a little timeline here of the last six months. Our relatives in Winnebago and Omaha were put in a horrible situation last July. My heart is heavy for them and for what they're going through, and for all of our tribes. In August, the second week in August we had a council meeting. The acting CEO came to our council and I said, what are we doing to prepare for CMS? What do we have in place? How can we help? What resources do you need? How can we work together to make sure we're ready, that this doesn't happen to us?

That CEO told us, they're completely ready. They didn't need any help. They had everything under control.

November 4th, an organization known as DNV that's hired under contract by Indian Health Service came in, surveyed the facility, said it was the best survey that our facility had in eight years. Best survey, very minimal concerns found. A week later, on November 8th, OIG visited. The CEO sends an email out and says, congratulations, staff, passed with flying colors, we impressed the OIG, we impressed DNV. CMS, bring it on.

On November 16th, CMS arrives. On November 18th, they put our emergency services in immediate jeopardy because they found situations that existed that posed immediate and serious threat to the health and wellness of any individual seeking emergency services there. On December 6th, our ER went on diversion.

All that happened within one month. We were told continually a year prior to that, everything's okay, don't worry about it, we have it under control. I had regular meetings, multiple meetings every month, IHS, this is the complaints I'm getting. These are the stories I'm hearing. Here's a copy of the complaints.

Seventy-nine documented complaints that I have not received a response from Indian Health Service on. Seventy-nine.

They told us their main problem is contractors, the quality of contractors. Last week on our call, our weekly call that they update us with, well, what are you doing about that, IHS? You have an area-wide contract with these companies. What are you doing to hold them accountable? How many meetings have you had with them? What expectations have you provided to them? How many contracts have you canceled, if this is such a problem?

Ms. Espinoza, you make a good point. I'll take that into consideration, that's something that we can start working on. But no, we haven't done any of that yet.

I sat in the close-out at the hospital when CMS left, listened to what they had to say. The survey, Interior's, mind you, at the end of the survey is saying, the quality of care here has to improve, and I highly recommend you include the staff providing this care in the plan for correction that you're going to submit to us. Last week on that conference call, same conference call, same group of people, the staff is telling me they haven't even see the report. They don't know what their corrective actions are.

So I asked this governing body of our hospital, how have you involved the staff that's doing the work? Because I sat there and witnessed in these meetings, it's not them involved in this. It's this team for area office that has been deployed here made up of people removed from other reservations, developing a plan of correction for the Rosebud Hospital that the staff doesn't know about. So, one, if the staff doesn't know that there's an issue and there's something that they need to improve on, why would they improve it?

So this recommendation by CMS at that close-out, that that area office was on the call with, they ignored it. So we continue to have the same things happening. The practices haven't changed. The policies haven't changed. Nothing has changed. The only thing that continues to change is our people continue to suffer and our services continue to decrease.

I can stand up here and I can go on and on. I could share my horrible experience with the Indian Health Service that I had. I was a registered nurse for them for 10 years. I work for them, hard. And it was such an unhealthy environment, and it affected me in such a negative way, I had to leave that. My profession that I had worked for, I put that down and walked away for my own health.

This has to change. Has to change. It's unacceptable and people are going to continue to die, we're going to continue to have this. For what? All this drama? It's not changing anything. It's horrible. It affects every one of us on a level you can't even imagine.

And I'm asking everybody here to take these things back to who you can to help us change this. Mr. Ganard, I'm asking you to hold your staff accountable. If your job is quality, then I want to see quality. And if you can't do the job, then step down so somebody else can.

Thank you.

[Applause.]

Mr. ANDREWS. Thank you, Ms. Espinoza, for that heartfelt, we can all say how heartfelt were your comments.

Is Chairman Flute here? Is there a representative for the Sisseton Wahpeton?

**STATEMENT OF SARAH DAKOTA, HEALTH COORDINATOR,
SISSETON WAHPETON OYATE TRIBE**

Ms. DAKOTA. Yes. Chairman Flute was not able to come. I'm Sarah Dakota, I'm the Health Coordinator from Sisseton Wahpeton Oyate. So I'm here on behalf of the tribe.

I agree that everything that has been said today, a lot of important things have been said today. The thing that is, a week ago I really had not heard about any of this. I want to thank Evie Espinoza for sharing with us at Sisseton Wahpeton the report from Rosebud. We were not aware that some of these problems that are occurring.

So east of the river, we don't have hospitals. We have health centers. And the same types of issues with the emergency room and hospital is not occurring. But I guess what we were aware of was that our doctor, one of our permanent doctors, was assigned to go over and help at Rosebud. And I'm sure we want to help. But it leaves us short-staffed, because our positions aren't all filled either. And we have vacancies. We're using the contract doctors, and many of the same issues that have been talked about today are our issues, too.

The other mystery that was solved is that our practice, when we don't, because we don't have a hospital, and is that if someone needs an elective surgery, like a tubal ligation or something of that nature, they need to be referred to an IHS facility. So we had a patient who has been waiting for a tubal ligation since November, kept faxing her stuff out. And she had the impression, the staff at our IHS must not have been aware that this was happening in the referral facility either at Rosebud. So they kept faxing the paperwork out. This person's been waiting for their elective surgery and wondering, well, they keep losing my paperwork.

I wanted to mention about vacancies. We have had vacancies in our behavioral health department for three years. This past year, we're having a lot of suicidal behavior in children. We had some completions. And it isn't that we don't have the funding to hire the positions, we just can't get the positions filled. So the question is why? Why can't we get the positions filled?

We have the same concerns as Sisseton Wahpeton about quality. I think you've noticed that Mr. Tom Wilson from KXSW, our radio station, is here. He also has something to say about quality that I think would be, if he would be willing to speak at this time.

**STATEMENT OF TOM WILSON, STATION MANAGER, KXSW
RADIO STATION**

Mr. WILSON. Good evening. The quality, it's like we get put on the back burner. To come out here, I had to wait an extra day and change my flight to see the doctor to get my meds filled. And to see the doctor only took me five minutes, to get my meds filled. But it cost me like \$75 to change my flight to come out here, which I said, be there Friday, we had a set, scheduled appointment to get everything filled. And it only took me five minutes to see the doctor, because I had to cancel everything just because of that one thing.

Some of the listeners are FaceBooking me and asking if they can ask a question. So I don't know if I could or not. One of them is

why the SWO and the Great Plains Region can't retain doctors permanently.

Mr. ANDREWS. You ask a good question. We will certainly take that back. Of course, we have our friends from HHS here that we'll be obviously directly communicating with. I don't want to put them on the spot, but this is the type of information, that back and forth, that Tony and I need so we can continue to develop and advocate for all your health and on all your behalf. So that is the best I can give you right now.

But I expect other great questions to come forward as a result of this listening session. And of course, the many questions that were generated by both, all three panels today.

Mr. WALTERS. I'll just add a real quick thank you. The question of attention, that's across the board. I don't think it is just in the Great Plains Region, as you mentioned. But I think we've heard from different folks all day today that it's across the board with IHS, that issue. They're trying as much as they can to work on those issues.

So we'll keep working with them and tribal folks and tribal leaders who come in and express these issues with us.

Mr. WILSON. The doctors, the nurses, the staff, they need all that. So kudos to all the nurses that are out there that give you that extra care. When we make an appointment, the daily appointment, 8:00 o'clock you start calling. By 8:03 it's all filled up. And that's the frustrating part. I don't know how it can fill up that quick, in three minutes. It takes me three minutes just to say "ah" before I go on and get my appointment.

So thank you.

Ms. DAKOTA. Sisseton Wahpeton is interested in being a part of the finding solutions. We're interested in that. And we look forward to more dialogue. Because we don't want what has happened at Rosebud, Pine Ridge and Omaha Winnebago to happen to us. Thank you.

Mr. ANDREWS. Thank you. Is there a representative from the Winnebago Tribe of Nebraska?

**STATEMENT OF VINCE BASS, VICE CHAIRMAN, WINNEBAGO
TRIBE OF NEBRASKA**

Mr. BASS. Good evening. My name is Vince Bass. I'm Vice Chairman of the Winnebago Tribe in Nebraska, northeast Nebraska.

I heard a lot of real good testimony today. I am not going to go over it and be redundant. I know you're looking for solutions also. First, allow me to say that I think it's important to note that Winnebago Tribe is a treaty tribe. Our forefathers had the wisdom to put into our treaty that the Federal Government take care of our health care of our people forever. So that's in there. That's noted, that's in there. That's a big part of the reason why IHS decided to locate the Winnebago IHS hospital on our Winnebago trust land.

So I wanted to get that out, I wanted to make that clear. Also, I wanted to say our people were moved from Ohio, Michigan, Minnesota, Wisconsin, Iowa, western South Dakota and back down to Nebraska, where we currently reside. We lost thousands of tribal members during those, as they moved us, due to disease, due to starvation, punishment and just the, they didn't have planes or

anything back then, so naturally they had to walk. Most of our women and children and elders had to walk.

So what I'm saying is we paid for this hospital already in blood. So we feel that we don't need to continue paying for this hospital in blood. We lost five Winnebago tribal members, and one was too many. So we're very, very angry.

And yet we want to be able to work with everyone involved to try to resolve some of these issues that we currently face. It's really a huge issue. I mean, look at all the different people, look at all the different tribes. We're very thankful that the Senate Committee on Indian Affairs held this oversight hearing, so we can bring this to light and bring up a lot of evidence and have people testify, and bring the truth out. We heard from IHS. And we also heard the truth from the tribal members. So I kind of wanted to say it like that way.

I don't want to go on and on, either. But I do have a list of some recommendations from our tribe that I would like to share with you. It's also in our testimony, but there may be people here who don't have that testimony. So if you don't mind, I would like to go, starting with number one.

First of all, we would ask the Senate Committee on Indian Affairs to examine the role that the Federal employment policies and regulations are playing in allowing incompetent and under-trained employees to continue to work in the Indian Health Service. Employees need to be held accountable for their actions. No longer can IHS continue to protect, cover up, shuffle, transfer or perpetuate incompetency.

Second, we recommend that IHS be mandated to institute a formal process for investigating any report of a questionable death or other unusual medical incident in any of its facilities. When problems are identified, immediate action must be taken to correct the problem, including disciplinary action against any employee who has failed to do their job.

Third, we recommend that the IHS mandate as a condition of ongoing employment that its employees report any improper care or mismanagement that they observe, and that those reports be sent directly to central office. The standard of care must be raised and every IHS employee should feel responsible for helping to fix this problem.

Fourth, we recommend that IHS be authorized and directed to immediately terminate any employee who retaliates or threatens to retaliate against a person who files such a report. The culture must change. Employees should be encouraged to make improvements and find better ways of doing things and not intimidated into maintaining the status quo.

Fifth, we feel strongly that each of the tribes who are served by a direct care facility should be given full and immediate access to any CMS accreditation or other third party reports or studies performed on that facility. We further recommend that all negative reports should be shared with this Committee and its counterpart in the House. IHS needs to stop hiding the ball.

Sixth, we recommend that IHS be directed to ensure that no tribe suffers the loss of services or funding because of IHS mismanagement. The third party billing for Medicare and Medicaid

represented a sizeable percentage of the Winnebago IHS hospital's operating budget.

Seventh, we insist that IHS mismanagement should not be used as an excuse for eliminating or cutting back on services or funding. Already, IHS is discussing how the under-utilization of our facility makes it difficult to seek the funding necessary to fix its problems. It's like a death spiral. IHS creates an environment that people do not want to go to. They refuse to admit patients because they fear further scrutiny. Then they conclude that the hospital is too under-utilized, so maybe they should shut down some of the services and funding. This is totally unacceptable. It is a flagrant violation of the Federal Government's treaty and trust obligations and someone should be fired for even raising this as a possibility.

Eighth, tribes should be given a real role to play on the governing bodies of IHS-operated facilities, not just a token attendance right. I'll give you an example. The IHS will tell you that since their corrective action plan has been implemented, our tribal chairwoman has been invited to participate in the final interview process for key positions at the hospital. This is true. What they fail to tell you is that she only received the resume just before the meeting and she was never told how many others applied for the job, who they were, what the differences were in their credentials or even how many candidates were there. That's in my testimony. I came up with a couple more.

As Chairman Frazier alluded to earlier, he feels that compacting may be the only way out of this. That's why the Winnebago Tribe is doing this, because we feel this is the only way out. Our hospital has been managed by IHS for all these years, even after the Dorgan Report. The same things that you're hearing today, it's still happening. In fact, it's even worse than when the Dorgan Report came out in 2010.

Tribes shouldn't feel that they need to exercise self-governance to fix IHS issues. We have no confidence in IHS. We will take over using the compacting, self-governance process to manage our hospital. We are in the process now, in the planning process.

There is a major lack of communication. For example, we lost accreditation on July 23rd of 2015. No one told us, neither CMS, IHS. I heard it on the evening news. So that's just an example. And you heard other examples of lack of communication that occurs over and over and over again.

As you are doing today, I would allow tribes to have input on what's going on. Because as you know, the solutions to the problems in Indian Country are best provided by Indian people. So we haven't had a whole lot of communication with the other tribes in the Great Plains area, but we intend to. And I hope that all the tribes don't feel that they need to feel obligated to compact, even though we're going to have that discussion and we're going to work at it together if that's what we decide to do.

So I wanted you to know that the tribes in the Great Plains are pretty much all united on this. I do not know one tribe that is not united on the issues that are facing us right now. In fact, throughout Indian Country, I think I can say that's almost true as well. I think you'll see other things coming up in other parts of the Country that's happening in the Great Plains region today.

So I just want to say thank you again for taking the time to listen to tribes. We're in a situation where we need to all work together. And I think we can do that. I think awareness has been raised. Because a lot of people didn't know what was going on. That lady from Sisseton Wahpeton did not know what was going on.

So now that everybody knows what's going on, I think we could all get together, and we really look forward to future meetings where we can collaborate and work jointly to resolve these issues. I thank you very much.

[Applause.]

Mr. ANDREWS. Thank you, Chairman Bass. Very heartfelt as well.

Have I missed any other tribes that would like to have their representative speak? Sir?

**STATEMENT OF CHARLES HEADDRESS, VICE CHAIRMAN,
FORT BECK ASSINIBOINE SIOUX TRIBES OF MONTANA**

Mr. HEADDRESS. I want to thank the Committee here who is absent at the time. I think they have our back. I think the Winnebago Tribe and the Rosebud Tribe should have been the first ones at the table to be heard while they were here, because that impact would have been, it would have been sent home a lot better. I'm not saying that the staffers don't work hard, we appreciate all the work that you guys do, also.

My name is Charles Headdress, and I am the Vice Chairman of the Fort Beck Assiniboiné Sioux Tribes in Montana. We have the very same issues. We've had two hospitals that kind of teetered from time to time, Blackfoot Hospital and the Crow Hospital.

I'm also the regional representative to the National Indian Health Board board of directors. We did have, two weeks ago we had the Winnebago Omaha Tribe in to talk with us, and Rosebud also, by teleconference.

As you know, last year we had those non-profit organizations serving all 565 federally-recognized tribes when it comes to health. The United States assumed the Federal trust responsibility for health by exchanging compensation and benefits for peace in Indian land. We all know that. In other words, we prepaid for these programs.

As recently as 2010, when Congress renewed the Indian Health Care Improvement Act, they have found it is the policy of this Nation to ensure the highest possible health status for Indians. And to provide all resources necessary to effect that policy. I think Senator Tester said it best when he says, fund it.

I'm not going to go over a lot of this stuff because it's redundant, everybody has had their say on a lot of it, so I won't repeat it. So I'm going to skip over some of this stuff. The problems that were in the Dorgan Report exposed much of this chronic mismanagement. A subsequent 2011 report by a separate HHS task force noted that "The lack of an agency-wide systematic approach makes it virtually impossible to hold managers and staff accountable for performance and to correct problems before they reach crisis proportions."

The Administration was quick to deploy National Health Service corps members to West Africa to treat the Ebola outbreak in 2014. But when the health crisis occurred in Indian Country, the tribes were told that there was just a national shortage of physicians, there's nothing that could be done to get more medical staff to the reservations.

While the issues in the Great Plains are certainly concerning to all of us, we have no reason to believe that they are isolated to this area, and they aren't, believe me. The National Indian Health Board has received reports from other IHS service areas of patient misdiagnoses and subsequent death, lack of competent providers and IHS' continued failure to provide safe and reliable health care for our people.

One of our members recently went to the doctor and laid out the problems that they were having. The doctor asked them, after all that was said and done, well, what is it that you want? So in other words, he could have said, well, give me some Percoset. Give me some pills. Let me take care of it.

That's the kind of reaction that we get from some providers. Not all providers. This provider happened to be a contract doctor with no skin in the game, really. They get paid a high salary just to give you a Band-Aid.

Alcohol and substance abuse are very prevalent, and this leads to many, many health care problems. We have the Bakken oil plate right next to us, and with that, they had 100,000 people come in from all over the United States and foreign countries to work. And with them they brought all the problems, from crime to drugs. We have a funnel of methamphetamine coming up through there right now that has affected our tribes greatly. Once beautiful people are walking around like zombies now because of this. And it's happening all over Indian Country, not just where we're at.

A problem with lack of dentists is another huge issue. As we all know, dental care plays a big role in your health care. It can cause major health care problems if your teeth aren't taken care of. We are so understaffed that we quit making appointments up at our reservation and have five slots a day for the doctor to see patients. We almost have fights outside the clinic because people are fighting to get in to see that, to get in one of those slots. That's ridiculous. It wouldn't happen anywhere else. At least open the door, let them stay warm.

And again, I'm going to skip through all this, because it's been said already. We have testimony from the Phoenix area, a report to that the National Indian Health Board that her mother was treated for a urinary tract infection by the White River IHS Hospital. When her condition did not improve, the patient's family was reportedly told by IHS medical staff, "What do you want me to do with her? She's an old woman."

After several more days, the patient was transferred to another facility in Gilbert, Arizona and found to have pneumonia, there was kidney stones in her gall bladder, two blood clots in her left arm and a serious blood infection from the previous urinary tract infection. The patient passed away just a few days later.

Now, we could go on and on. What will it take for the U.S. Government to fulfill its promise of providing care to Indian Country

that is safe and reliable? In my home State of Montana, the State Government has created a Director of American Indian Health position. We applaud them for that. We work very well with our Governor and Senator Tester and Senator Daines. I wish they were here to hear this.

But is emblematic of the Federal Government falling down on the job. While it is a good move for our State, why is the State doing it? Our treaties promise health care delivery from the Federal Government, but clearly it hasn't been working. We understand the Federal budgets are tight, but the treaties that we signed are not discretionary and should not be held to unrelated political battles in Washington.

Nation Indian Health Board tribes have asked for budgets each year that would bring IHS up to the same status as other American health facilities. Right now, this is \$30 billion. To begin to phase in this amount over 12 years, we are requesting \$6.2 billion for IHS in fiscal year 2017. But funding is another thing. All of the facilities are lacking medical doctors, nurses, everybody. We just are totally lacking. And we realize that recruitment, housing and all those things that have been spoken about impact all of that.

But again, I go back to what Senator Tester said: fund it. The Federal Government needs to fund it adequately.

Now, I don't know where they all went, I know they have very busy jobs. But they could be talking about getting rid of Obamacare again, for example, or maybe how many bombs we will need for this next war we will be in. Well, we are in a war, and we have been in a war for years. In our community, for example, if you have a heart attack, it will cost \$25,000 to \$30,000 to get you to the closest critical care hospital, which is 300 miles away. Here in Washington, if somebody had a heart attack, not near that amount. All that eats into the budget that the local IHS is meting out to us for health care. And we have many heart attacks up there.

This is why preventive medicine investments are so critical. We cannot be wasting our resources on treating symptoms, we need to invest in whole health systems. We consistently hear again that IHS mismanages and IHS is substandard. Accountability measures are enforced sporadically at best and often managers have little training. When issues do arise, it is unlikely that an employee would be let go. They just get moved somewhere else. And that's been said.

Unlike in the private sector, where the number of patients impacts the overall physician pay, IHS medical staff have a set salary and there is really no incentive to go above and beyond to meet the needs of the patient. In many ways, IHS is still operating a health system designed for the 1950s. Several of the reforms enacted by the Indian Health Care Improvement Act of 2010 like demonstrations that tests no knowledge of health care delivery have not been implemented. This represents another broken promise to Indian Country.

In Alaska, the tribes have a primary health system that works closely with the VA and focuses on a hub and spoke system to get better access for care to rural villages. Why can't the IHS be a leader in innovative health care strategies as the tribes have been?

Two weeks ago the National Indian Health Board passed a motion that would call for our representation to investigate a situation at IHS facilities across Indian Country and embark on a path toward finding real, sustainable change at IHS. As part of this work, the National Indian Health Board conducted listening sessions with tribal leaders, patients and medical professionals to determine new policy steps that IHS should take. This effort will be targeted at finding ways to achieve sustainable, long term change across the Nation's health system.

In closing, I want to share a story about my health care. I hope no one takes it too seriously. It is a funny story, but it's not funny. But I went to, four years ago I had an issue with my heart. I went in to see IHS two or three times before I was finally referred. I said, I'm short of breath, I need to be sent somewhere they can look at it. After two times, I was turned down, they finally sent me out to a cardiologist 300 miles away. So when they went in and did the tests on my, they found out I had 94 percent blockage in two arteries. So they immediately took me into the ER and put in two stents.

I came home 100 percent better, could breathe a lot better. And I was scheduled to go down for my follow-up in one month. So as the health care process goes with IHS, you have to take that follow-up paper to your provider, your provider at IHS, and he takes it to the Committee, the PRC committee, and they either deny it or approve it. Well, I was denied my follow-up.

So what I want to say is, what they were telling me is, forget about your engine, we'll just fix your exhaust. Because they gave me a colostomy appointment just one week after that denial. So they said the hell with your engine, let's just fix your exhaust.

[Laughter.]

Mr. HEADDRESS. And I told that to Tester at one of our hearings in Montana. It's funny in a way, but it's not. And it happens all the time in Indian Country, not just to me or anybody else in our area. We have dealt with this for a long time.

And I do want to give a shout-out to Indian Health Service. I've worked with some of these people, I was an employee of Indian Health Service for 30 years. I retired in 2004. And I worked with some of the people in this very room, Dorothy, Mr. McSwain, is he still here? And some of them are very dedicated people.

But again, they do not have the money to do the things that they know they need to do. And we beat up on them all the time. Some of it deservedly, but a lot of them are very hard workers, especially the nurses, the people that are out in the trenches doing the work. We need to get rid of some of the administrators and make more doctors. That's the bottom line.

So thank you for your time.

[Applause.]

Mr. ANDREWS. Thank you, Mr. Headdress.

Any other tribal organizations that want to address us? Please.

**STATEMENT OF ADRIANA SAUNSOCI, VICE CHAIR, OMAHA
TRIBAL COUNCIL**

Ms. SAUNSOCI. Good evening. My name is Adriana Saunsoci, and I'm the Vice Chair for the Omaha Tribal Council. I'm here on be-

half of the Omaha tribal members and all the rest of our nations, our tribes, not just my own. I'm here for the mothers, the fathers, the brothers, the sisters and all the family for patients of facilities of Indian Health Services and the hospitals.

I want to say thank you to all those tribal leaders and individuals that were up to share their stories to you. Again, it was said that a lot of us have a lot of very similar issues. And they are very, very similar.

I want to say thank you to the Winnebago Tribal Treasurer, Tori Kitcheyan, for being up there and speaking on behalf of the hospital. I think she just kind of forget to mention Omaha Winnebago Hospital over a handful of times. But regardless, I'm here on behalf of all of us.

I'm speaking, not reading anything. What I want to share with you is, some of you may know, on August 3, 2013, I myself had a child. I don't know how many of you are parents in here. But I had a child. She was just a month away from being three years old. There was a horrible, tragic accident. We got my child to the ambulance. From the ambulance we went to what's our life link on the Winnebago Reservation, it is the Omaha Winnebago Hospital. We went to our life link to try to save my child.

We were unsuccessful. So I stand here before you as a grieving mother today and the vice chair, again, not just for my people, but for all tribes, to say that this cannot continue to happen. I pray for better things for our people.

I blamed myself for a long time and held guilt for my child's death because of the way that it happened, so tragically. And a year later, just a little over a year later, we get a new acting CEO at our facility. So when she came to report to us in Macy, Nebraska, the Omaha tribal reservation, about the issues at the hospital, she told us some very disturbing things. And with the things that she shared with me, one of the questions I asked her, I try not to mix my personal and my own life with my work, but at that very moment I couldn't help it.

I asked this individual, and her name was Dixie Dykowski, which by the way I think she did a very good job while she was there, but when I asked her, so you're standing here and you're telling me, you're telling me that if you had a trained staff in that hospital, people that knew what they were doing, the crash carts were working or they knew how to use them, you're telling me that my child could have been here? And she said yes. I'm so sorry, but, yes. So these are the things that are happening, not within just my own community, but within all tribal nations.

A year later, I had to take my son back, and of course I suffer from post-traumatic stress disorder. I have to take my son back repeatedly because he had fevers, he had chills, he was convulsing. But they would get his fever down and they would send him home. It happened twice.

I couldn't take it, I couldn't go back there anymore, so I took him to the city of Onawa, Iowa. And they kept my son a little over a week and gave him antibiotic treatments and said I was lucky that I got him there.

Now, can you imagine, after the loss of one child, if I were to lose two? Now, again, I don't know how many of you have children, but

that's the worst fear of a mother, is to lose another child. Let alone lose one.

So I come here today again to share my story, not just to get her story out, but to share that this happens all over Indian Country. So be our voice, I'm asking each and every one of you to be our voice and help us to improve the quality of life. It is not about the almighty dollar. It is about the life of our people.

Thank you.

Mr. ANDREWS. Thank you for sharing that story with us, very powerful. I think your words resonate with all of us here that are listening to you, that I think that's our goal, to make sure that tragic events like that don't happen anymore, to anyone, anywhere. So thank you.

Is there anybody else? We've come to a point here where we've heard from tribal leaders and tribal organizations. So feel free, this is your time. If you want to address us. Sir, please. If you'd just introduce yourself.

**STATEMENT OF JAMES RED WILLOW, EXECUTIVE COMMITTEE
MEMBER, OGLALA SIOUX TRIBE**

Mr. RED WILLOW. Thank you. My name is James Red Willow. I'm with the Executive Committee of the Oglala Sioux Tribe. Our President Steele had given earlier testimony as well as our tribal council representative on the HHS committee, Sonia Little Hawk Weston.

But there aren't too many things I can say that haven't already been said except treaty obligations, of course. McSwain was near our reservation but within our treaty territory of the Black Hills in a town called Spearfish, where he heard many of the stories that were told today concerning lack of health care. It wasn't too long ago in our past history that the only health risks that many of us tribal nations faced were the bullets and sabers of our enemies. But because of our ancestors' refusal to surrender, we entered into treaties. And our treaty, the 1868 Fort Laramie Treaty, Article 13, guarantees us health care, recognizable in international courts.

Now, at this point in our lives, the things we have to worry about concerning our health are the stresses that we have to go through to guarantee that we will have proper health care. And that stress upon our individual members, especially our women that have the care in their hearts for the people, the children. There's an old saying amongst our ancestors that if the women of our nation's hearts are on the ground then we are no longer a nation, we will not survive.

So the stress that is put upon our people compounds those health issues that our people face, diabetes, heart disease, a myriad of smaller ailments that aren't treated properly or have the necessary physicians there to see you through your illnesses, physicians that leave because their obligations in the military are ending or they're no longer wishing to be there. So patients have to rely on a new physician for health care, and they might not have the same treatment by the previous physician, given different medications, et cetera. This stress also relates down to our children.

I gave testimony here when Senator Abourezk was the chairman of this particular committee. I don't know if there's too many peo-

ple in this room that remember Senator Abourezk, but I was on a council, tribal council in a treaty organization back in 1976 when I gave testimony regarding health care, law and order, et cetera. And here I am today, 40 years later, still giving testimony. But I'll continue to do so. I have exceeded the expectations of the statistics of the government in living past my 50 years as expected by the U.S. Government. The women of our nation are only a few years beyond the mid-50s that are expected to live.

So I'm going to defer further testimony to give others, and submit written testimony. There is a lot of complaints that my office receives from the people of the reservation. I live 100 plus miles from Pine Ridge in the northeast corner of the Pine Ridge Reservation with the Eagle Nest District. Daily I travel to Pine Ridge. I pick up hitchhikers that are hitchhiking to the facility in Pine Ridge and have to wait for hours and hours, some tell up to 10 hours in the emergency room, waiting.

But there's a shining example on our reservation of dedicated people within IHS as was mentioned by the gentleman previously. Some of those individuals work tirelessly in what is known as boots on the ground in some circles. Pine Ridge Indian Health Service has two satellite clinics in the Medicine Root District and the Eagle Nest District. We in those two outlying satellite health centers would like to be a standalone in case the hospital in Pine Ridge was ever to be shut down. That would not affect our two health centers, we would still be operational and not be shut down.

But the health issues that confront our people, no doubt we will, in the future, our systems will develop to the point where we will be a healthy people again. Our diet in the past consisted of natural foods. And we didn't have the myriad of diseases that affect us now. It's with the diet also that our people are suffering.

But with that, I would just like to say that with these testimonies that we all give, we are expecting some type of action that would give us better health care. And that is through the Indian Health Service. So may the Great Spirit help us all if IHS does not live up to the expectations that we have.

Thank you.

[Applause.]

Mr. ANDREWS. Thank you for that.

STATEMENT OF DONNA SALOMON, OGLALA SIOUX TRIBAL MEMBER

Ms. SALOMON. Thank you. My name is Donna Salomon, and I'm a member of the Oglala Sioux Tribe. I traveled here from Pine Ridge Indian Reservation in South Dakota.

I had a number of issues to address, but I know from listening all day that all of it has been said as to what our tribes need. So I want to share a personal experience. I'm the eldest daughter of ten siblings. Three years ago, in July of 2013, my father was injured in a car accident on the Pine Ridge Reservation. He was taken to the Pine Ridge Hospital and transferred on to Rapid City Regional Hospital. That happened on May 11th of 2013.

On May 30th, he was transferred to the advanced care hospital in Billings, Montana, where he stayed until July 26th, 2013. For almost three months he was hospitalized, they had him on a trach

and a ventilator. He had a fractured neck and had a punctured lung.

Repeatedly, he wanted to go home. I come from a family that believes in traditional healing. We have medicine people. We made repeated requests to Indian Health Service and they denied us every time to take him home. I felt confident had he gone home, our ceremonies, we have Yuwipi ceremonies that could have helped him to recover. But instead, our CEO of that hospital continued to deny our request. All we wanted was to take him home. And he would not provide a receiving physician to accept him home. He said Pine Ridge did not have respiratory care services, did not have certified nursing staff nor equipment.

And finally, we just said, we don't want him to go to the hospital, we want him to go home so we could have the ceremonies that he wanted to help him with his healing.

On the last day, when we finally contacted tribal leadership to help us, I had guardianship of him. I wrote to Senator Tim Johnson, I contacted Tex Hall, from the Chairmen of the Great Plains tribal chairmen, I reached out all over. I had him courtesy copied to Department of Health and Human Services, Indian Health Service, everywhere I could think of. I have my letters that I am going to attach to my written testimony.

While he was in Billings, he contracted MRSA. And I know that it was there, because right across the hall from him there was another with MRSA. And that weakened his system so bad, the medicine, the ten days of those strong medicines took him down. My father was 84 years old, he hardly ever went to health centers. If he got sick, he went to the ceremonies. His first language was Lakota and he only went to sixth grade. So he couldn't talk to the doctors, he couldn't understand some of the services that they were giving him.

He already had a weak kidney. He already had problems with his lungs. But they insisted that they continued to keep him on oxygen, continued keeping him on medicines to bring his kidney tests up. And when they did that, it knocked his liver tests down. So they were constantly going back and forth trying to get him stabilized.

And he kept motioning to us, take me home. And we would reach out to Allen Davis and he would deny us.

Finally, on the last day, on July 26th, he finally agreed. And so we got happy and we were going to go. And then he changed his mind and he said he couldn't do it. So we called our leadership, we called President Brewer, we called all the tribal council to help us. So they called up there, and so he changed his mind, said, okay, we're going to bring you home, or you bring him home.

The attending doctor at Billings, Dr. Fenn, he must have felt sorry for us because of the struggles trying to get him home, that he finally said, when he heard Allen Davis say, I will send for air ambulance to bring him home, but you need to provide for the nurses to accompany him back, and he's not going to come back to the hospital. He's going to go straight to his home. And I'm going to receive him and that's about it.

So we had to have the tribe meet us at the airport with the tribal ambulance. They met us there. He had Dr. Mitchell meet us at the

airport and Jay Sambutans, who was a social service worker. They met us there in Rushville, Nebraska, which is only a 25 minute drive from Pine Ridge. And this is my dad. He was still conscious. When we left from Billings, he was happy. He indicated to me as happy. I reached around, I rode with him on the air ambulance, reached around, hugged him and said, Dad, we're going home. Are you happy? And he nodded his head.

And when we pulled into Rushville, he was still up. All my family was there and they greeted him. And Dr. Mitchell got in the ambulance with him and we went home. I don't know what he did to him on that 25 minute ride, but when he got home, he was unconscious. He stayed that way until 3:00 o'clock, 3:27 the next morning, he passed away.

The worst thing was, before we left, when he told us he would not give my dad any medicine, Dr. Fenn gave me a prescription because he was worried that my father needed comfort care, some type of medicine to keep him from being too agitated when that time came. So he gave me a prescription and I filled it.

He told Dr. Mitchell about it, so when we got there, Dr. Mitchell asked me if I had it, and I said yes. He didn't administer it. He told me he would let me know when I had to give him the medicine.

About 12:30 that night, he was still there and he told me, I think you'd better give him some medicine. And I looked at my dad and he was still laying there unconscious. So I looked at the little bottle and I just gave my dad about one little drop that was not even a third of what was prescribed, because I didn't think he needed it.

About 2 o'clock in the morning, I was surprised because Dr. Mitchell came up to me and he told me he was leaving now. And when I looked at him, he had tears in his eyes, because throughout that time we were singing, and my brother was trying to do the ceremony, but he said my dad's spirit had, something had happened, his spirit was weak. And Dr. Mitchell approached me in tears and red-eyes, and told me, had I known how important it was for your father to get here so you, your family could go through this, I would have told Mr. Davis to bring him home weeks ago.

I could have slapped him but my father taught us not to disrespect people. My father passed away. The next morning the funeral home came after him. About a half hour later, or an hour later, we got a call from the funeral home and they said, you need to come up and do our arrangements now. We could not take your father's body to the hospital, to the morgue because their refrigeration units broke down. We can't keep him too long.

I'm here today to tell the Committee, we need respiratory care services on our reservation. When my father wanted to come home, we were told, there are no respiratory care services close to home. We contacted Rapid City, there was nothing there. We contacted the VA, because he's a veteran. Fort Meade doesn't have it, Black Hills, veterans hospital doesn't have it. No other tribes in the Great Plains area has respiratory care services.

We're in Pine Ridge. We're 300, 400 miles away from the closest respiratory care. And that's only if they're available. What's appalling is that IHS told us that during this time there were five other cases similar to my dad. They were in Denver and Omaha and Bil-

lings and Minneapolis. For our family to stay in Billings for almost two months, it cost us almost \$2,000 just to stay there. That was not counting the transportation or the food. Luckily, I have a job and I have a business, so I was able to keep the rest of my family so we could remain there. My father not being able to understand very much English, one of us always had to be there so we could translate.

That's what happens to our tribal elders. They don't need to do that. IHS does not have enough money, they told us, to provide that type of service. I have a lot of people that came to me after they heard my story. It was in Lakota Country Times his story was printed. And they told me that their husbands, mothers, grandmothers all died outside. Chief Oliver Red Cloud was one. He was on respiratory care services and they sent him to Denver. He could never go home. He died in Denver. He was the Chairman of the Black Hills Sioux Nation Treaty Council. His life, whole life, he fought for treaty, treaty rights, treaty obligations. His forefathers fought for treaty. And it's a darned shame that there's a grandson of Chief Red Cloud who could not go home because of lack of the type of specialized care that he needed. They wouldn't even take him home, to go home to his home where he wanted to go.

These elder men and women who tried to protect us, who tried to teach us, preserve our ceremonies, I just cannot help this. They failed our people. The episode of care for my dad started in Pine Ridge. They had that responsibility all the way to when he was brought back. There were no advocates that went there. There was no follow-up. They did not check to see how he was doing.

I didn't even realize that Medicare only paid for 45 days for that type of care. At the end of that 45 days, they were trying to make us turn his machines off, not because he had internal organs shutting down or nothing, just that there was a 45-day limit.

How many of our people who do not understand Medicare limits are told to go make a decision to shut a machine off? How many? We almost did, at that 45-day limit, we almost shut that machine off, because they told us we had to. We didn't understand, we thought it was because it was of his health. But we found out it wasn't. IHS informed us that our dad had Medicaid as well, so once advanced care hospital found out my dad was Medicaid eligible, they went in there and they started respiratory, physical therapy, everything.

But by then, it was too late. It was too late. And I'm a living testament to what happened to my dad. And this is just one tribal member. And I know, Great Plains Tribes, you all have the same problem. Your people are sent out there and some of them, the majority of them never return. They come home in a box.

My father wanted to come home and be connected to his homeland. And we made sure that he was brought back. Had he not been brought back, we had a van ready and we were going to, if we had to get an air tank and a vacuum, we were going to make sure, if he died on the way, just so he knew he was going home. That's all we were worried about. But these are stories, you heard the lady earlier tell you about losing her baby. This is our dad. He has over 130 grandchildren who walked in a walk to the Pine

Ridge Tribal Headquarters asking to bring their grandpa home. And we had to fight and fight and fight.

I thank you for listening. I thank Emily and Jackie for going to Pine Ridge. I thank Darren Benjamin for going to Pine Ridge to see how we actually live and what we actually go through.

I thank you, and the Senators who sent their staffers, to Senator Thune for sending Jeannie down there all the time. I'd really like to thank all of you for listening. Thank you.

**STATEMENT OF JERILYN CHURCH, CEO, GREAT PLAINS
TRIBAL CHAIRMEN'S HEALTH BOARD**

Ms. CHURCH. My name is Jerilyn Church and I'm the CEO for the Great Plains Tribal Chairmen's Health Board.

I purposely waited to speak because I wanted to give our tribes an opportunity for their voices to be heard, because for far too long, they haven't been heard. The stories that you've heard today are probably just the tip of the iceberg. We hear stories like that over and over again.

So I won't take too long, but I just wanted to share with you from the perspective of our organization. Our organization, the governing body consists of the 18 tribal chairmen of the Great Plains region. Our role really is to help be a collective voice, to be present when there are many tribes that are not here today, because they didn't have the resources to get here or to be here, and to be of support for our tribes in their endeavors.

I think our organization has also a really unique perspective in that we work very, very closely with the Indian Health Service regionally as well as nationally. And our organization consists of predominantly tribal members of the tribes that we represent and that we work for. We advocate for the priorities that the chairmen set as board of directors.

I have to say that I've read the reports from Winnebago and Rosebud and Pine Ridge. My emotions vacillated between incredible sadness and just incredible anger. Our region asked for a hearing, but at the same time, my thoughts were, we had this hearing six years ago. And there isn't anything that you heard today or anything more than you could hear that wouldn't have already told you and you wouldn't have already known from six years ago.

So I also come with a little bit of skepticism. I'm also a little tired so I probably don't have a very good filter right now, either. But when I look at our region and I look at Indian health in our region, Indian Health Service, they are also our community. What I don't want to see happen as a result of this is that the challenges and the discrepancies are used in such a way that hurt us further. So I'm aware that there are some political leaders that would just as soon give out cards and do away with Indian Health Service, and contract it out maybe even further.

But there are no other providers out there that are going to love our people as much as our own people do. And there are a lot of good people within the Indian Health Service that dedicate their lives.

So what I hope will happen, and my suggestion, I want to be solution-oriented, I kept telling myself, okay, solution-oriented. So the solutions that I see as viable solutions, first and foremost, is

fund Indian Health Service at the level of need. We facilitate budget consultation, and this will be the fourth year of doing that. We don't provide a needs-based budget. We provide a zero-based budget. So they come and ask us, if you had this percent, what would you do, if you had this percent, what would you do. And if you had a decrease, what would you do. Well, we just ignore the decrease.

But that's not budget consultation. That's dictation. And that keeps us at a level that we will continue to hear and experience the kinds of things that our region has experienced if we don't have that budget.

And I'm not talking about throwing money at a broken system. I'm talking about funding systematic change from the top down. Congress is just as culpable as the person that was in the service unit that didn't respond in a way that was appropriate. That responsibility starts from there all the way down. So fund the region so that we can have systematic change and that we can expect and have care at a level that our region deserves.

I spoke with, I'm on the Coalition for Medicaid Expansion in the State of South Dakota. One of the conversations that I had recently was about the VA and how the providers in our region were complaining that they couldn't compete with the VA, they couldn't compete with their salaries and they couldn't compete with the benefits packages that they offered. And we're struggling to just pay even at a level that is appropriate and competitive.

So I want us to have a system where providers wish they could provide as good a care as Indian Health Service, as IHS. I want a health system in our region that we can be proud of. Because our family members, many of our family members are working in that health system feeling very demoralized, feeling very helpless, and feeling as though they're doing the best they can with what they have and it's not good enough. They get beat up over and over and over again.

I want people to be held accountable that need to be held accountable. I came into an organization four years ago that wasn't functional. It took me six months to determine who needed to stay and who needed to go. And it took me three years to get that organization to a level where it's functioning with ethics and financially viable. That can happen with Indian Health Service.

But the investment, Congress needs to be willing to put that investment into it. And it is not asking too much. We make up 2 percent of the entire population of this Country. We are the genocide survivors. So it's not a big ask for this Country to fund schools, health, our judicial systems at a level that allows us to live functional, healthy lives.

These reservations were created by this government. Those treaties were made with this government in exchange for the well-being of our people, and it's not happening. I'm singing to the choir for the most part, here.

But I hope I'm proven wrong. Because throughout this process, from the time when Ms. Newman came out to South Dakota into our region, on one hand I was happy that they were there; on the other hand, I have no reason to believe that you're going to do anything different than what you've done before. So I hope you prove me wrong.

Thank you.
[Applause.]

**STATEMENT OF KATHLEEN WOODEN KNIFE, COUNCIL
REPRESENTATIVE; VICE CHAIR OF HEALTH BOARD,
ROSEBUD SIOUX TRIBE**

Ms. WOODEN KNIFE. Hello, thank you. My name is Kathleen Wooden Knife. I'm a Rosebud Sioux Tribal Council representative. And I'm also the vice chair of our health board.

I have listened to everything today and it's been quite emotional. I'm going to do my best not to get emotional, because I have a lot of compassion, every direction. And listening to my colleagues and listening to my other relatives speak today, I sat here in tears many times. I will try not to do that; if I do, please bear with me.

I want to give a little bit of a balance here for myself. I left, I was two days short of my 15 years in the Federal Government when I was elected to my position as a tribal council leader. My goal was, one of the things I wanted to do was to see what I could bring from the government to the tribe and the tribe to the government. Because I lived it. We've heard a lot of testimony on the bad experiences we've had. I've had them. I've had family members that have died. We all have. My colleague has experienced quite a bit of sadness. And so it become very emotional when you have family members that die and you can't do anything about it.

I know from being an employee at Indian Health Service, I had five years with the Bureau of Indian Affairs and ten years with the Indian Health Service. While employed there, I know that it is factual, it isn't disgruntled employees that are saying we're threatened, or, I have to be afraid for my job. When I first started working for the Federal Government, I walked into a department that had so much hostility. I did a ten-year history on the supervisor of that department.

And as you hear people say that people are protected, okay, she had people as high up as HHS. And the experiences that we go through, in the department I was in, employees were becoming ill. One of the people I worked with was a relative, she almost lost her baby, she had complications. I was sent to a heart hospital thinking that I had heart problems. It was the stress level of the environment we worked in.

That isn't something that is made up by employees. That is factual. We have employees in our system now that want to talk, but they can't. We have things going on as far up the echelon as you can reach, that are experiencing this fear of retaliation.

There are a couple of situations, I'm going to just do a small comparison. You have a violation of sexual harassment at a high level. That person still works. He gets moved around and is still employed. You have the same complaint at a lower level. That person, the lower level echelon people, the blue collar workers, the people that have their feet on the ground, that do the laborers' work. That person can just immediately, with a little bit of paperwork, be removed.

I know for a fact, I worked in administration. And so, we talk about our health, our losses of our people. We chose [indiscernible]

health for our people. And all my relatives here have touched on that.

But I'm going to touch on the other part of it. Because being the voice of the people, we have to speak for both sides, and we have to speak for the ones that are getting that bad health care, and we have to speak for the ones that are within our system. As somebody has said, we have good employees, we have bad employees. We have good administrators, we have bad administrators.

One of the things that I experienced is, and I don't know if it's just overlooked or why we can't come to a resolution with it, is that when you're at a health service unit and we're having issues, in administration, I was administrative assistant for our clinical director. I had at least 10 clinical directors in the time frame that I was there.

One of them, his main priority was warm bodies. He didn't care about the quality of health care we were bringing in with our physicians. Every time a contract position would come in, let me make you a deal here. I want to make you a deal here, because I've got to fill my quota of warm bodies. Because when I signed on here, that was my goal.

This same physician, before he left our Rosebud Indian Health service, had a fist fight with one of our doctors on our inpatient ward. The same doctor who we knew had a history. And I'm going to bounce around a little bit, because I've worked in property and supply and I've worked in administration. I've seen stuff at both levels. In the department I worked in, I wore a lot of different hats. I worked with HR, I worked with backgrounds, I worked with the medical staff, I worked with contract, I worked in a lot of different areas, because our service unit doesn't have that funding to have that number of employees there sometimes.

So those of us that sat in that main office, we were the main people that caught everything. I've heard stories from our people in housekeeping, our security, our nurses, our doctors, our administrators. They come into administration and they need somewhere to vent. And because we're the ones that are up front and center, we're the ones that they vented to.

So there's a lot of things that I knew. I sat in medical staff meetings and I listened to the review of credentials. I finally refused to sit in there any more, hearing the dings that were on the physicians that were coming to our hospital to take care of our people. I told my boss, I'm not doing this anymore, I don't want to sit in these meetings anymore, because I don't know how you people sleep at night, knowing that we're bringing physicians in that have issues or have these dings on their credentials. I would sit there and I'd go home and night and I'd think, how, you know, I don't want my relatives having this doctor take care of them when wherever he was he lost his license for this reason. But yet we're forced to accept whatever we're given. That's unacceptable. I mean, it was so sad I refused to do it anymore.

Like I said, I come from being a patient, I come from being an employee. I left there because I wanted change. I wanted to see both sides of it.

When you bring in these quick fixes, when I left the government and I became a tribal council leader, within months we had our

meeting with the area director. He refused to come to our reservation and meet with us. He wanted us to go to Pierre, 100 miles away from where our reservation is, to meet with him. And when I got there, I was pretty fired up, because when I walked in, I walked into a conversation that pretty much got me riled up. And my colleagues know that, sometimes I get excited and I talk really fast. And when I start going, things shoot out one after another.

It was my opportunity to say, I am no longer a Federal employee and I finally get to say what I need to say because I don't have to worry about losing my job. I don't have to work about getting written up for this. And so I said what I needed to say because I was very upset. And I said to this person, more than one time, a lot of people have mentioned today they're happy that this person is no longer with us, but I said, you know, you don't know what it's like. You, and I don't mean to insult anyone, but I said to him, you are an urban Indian. You have no idea what we go through. I said, you need to come to our hospital and see our doctors and get our care for a month.

The last time that he was at our council meeting I told him, no, not a month, I want you to come for a year. I want you to bring yourself and our family and see what it feels like here. Because you have no idea what we suffer from, what we go through. And he stood and he told us, and you know, I've heard other tribal members say this, lip service, it's really amazing to hear how many of us know lip service very well. Because many times that's what I say we get. As a tribe, we get lip service. We're going to do this, we're going to do that.

I finally said, in here, in my [word in native tongue], I don't believe you no more. Everything that you've told us, everything that you've committed to that we're going to fix this with, the transparency isn't there. Because everything that we're told, you can take it with a grain of salt. Some of this will get done in due time. But you know, if you're up here and we're down here at the service unit level, at the IHS level and you're getting this care, if you suddenly see it's up here and you've never been there to have that care, if you've never been there to experience the deficiencies that we have, that lack of quality of care, that lack of continuity.

I lived off the reservation a part of my life, so I know what it's like to be on and off the reservation. It was nice living in the city, seeing the same doctor, knowing that I was having that good care. But like somebody else here mentioned, you go into our hospital, we see a different doctor, we give our whole history. You can never go back and see that same doctor.

You know how frustrating it is to have to repeat your entire health history? Okay, now, what were you, oh, I see in your record, this is in here. And you get so frustrated you just say, well, this is what they told me the last time and this is what I have and I went on WebMD and these are the diagnoses that I found with myself, so if you could just give me the medication or refer me or do something else then I won't have to repeat my whole history again. Because these are my symptoms. You know, it becomes very frustrating.

The part on the administrative part that I wanted to mention, I know I bounce around a lot because I get really excited. And sit-

ting here, everything turns, my wheels turn and I kind of get carried away. But every time we have this Band-Aid, this quick fix, and that's what I call it, you know, assessment after assessment, why are you going to keep assessing us? Why? Because you do these assessments that somebody else already did. Why aren't the people in our own facility capable of assessing their own issues? A lot of it comes from up here. Senator Dorgan's report is almost ebbd in the back of my brain because I've read it and I've read it and I've read it. And I get so frustrated because I say, this is everything that we've been going through. I printed it off and I gave it to all my colleagues at council. There's 20 of us. I gave everyone a copy, I said, read this. Read this before IHS comes here so you guys will understand we're right where we were before.

But bringing people into our facility to temporarily fix us, you're bringing people in that are going to come in, they're going to have knowledge of where they were, what worked in their system. As I talked to some of the other tribal reps, I said, you could take this person, this person and this person and send them to our facility. And each time you do, coming from administration, we sit back, we know, okay, we have a new acting CEO coming in, we have a new deputy coming in. Which people are going to be there first so they get their way? So they can still get things how they want them? That does happen.

The next thing is, now, I wonder what kind of a plan this one has for us? Because we just got adjusted to the last CEO, and this is how their management functioned. This is what worked at their facility. This is what worked at their tribe. Now they're going to come to our facility and this is how we're going to run. So everyone has to adapt to this person.

Then something happens and they get sent out. And then the next one comes and it starts all over again.

What this actually does is causes a great hardship on the facility employees. Yes, we have good employees. And we have bad. And we have these people that come in, yes, some of the ideas are good. But maybe they're not fit for our facility, because we're alike but we're different.

But every time this happens we all have to readjust. But what happens is it affects us in many ways. It affects the people in administration that are not administrators. It affects our entire support staff. Because everybody has to readjust.

But after we do this for so many times, the morale drops. And everybody only wants to do what they have to do. But what hurts us the most is when this keeps happening, this effect, this merry-go-round that we're on, is our people suffer. Because if our employees aren't happy and they're not functioning fully, because of the administrative changes, and giving up that, well, Aberdeen has got their favorites, Aberdeen has their family, now they're going to send somebody else, now they're going to start over. When people just kind of getting into it and they give, they kind of almost want to give up.

But it hurts our patients, that's what hurts. It hurts our people. Because as you climb that ladder, to the nurses, the MSAs, to the people in the offices, how they feel affects how I get my health care treatment. So it goes on and on.

So from coming from the inside, I know this stuff is true. I have experienced it. I've witnessed it. I have seen Douglas factors done, just like that, to get rid of an employee. But administratively, what I say and I say we all share that same thought is that, recycle, recycle and promote. Recycle. We did resolutions. We didn't want this person here because they were resolutioned off another reservation. Here they come. Re-do how our system is.

I walked out and I came back in and I thought about something. We try to figure out what's broken, we know what's broken. We tried something different, we said, okay, well, we keep getting people from within the system. And they're just already conditioned to do things this way. You're already like robotic in how you do it. I used to get so frustrated at Mr. Cornelius, because he seemed to be, and I said it to him and I won't deny it, I said, you're very well versed, you sit there very, with that Chessie-cat grin and you bob your head and you smile. And the thought behind that smile you don't know. But because everyone comes in this way, after a while you start to wonder, is it the Federal Government? Is it the people that we're bringing in? Still we tried it. We went with a CEO and a clinical director that weren't Federal Government, that weren't in IHS. And it was just this catastrophe, such a big catastrophe as what we already experienced.

Right before all this stuff happened with Rosebud, they both left and went to the VA. Poor VA. Because as my friend and colleague here said, they told us we were good. I sat in on that one review with her. We sat across the room from each other and my mouth was like, because I was saying, they said we're the best. They said we have this good review, our ER was great.

When our last CMS review had come to Rosebud, we had so many dings, we had so much wrong. And then for five years later, or however many years later it was, for them to come to our ER and say how fantastic our ER was, I couldn't believe it. I was in disbelief. I was angry and went out of there cussing and I don't really cuss that much unless I'm really angry.

But I could go on and on but I'm not going to, because everyone here has shared the exact same things. What goes on at your hospitals goes on at our hospitals and we suffer. With our diversion, people are being sent out.

I sit on way too many committees at our tribe. And I sit on budget and finance committee. We have to find money. Last year, by February or March, our money was gone. Because when people get sent out, they come to us, we have to make up that difference, for families to travel, for their motel, for their gas, for their food. But also for the people they leave behind, because in our culture, there's always that main person that goes and you also have that main person that takes care of the family at home. And it's usually that person that's going with the relative. So then he or she has to make sure that she's taken or he's taken care of, whoever's left at home.

I didn't get to write down what I wanted to say, but I really have talked and talked. But one of the other things that I want to talk about before I sit down is the safety and health of our employees is also of a great concern. It's not just the people that come to our hospital for care, it's our people that work in our hospitals.

In our hospital, our former CEO, I went up to address an issue and he called me very unethical, because I didn't, you know, we come here with our history of everyone nets out on our reservation, all the things that are going on. I went, and I'm going to touch on my personal at the moment. I went there, first as a tribal council rep, then as the vice chair of our health board. I went on behalf of three tribal members. One of them happened to be my husband. And I went there because I couldn't get hold of one of my other colleagues to address it and it was something that needed to immediately be addressed.

We don't follow safety, health and safety standards like what we should. My colleagues standing behind, he and I and Evelyn Espinoza, we all come from IHS. Fresh from there to where we're at. Evie left about a year before us. But my colleague back here was a safety officer, so he knows a lot about what I'm going to mention. But the houses there are so old on the lower compound, you have a lower compound and you have a new compound. The ones at the lower compound are very unsafe, they're very unhealthy. They have asbestos in them.

There was a fire and there was an old building with both asbestos and black mold. These three employees had to go down there without any safety gear. I asked the CEO to do a webcident. I asked him to do an air quality check. Neither one was ever done. My person that was very special to me has been subjected to one house where, when they got done, they brought them the safety gear and said, oh, this house tested positive for methane, you need to put this on, they were already done with the house. He tore out the entire living room and a kitchen area, the tile had asbestos in it, the glue.

Okay and then comes the thing with the black mold. I went in there, I'm asthmatic. I barely got into the building, I couldn't breathe, I had such a severe asthma attack. Well, he no longer works there, because I'd rather have him in my life than have that second income.

But my point in this is that you take these concerns to them and they don't listen to you. There's other things there that go on, and we're not heard. I could go on and on, I could write a whole book on all of the bad issues that our people have suffered from, because I hear them and I've experienced them and what goes on with the employees. Our employees also need to be heard.

When people come out to talk to us, it's just like someone else mentioned, I was an employee there, I know, you can't. You're afraid to go to the tribe because you don't want to get fired. We had a contract person that came to the tribe and the next day, he was fired. So we know, those that work there at the IHS tribal level within our reservations and at the area office level. I don't know about the HHS level, but as far as our area office level, there are employees that know things, there are employees that are going through hostile work environments, there are people that are mistreated. There are cliques, there are favorites. There are unfair hiring practices.

I have been getting information along the way, and I know for a fact that this happens. So when you go out and talk to people, Emily knows, she walked with us through our IHS, it's very dif-

difficult to do because there's that barrier, there's that protective arena that you can't get beyond. You're going to be told, oh, no, we have transparency, we work with you, we do this and that. It isn't there.

So when the times comes and you do another hearing or you take testimony, I ask that you go and afford the employees at the service unit level and at the area level the opportunity to talk to you and protect them so they don't have to worry about being fired. Because you know, they're going to tell you things that, sometimes when you're in an administrative position you're going to believe the person that's at the next level below you because you have that confidence in them. But it doesn't always work that way. Sometimes you're believing things that you are being misled, information being misconstrued.

I have more to say but I'm going to quit because I could probably stand here all night. Ten years of history in the IHS is a long time. And working in property, going to administration, being the clinical director's assistant, there are some nightmare stories that I could tell you about things that went on at our hospital.

I have information that I protect because I was background coordinator. There's things that I know that are done not according to policy. So I wanted to share that, because I know that it's mentioned and a lot of people are giving their testimony on their actual heartbreaking family losses. But I wanted to give the other side of it, being an employee there, being a Federal employee for Indian Health Service. I know.

And so I'm speaking on behalf of my former friends and colleagues at IHS and family and members on our reservation and others. Thank you.

Mr. ANDREWS. Thank you.

STATEMENT OF C.J. CLIFFORD, REPRESENTATIVE, WOUNDED KNEE DISTRICT, OGLALA SIOUX TRIBE

Mr. CLIFFORD. My name is C.J. Clifford and I'm from the Oglala Sioux Tribe. I'm a representative out of the Wounded Knee District.

I will try to be brief and directly to the point. First I would just like to share with you, I would like to see some immediate action taken. Most recently here, as of Sunday, we lost a 23 year old young man that paid a visit to the hospital, was given some meds, went home. A few hours later, he told his mother he was having a hard time breathing. They loaded him up in a vehicle and he passed away in the vehicle before it could leave the yard. That just happened Sunday. They're making funeral arrangements and I understand, speaking with his mother, they are doing an autopsy. But that's something that's very alarming, that came out of the Pine Ridge Agency.

Also another medical one is a young 40 year old male went to the dentist for toothache, was given five shots on the side of his mouth and now he's got a permanent droop on the whole left side of his face. Indian Health Service out of Pine Ridge, their dental unit.

Also I want to talk briefly about the consultation process that Indian Health Service and other agencies use, Federal agencies use

to address issues. It's not a true consultation, nor do they follow their consultation policy. It's more of a dictation, that this is what we're going to do, and we just come to have you sign in and we say it's a consultation. There's no notice going out. I believe that there should be a uniform consultation policy for all extensions of the government that deal with Indian affairs. They should all follow one base, because they're all different.

I want to talk about the employees' rights and their job. A person's life in the Indian Health Service, it's more important for them to take care of one another, rather than the people that they're there to serve.

I want to talk about the drug testing part of our lives with Indian Health Service. You people don't have to drug test. And I have a problem with that, because we have people out there that are in actual need of pain medications, and they enforce what they call a pain management contract. They enforce that on each and every Native person that goes to the hospital, to sign a pain management contract prior to getting medication. And then from that point on, they are drug tested each time they go in to get a refill.

Now, tell me how that's supposed to work with the fact that we have rampant drug use amongst our employees at these areas? And they're not mandated to drug test. But yet you can enforce it on a person that's in actual need of a narcotic to help them live through their life through the day and they're forced to do a drug test constantly. There's many problems with Indian Health Service today. And it needs to change. There's new and better ideas out there people have that I think they should be listening to.

I want to thank you guys, because I do know you are the ears and eyes and hands of the Congressional people. Thank you. And I guess not to keep you guys very long, I too would like to have you guys relay a message to your bosses that we thank you for listening to us from the Oglala Sioux Tribe.

Mr. WALTERS. Thank you.

STATEMENT OF BRIAN DILLON, REPRESENTATIVE, PARMALEE COMMUNITY, ROSEBUD SIOUX TRIBE

Mr. DILLON. My name is Brian Dillon. I'm a representative of the Rosebud Sioux Tribe out of the Parmalee community. I also am a member of our health board.

I'm going to be as quick as I can here. I want to start off by saying, we are all valued on our contribution to others in our life. Our family and relatives and our tribe rely on our contributions, our productivity as an individual. For us to be at or near our potential as productive tribal members and citizens of the United States, we must be healthy in our body, mind and spirit.

Currently, our productive and contributions in life are severely impacted by inadequate health care. It reduces our educational, economical and parental viability.

Just to give you a couple quick examples that are personal to me, my daughter, second oldest daughter, just gave birth to my first grandson, four and a half days ago. And the reason why it's kind of a big deal is currently at our hospital, we don't have, well, we might today, have an OB doctor. I'm not too sure. It's kind of a two weeks on, two weeks off type rotation. Prior to that, they didn't

have an OB doc, so we had to change her health care provider from IHS to a local facility, which happened to be 53 miles from my house.

Luckily, it didn't provide us with any major complications. She was able to deliver a healthy baby and it wasn't a big deal. But if it had been, that may have impacted not just her, but my grandson's productivity in life. It could have ended or it could have been impacted to where the child or the mother could be less productive as a parent, eventually, economically for their family and for their tribe, their community, been a viable aspiration for the local education system or what have you, all of those things.

I have another daughter, my youngest daughter, who's 13 now. When she was a first grader, she was diagnosed with discoid meniscus, which required surgery to correct, or hers did. The IHS, Indian Health Service, decided that they were going to pay for, she had to have it done on both knees. They decided they were going to pay for her to have it done on one knee first, go through a little bit of the healing process, rehab and then do the other side.

Well, we went through the process on the first knee, and when it came time for the second one, her referral is not approved. So she's only had surgery that she should have had on both knees on one knee. And the reason why I'm bring up the productivity is, it's causing her, she's a very adamant athlete. She runs cross country with a great, severe amount of pain. She plays basketball, jumping, with a great, severe amount of pain. She likes to lift weights, volleyball, you name it.

And it has impacted her negatively. She struggles through it, but again, as a father, it makes me wonder, if it's impacting her to where she's not going to realize her full potential as a child growing and doing those things, and how that might affect her as an adult. Because she's starting to exhibit things that are in her decision-making process that are negative right now because of that limitation. And I'm done with that.

On that note, I ask the following questions of the Indian Health Service. Question one would be, can the Indian Health Service determine the loss of productivity of tribal member patients that die due to inadequate care? Differentiating from if they just die of natural causes or what have you.

Now, the second question would be, with that in mind, can it be determined, the loss of productivity for those with a debilitating illness as it progresses from a category four to a category one? One being loss of life, potential loss of life or limb, and that's when our purchased referred care dollars kick in. That's what I'm getting at with the example of my daughter. She's at probably a four or a three. The reason why she had the surgery on the first knee was because at that time I had insurance through my employment provider, which was the Indian Health Service, at the time. When it came time for the second surgery to be done, I had dropped my insurance and I was no longer an employee there.

So the referral process probably went so far as, no longer somebody else to pay for a majority of it, or IHS pays the co-pay, the instituted the payer of last resort. And I can't afford the surgery on my own. And being a tribal member and now employed by the tribe, indirectly I guess, I have a choice whether I want to have

health care or not through the Affordable Health Care Act or if I want to ask for the waiver and all that kind of stuff. Those are just two questions that I'd like to have answered.

I know within Indian Health Service also they have, in their Office of Environmental Health, they have the sanitarian to do similar type studies on loss of productivity due to motor vehicle accidents or things of that nature. So I know it probably can be done.

Thank you.

Mr. WALTERS. Thank you.

STATEMENT OF ISAAC SMITH, WINNEBAGO TRIBE OF NEBRASKA COUNCIL MEMBER

Mr. SMITH. First of all, I want to greet each and every one of you. Good evening and thank you for your time. I'll keep this short, just like everybody else said.

The second thing is, I'm from the Winnebago Tribe of Nebraska. I'm a tribal council member. Currently, right now, I serve on there and I also am the fire chief for the volunteer fire department back home.

A lot of the stories and a lot of the things that were shared here this evening really pull at your heart. And if they don't, that's when you really got to stop and think, what did I sign up for this job for.

The other thing is, I was on a call, several calls, but I'll share just two with you real quick, and I'm going to speed up my talking a little bit. I do better that way. I know everybody's probably hungry, because I am. One of the things is, we got a call on this veteran who was at home. So we ran the ambulance out there with the EMTs. We got out there and they were doing CPR. We walked in there, we carried our stuff in there and we started doing what we had to do. His family was standing around. And we knew that if we can get this gentleman to the hospital, he has a good chance, more of a chance than what we could provide right now.

So we kept CPR in progress, we loaded him in the ambulance, we even stopped a train midway and made them back up so we could get the ambulance through. We drove him into the hospital there in Winnebago. And some of you are familiar with crash carts, what crash carts are. So I got to see it from my own eyes and to this day it still carries a certain place in my heart for this family and for this gentleman.

One of the things was, we unloaded him out of the ambulance there and we turned around and we were taking him into the ER. And the doctor came in, we called ahead, they knew we were coming, we told them we were three minutes out, we're going to be at your front door pretty quick. So we turn around and we brought him in there. And the nurses in the ER didn't know how to even operate the crash cart.

So that's one of the things that's crazy about this whole situation. And one of the other things is that, when you go into health care, ultimately you are there to help people. You are there to help all the people that may have an issue with their physical being.

So the wires on this crash cart were all tangled up. Now, I don't know what kind of degree you got to have to untangle some wires

to some life-saving equipment. That's one of the things that really was frustrating.

The other part of that was this crash cart wasn't even charged, wasn't even plugged into the wall. So I'm still trying to find a way to find out how you get these guys with a degree to plug in these carts.

So the other thing is, I went through that, I got to see that and we did CPR on this gentleman for 45 minutes. On top of that, we had another shift come in and they started in. We worked on him for an hour and a half before they called it on him. We had a faint pulse come up, and so they turned around and they tried to bring him back. Because that crash cart wasn't taken care of properly, we had to pull the stuff off the ambulance. And the stuff off the ambulance only lets you go to a certain limit. So the stuff at the crash cart would have helped if it was there. Little simple things like that.

Another time was another gentleman, he lived in town. So the transport was a little bit quicker, a little bit faster. We got him in there and we were doing CPR on this guy. And he already had a leg that was cut off from diabetes. We brought him in there and we were doing CPR on him. And it's the same issue. These are two weeks, about two weeks apart. Same issue. The crash cart was tangled up, wasn't charged.

So then this time, there was two crash carts there. All right, we might get somewhere now, they're pulling out a second crash cart. But the thing was, neither one of them was charged. But the second one was untangled, all the wires were untangled. So they did try to make an attempt somehow there.

But there's a lot of different things like that that go on in this hospital there in Winnebago, Nebraska. Yesterday, we got word that there was a vehicle accident in Macy, Nebraska, these representatives of the tribal council that was here earlier. There was a police officer, his vehicle flipped. So at the time, they pronounced him at the scene from what I know. But they didn't let the hospital know that they were going to bring these people in that were involved in this wreck. So what they did was they turned around and they started diverting everybody up to Sioux City, 20 miles away.

And these are some of the stuff that goes on. Some of the stuff isn't going to take the swipe of a pen. Some of the stuff is just going to take common sense. But these are the people that we pay high bucks for to come in there and be able to push that crash cart from point A to point B. Plug it in and start it, everything. It's common sense, some of these problems.

So if there's anybody that's out there that get hold of a common sense, let me know, because I'll try to get some for everybody. That will take us a lot farther.

But I just wanted to say that much, and to the tribal members and the different representatives that are here, I want to say thank you for sharing all the stories, all the thoughts and feelings with us. Because these are the kinds of things, if we work together, and be good to one another and help one another, we can make this happen in a good way for all of us.

Then when we are able to do that and we reach a certain point, there's going to be something that we're going to take home with

us. It's not going to be a paycheck. It's not going to be money. It's going to be a good feeling in your heart, knowing that you helped people, clear over on different sides of the Country.

And if you have a hard time at work one day, some day, somehow, stop and close your eyes and imagine one of your closest loved ones laying there in a hospital bed with all kinds of things going wrong and not being able to get taken care of.

So I just wanted to leave you guys with that thought. I really appreciate all your time. Everybody that does something here, I want to say thank you to you, from the bottom of my heart and from where I come from. There's a lot of people back home that are really grateful that you guys made time for us to come over here and to hear what we had to say.

So thank you, God bless you.

Mr. ANDREWS. All right. I think we've hit that hour of night, it's been a long night. Let me first and foremost say thank you to you all. Part of a listening session is exactly this; we're in listening mode so we can then act on your behalf. I know the hour is late for staff, and obviously I want to thank them for staying with us and listening collectively on this side of the aisle, on this side. We will take what you have to say and we will work for the betterment of your communities, especially the health care, which we've heard all day today.

For those who didn't get an opportunity to speak, obviously you can submit your statement. The record will be open for a couple more weeks. But even then, we will continue to have the dialogue so we can improve the process.

I want to thank everybody for their time. Obviously the heartfelt stories will stay with us. I really appreciated that.

Tony, any last words?

Mr. WALTERS. I just want to thank everyone for coming out and sharing their stories and concerns and suggestions and ideas for how to improve IHS in every aspect of health in the communities. I know a lot of you traveled from pretty far away, so it's good that you were able to come in and share these stories with us, good for us to hear. I know they are difficult stories to hear and difficult stories to tell. But they do need to be told, they need to be heard. They do drive action, they drive agencies to do better, they drive staff here to advocate harder for these issues. So we certainly appreciate everyone's time and commitment to improving these issues in your communities. Hopefully they will drive some solutions here from D.C. that can help communities out in Indian Country. Thank you.

Mr. ANDREWS. Thank you, folks. That concludes the listening session, but it doesn't conclude the work that we're going to do. Thanks again. Safe travels back.

[Whereupon, at 8:25 p.m., the listening session was concluded.]

A P P E N D I X

PREPARED STATEMENT OF SUNNY COLOMBE, MBA, ROSEBUD SIOUX TRIBAL MEMBER

Good Afternoon Chairman Barrasso, Vice Chairman Tester, and Members of the Committee. My name is Sunny Colombe. I am an enrolled member of the Rosebud Sioux Tribe in South Dakota. Although I was not born or raised on the reservation, I remain close to the community through my family and friends. My family is dedicated to the welfare of our people, and my mother has been with IHS for over 40 years.

Growing up hearing about the health disparities our people face, I believed I needed to take what I had learned and put it to use in the healthcare field. After receiving my master's degree in business administration from National American University, I applied for a position with the Rosebud IHS Hospital. In 2006, I moved to Rosebud, SD after accepting a position as a supervisor for Contract Health Services at the Rosebud IHS Hospital. After five years of service, I resigned in 2011.

I left IHS because I wanted to improve the overall health of my community. As the contract health supervisor, the people coming into my office were often afflicted with terminal illnesses. The only patients approved for contract health funds during my employment were priority one. Priority one care includes or emergent or acutely urgent services that are necessary to prevent the immediate death or serious impairment of the health of the individual.

I now work for Great Plains Tribal Chairmen's Health Board, a non-profit organization which promotes preventative healthcare for the tribes in South Dakota, North Dakota, Nebraska, and Iowa.

My views today reflect my personal experiences with the Indian Health Service (IHS), and not that of my organization, nor the tribal nations in our service area.

During my time at IHS, I witnessed multiple obstacles that directly impacted patient care including antiquated technology systems, cumbersome policies and numerous employment vacancies and employee retention issues. This is not to say that IHS lacks passionate employees who advocate for their patients and the best possible healthcare, because I also witnessed those employees in action. "Do more with less," was repeated frequently, but at the end of the day, only so much can be done with less before the population it serves suffers the consequences.

While living in Rosebud, I was fortunate enough to give birth to one of my daughters (Addison) in the Rosebud IHS Hospital. I am thankful that I was able to receive obstetric care from the same medical provider during my whole pregnancy and delivery. I was also lucky enough that at that time there were ultrasound services available to complete and complement my prenatal services. The care I received was wonderful. The nurses and doctors were compassionate and capable.

The problem is that my positive experience with Addison is unique. In most IHS facilities, especially those in extremely rural areas, expecting mothers do not have access to continuous, competent and compassionate care. Other patients seeking care at Rosebud IHS Hospital, the facility where I delivered, also do not have access to basic prenatal services.

I was recently visiting a fellow member of the Rosebud Sioux Tribe who expressed his frustration with the lack of obstetric care available to his daughter. She is a first-time mother and there was not a provider on staff for her general prenatal care. She was told that an obstetrician-gynecologist had been contracted and would be available "soon", but gave her no more indication of how long they would be available to provide care. This young lady has become so frustrated with the situation that she no longer wants to seek care. Her experience at IHS has resulted in being skeptical of need for prenatal services.

In my experience as a former employee, contracted physicians come and go frequently, or alternate week to week or month to month, at best. Contracting providers is a great alternative when a vacant position cannot be filled; however, when this tool is over-utilized it undermines quality and continuity of care. There is often no relationship developed between the provider and the patient. When capable and

accountable providers are not consistently available, patients suffer the consequences.

Within the first few years of my daughter Addison's life, we utilized the Rosebud IHS Hospital emergency room and clinic frequently. Since she was born, she has had digestive and respiratory issues and extreme eczema. Every day she experienced severe vomiting; so much so that she slept in her infant swing to prevent choking in her sleep. She had open eczema sores that bled on her arms and chest. Despite our many visits to the Rosebud IHS Hospital, we received little more than recommendations to take Benadryl and to provide albuterol treatments.

When no solutions were forthcoming from providers in Rosebud, I traveled 180 miles to the Rapid City IHS Hospital, the closest IHS facility with a pediatrician at that time. The pediatrician there had been a long-time IHS provider, and always ensured that my daughter received the best care IHS had to offer. The doctor mentioned numerous times that my daughter's symptoms could be allergy-related. However, an allergy test from a specialist does not, nor would ever, meet the criteria for an approved PRC referral, as most facilities in South Dakota are only able to refer priority one cases, where life or limb are in jeopardy. At the time, I could not afford insurance, nor was I eligible for Medicaid. So my daughter continued to suffer for two years while waiting for basic diagnostic testing.

In 2010 my daughter's symptoms ultimately became so severe that she was transferred by air ambulance from Rosebud to Sioux Falls, SD for care. The expense of her continued emergency care far exceeded the cost of an allergy test. The cost of emergency air transportation is about \$20,000 and a consultation and allergy test is about \$500. After my daughter turned two, about six months after her emergency transfer, she was finally able to have an allergy test in Rapid City, SD with a specialist. It was confirmed that she was extremely allergic to foods containing peanuts, milk protein, and eggs—all things she frequently ate. Once the results were shared with the pediatrician at the Rapid City IHS Hospital, she was able to provide education, diet and medication to address my daughter's needs. The results were almost instantaneous. My daughter was able to eat, her asthma was controlled and her eczema cleared up.

Addison is a healthy, active seven year old now. She knows her limits, and is capable of monitoring her own diet and asthma based on the support and continued education we received.

Recently, I was saddened to hear that the pediatrician who helped us at Rapid City IHS quit. She told me she just couldn't do it anymore. Unfortunately, she's not alone. I repeatedly hear of the recruitment and retention issues within IHS. This was a wonderful dedicated physician who was with the facility for a long time. I wonder if an exit interview was completed to identify what it was she couldn't do any longer. What made her service there difficult? Could a solution have been found to retain her services?

I also have a three year old daughter, Jordan. She was born at Rapid City Regional Hospital in 2012, as the Rapid City IHS Hospital does not do deliveries at their facility. Having been an employee, specifically a contract health supervisor, I knew the conditions under which her birth would be covered by Purchased/Referred Care (PRC). There are various denial reasons for PRC, include residing outside of a Contract Health Service Delivery Area, not qualifying as a medical priority, having alternate financial resources available, not providing notification within 72 hours of receiving care, and IHS available to provide care. To ensure I met the notification requirement, I called the Rapid City IHS Hospital within 24 hours of admission.

Typically a patient is contacted by mail or phone about the status of their referral. As I was never contacted, about a month after Jordan's birth, I called to check on my claim. I was waiting for verification that they had all they needed to process the claim for payment, or at the very least, a denial of payment.

They could have denied the call-in for alternate resources available as many pregnant woman and children are required to provide proof that they are not Medicaid eligible. No other denial reasons should have affected the coverage of that medical event. I was required to apply for Medicaid and provide documentation of my ineligibility while receiving care in Rosebud with my eldest daughter. It was just another hoop to jump through, even though I knew I exceeded the income level before applying.

I called and spoke to a Purchase and Referred Care staff member at Sioux San IHS, who told me there was no referral in the system regarding my PRC claim for Jordan's birth. He offered to begin the referral process and stated he would be happy to take the information. Shortly after this conversation, I received a denial letter in the mail for failing to notify within 72 hours.

In my experience, it is impossible to appeal an unmet notification requirement. So even with my knowledge of the PRC regulations and taking specific steps to follow the process, I was responsible for payment of the care I received.

At the time, I was fortunate to have private insurance and resources to cover the expense. The average IHS consumer without private insurance or Medicaid would most likely find him or herself responsible for the total cost of care and be sent to collections.

After resigning from IHS, I accepted my current position as the Chief Administrative Officer at Great Plains Tribal Chairmen's Health Board. Our organization provides technical assistance and health education to our member tribes in South Dakota, North Dakota, Nebraska, and Iowa. We have a variety of programs which provide preventative health education, including increased access to healthy, traditional foods, cancer prevention, tobacco cessation, maternal and child health, behavioral health, and epidemiologic support. Our focus on preventative health techniques gives me hope that the health of our people will and can improve.

With insurance through my employer, I am no longer limited in my personal healthcare choices. I choose to utilize the Rapid City IHS and I am glad that they are able to receive reimbursement for my care through third party collections. I know many of the permanent providers in the clinic and have absolute faith in them regarding the healthcare needs of myself and my children. However, based on the services available, I pick and choose which care I receive there.

Services at Rapid City, Rosebud, and many other IHS hospitals are limited, and there are some services that my family and I do not utilize. For example, my family and I do not utilize the IHS dental services because only very limited emergency services are available on an unpredictable basis, and when treatment is available, it often is not what a patient needs.

The Rapid City IHS does not have enough providers available to make an appointment for routine dental care. Based on which providers are available and the treatments they offer, a given patient may or may not receive care. The typical patient is expected to sign in at 7:30 a.m. on a first-come, first-serve, basis.

I have tried multiple times to receive preventive and routine dental services at IHS, and have been repeatedly told that they were not taking appointments. They take emergency walk-ins on a daily basis, but whether it is because of the lack of resources or provider knowledge, the universal IHS treatment for an injured tooth is to extract it.

Also, a year ago, I went to the Rapid City IHS Dental Clinic and was told that one of my teeth needed a root canal. While the clinic could not provide this service as they only provided emergency care, they did offer to pull it out. I chose to save the tooth and go elsewhere. Unfortunately, not all patients have these resources or options. Many are stuck with whatever services IHS chooses to provide.

My experiences as an IHS employee and my current position with the health board have provided me a distinct opportunity to see the big picture of Indian health care. While I understand that there are inefficiencies within the IHS system, I firmly believe that multiple opportunities for improvement exist in the Great Plains area, but the issues I have highlighted today, in conjunction with inadequate funding, makes improvements impossible and continues to punish the people we are all here to serve. IHS is funded at about 50 percent of the current need. Increasing one line item here or there when the entire system is under resourced won't solve the issues we face.

To say the least, it is disheartening to hear the personal stories of the communities the tribal leaders represent and the dire need for increased preventative care. The medical conditions may change, the communities may differ, the gender and age may vary, but their stories of inadequate healthcare remain the same year after year. While the need for preventative healthcare is universal, budgetary allotments coupled with poor management and inadequate oversight are never enough to support implementing adequate prevention services, even though they can often be more cost effective.

If my daughter Addison had been able to receive a simple allergy test at IHS, or been referred out for care earlier, tens of thousands of dollars, and more importantly her immediate well-being, would have been saved.

Again, thank you Chairman Barrasso, Vice Chairman Tester, and Members of the Committee for inviting me to testify before you today. It is my ultimate hope that the Indian Health Service, Tribes, and Congress can work together to find lasting solutions today to ensure and promote the health of American Indians well into the future.

PREPARED STATEMENT OF HON. HAROLD C. FRAZIER, CHAIRMAN, CHEYENNE RIVER
SIOUX TRIBE

The Cheyenne River Sioux Tribe is pleased to present these comments on the quality of Indian Health Care in the Great Plains. Throughout the past century the United States has repeatedly acknowledged its obligation to provide health care for enrolled members of federally recognized Tribes. This obligation was established through Treaties grounded in the U.S. Constitution, through Supreme Court cases which defined and clarified the federal trust responsibility to Indian nations and people, and through federal statutes, most recently the Affordable Care Act, which strengthened and made permanent the Indian Health Care Improvement Act. And yet, despite the law, despite well-intentioned providers and administrators in our health systems, and despite the repeated efforts of this Committee, our Tribal members continue to suffer from levels of disease and mortality not only disproportionate to other United States citizens, but also to Tribal members in other regions of the United States. Thank you for once again reviewing the inadequate standards of care provided by the Indian Health Service in the Great Plains; it is my greatest hope that this hearing may lead to actual, positive change in the Great Plains Region.

In that spirit, I submit the following specific comments on ways in which the Committee can improve health outcomes for Tribal members both at Cheyenne River and throughout the Great Plains.

1. Adequate Funding

Despite historic increases in the Indian Health Service's (IHS) budget since 2009, IHS continues to be underfunded at approximately 59 percent of need. The Tribal Budget Formulation Workgroup for IHS estimates fully funding IHS's budget on a true needs basis would result in an annual appropriation of \$28.6 billion. Were IHS funded at this level, Tribes would be able to partner with IHS to achieve health care on a par with the rest of the United States. The Cheyenne River Sioux Tribe urges the Committee to accept the recommendation of the National Congress of American Indians by enacting advance appropriations for the Indian Health Service and by increasing IHS's appropriation by 2 billion a year for 12 years, which would result in fully funding IHS on a true needs basis by 2028.

2. Immediate Needs: Mental Health and Substance Abuse

Two of the most immediate needs at Cheyenne River are mental health and substance abuse. In particular, youth suicide and methamphetamine use are at record levels on our Reservation. It is established that conventional, western treatment methods have little success treating methamphetamine addiction, because of the particular effects of methamphetamine on the user's brain and body. Successful treatment of methamphetamine addiction in Native Americans has been achieved in treatment centers which provide long-term, specialized treatment designed around Lakota principles and values. But there is only one such 16-bed treatment center in the Great Plains region, located on the Rosebud Reservation. To successfully combat the epidemic of methamphetamine addiction we need a robust network of culturally-appropriate treatment options.

Likewise, our mental health program, which the Tribe operates through a self-determination contract with IHS, is severely underfunded. We do not have the resources needed to respond to the high numbers of children with thoughts of suicide, and who attempt suicide or who copycat other suicides at Cheyenne River. In 2015, our number of completed suicides was triple that of 2014. We rely on outside facilities to provide higher levels of care for our youth who need treatment for thoughts of suicide and self-harm. With adequate mental health resources, proportionate to those provided to non-Indians, we could develop an in-patient mental health treatment center at Cheyenne River, which could potentially lower our rate of youth suicide.

The Cheyenne River Sioux Tribe urges the Committee to appropriate emergency supplemental funding for mental health and substance abuse in the Great Plains. In particular, we support continued funding of the treatment center at the Rosebud Reservation and funding of a new regional treatment center at the IHS Sioux San Hospital in Rapid City.

3. Long-term Elder Care

In the Affordable Care Act, Congress authorized expenditures of IHS funds for Long Term Services & Supports (LTSS). However, Congress has not to date appropriated funds to IHS for LTSS. Developing an effective, culturally-appropriate LTSS system is a priority of the Cheyenne River Sioux Tribe. We demonstrated this priority by constructing the Medicine Wheel Village, intended to be a 45-bed nursing home and assisted living center in the heart of our Reservation. But without actual

funding to LTSS through IHS, we have only been able to open the assisted living portion of the center, and currently serve only 27 residents. Elders who need higher levels of care must still relocate to off-Reservation nursing facilities. The Cheyenne River Sioux Tribe urges the Committee to fund at a meaningful level the long term care services that were authorized in the Affordable Care Act.

4. IHS Staffing Issues

At Cheyenne River we have a new hospital facility and modern staffing quarters. Despite these advantages, our service unit has a 27 percent vacancy rate, with 70 of the 262 positions vacant. While the majority of vacancies are clinical positions, IHS cannot recruit and retain not only providers, but also administrators and key staff. Key positions have remained unfilled for over a year. This situation can also be traced to funding. Because of limited funding, IHS providers are paid according to limited pay tables. Providers entering the IHS system, therefore, can expect to be paid well below their private hospital counterparts, and therefore do not choose to work for Indian Health. Because of this problem, the Eagle Butte service unit depends heavily on temporary contract providers, which cost three times more than a permanent employee. This not only depletes our local budget without improving services, it decreases patient trust in the hospital. Our patients know they will most likely be seen by a stranger whom they will never see again, which discourages patients from using the IHS system at all. Patients only seek care as a last resort, exacerbating the health problems we seek to improve.

The Great Plains Area Office responded to this problem by hiring two recruiters based in the Area Office in Aberdeen, South Dakota. The recruiters were tasked with recruitment and retention responsibilities for service units throughout the Great Plains Area. However, neither recruiter has been to our hospital, nor have they been successful in filling any of our open IHS positions. Instead, as other Great Plains Tribes have testified, IHS recycles bad employees from service unit to service unit. It is alarming that many of the doctors and administrators that performed poorly at Cheyenne River were promoted to Area office jobs or shifted to another Tribe. This is a great disservice to Tribal members.

The Cheyenne River Sioux Tribe asks the Committee to adopt and recommend to Congress the IHS budget increases under paragraph 1, to instruct IHS to waive its pay tables in areas such as the Great Plains where there are persistent problems with recruitment and retention, and to disallow IHS from recycling underperforming employees from Tribe to Tribe.

5. Patient Relations

In 2012, the Cheyenne River Sioux Tribal Council passed a resolution detailing problems in customer service and patient relations at the IHS hospital in Eagle Butte. The problems included a rigid and unreasonable appointment system, poor communication with patients regarding prescriptions and refills, and an institutional culture within IHS that did not engage patients in their treatment, did not respect their time, did not build trust with patients, and generally was neither compassionate nor respected the dignity of Cheyenne River patients. The Tribal Council demanded that the Service Unit Director create a written plan of action to improve patient experience in the Eagle Butte Hospital, to include a visible and accessible method of collecting patient feedback and a long-term patient experience strategy using:

- A cultural assessment by a competent consultant group in the area of customer service improvement for healthcare organizations;
- Adoption of a patient bill of rights;
- Development of standards of service excellence;
- Employee training on these standards; and
- Ongoing protocols for continuing self-assessment and improvement.

The Tribal Council asked for a written response to these demands, but IHS gave no response, and none of these changes were made. The Cheyenne River Sioux Tribe renews its 2012 resolution through this statement, and asks this Committee to refer the issue of patient experience to IHS for their immediate response.

6. IHS Priority System

The Cheyenne River Sioux Tribe must again state our displeasure with the IHS priority system. You have heard many reasons, from many Tribes, over many years, over the problems the five level priority system causes with our patients. IHS's justification for the priority system is simple: Congress does not give us adequate funding to meet all of the health needs of our population. Because we cannot pay for all needed health services, we must prioritize which health services we will pay for

and which health services we will not. It is unconscionable to not provide health care to patients needing emergency or acute care, we will pay for those services as a first priority. If care can be delayed, we will delay it until patients need emergency care. While this may make sense to accountants, it is completely backwards to medical caregivers. If care was not delayed, then emergency care would not be needed, and the cost of care overall would decrease. Tribes have challenged the priority system in federal court, but the courts have upheld IHS's agency-level discretion to choose to fund some individuals' care while denying others', given that Congress has never funded IHS at its true level of need. But the priority system has a deeper effect on our patients than being denied for a particular procedure. It erodes trust in the system, and creates fear of rejection in our patients, which pushes them to avoid care, often until preventative care is too late.

The Cheyenne River Sioux Tribe asks this Committee to support the funding request in paragraph 1, and in the short-term, to order the Indian Health Service to enter negotiated rule-making with Tribes to revise and reform the priority system.

7. CMS State Plan Amendments

Because of chronic underfunding, IHS and Tribal health programs have turned to other funding sources to supplement our budgets. Third-party billing, particularly to Medicaid, has been one of the largest sources of outside money. However, Tribes are limited in our application of Medicaid dollars in our program under the Social Security Act only states can design, implement and administer Medicaid programs. Tribal government are treated as local governments with respect to CMS, and must go through state Medicaid certification to access Medicaid dollars. The problem with this model, other than that it does not reflect the government-to-government model of federal-tribal relations, is that it limits the Tribe's control in including culturally relevant health services, such as peer counseling, in the Medicaid state plan amendments.

CMS does require states to consult with tribes regarding state plan amendments. In 2013, CMS created a best practices booklet to guide states in establishing meaningful consultation with tribes. However, the consultation process is essentially passive. States attempt to educate Tribes on how to maximize reimbursement of services provided by IHS and Tribal health programs, and to educate Tribes on proposed changes to the state plan and their impact on Tribes. However, under this model Tribes do not propose changes to state Medicaid plans. Cheyenne River would like this model to change from a teacher-student model to a health partnership model. If Tribal health programs are to increasingly depend on CMS dollars, then our governments need expanded control over the scope of the programs which are reimbursed. If Congress does not wish to amend the Social Security Act to allow Tribes to directly enter into agreements and plans to administer CMS programs, then we need a greater voice in the state agreements and plans.

Therefore, the Cheyenne River Sioux Tribe asks the Committee to require CMS to change its consultation policy requirements for states to a requirement for negotiation or joint-decisionmaking between Tribes and States with regard to Medicaid state plan amendments.

Conclusion

The Cheyenne River Sioux Tribe is honored to have this opportunity to share our experience and knowledge on this issue. Thank you for considering our comments on Indian health care in the Great Plains.

PREPARED STATEMENT OF YVONNE KAY CLOWN, CHEYENNE RIVER SIOUX TRIBAL
MEMBER

Thank you for having this hearing and testimonies.

We need drastic changes in the following issues:

Prevention healthcare, we need to be seen by specialists sooner than reach the priority one status. Prevention could have prevented my mom from dying of congestive heart failure; she was seen by IHS 3 times in same week and diagnosed as flu symptoms, while her autopsy reported CHF. SHE SUFFERED as huge needles were inserted into her lungs n heart areas to pull out the fluid by Dr. Virginia Updegraff, with 3 white nurses holding her in position as she moaned in pain. When mom saw me, she cried out my name and reached for me. The nurses were Jean Schupick, Pat Lane, and Lorraine Kintz. They ordered me out of her room. Then, they transferred her towards Mobridge, SD, in her ICU condition after our family was told she may not make it to morning. MaryC and I rode with her in the ambulance. Mom died 5 miles out of Eagle Butte, SD. She could have been sent out sooner than ICU status.

Eligibility for Contract health services aka Preferred Care: American Indian blood is defined as $\frac{1}{4}$ Indian blood to be eligible for services. Eagle Butte Indian health service has always paid for all enrolled tribal members. If this is allowed, funding has to be increased for all 21,000+ tribal members, scattered throughout the united states.

We need steady, long term, real certified Drs., not family nurse practitioners or physician assistants. I've been misdiagnosed several times. Number 1, my right eye needed an ophthalmologist asap. We have only an optometrist, who takes leave as he pleases. Its hard to get in to see him, even if the medical officer in charge referred me to him. His secretary said although he was present it was after 4 p.m., and he would see me next day. I suffered with severe eye pain with a hx of iritis. I returned to ER another day with similar symptoms, I was told I had only makeup in my eye. I was given meds that were of no help. 3 days later, I was admitted to the Rapid City Regional hospital for irretractable eye migraines, and spent 4 days for eye care. We need an ophthalmologist on site. Dr. Clarkson, optometry on board is very rude, unprofessional, scare, and appts are made at his direction. He needs to be replaced.

Number 2, I slipped off my sons porch in July 2015 after a small rain shower, and fell onto the sidewalk face first. I broke my nose, skinned my face, injured both my knees badly. The left one was swelling awfully. My right shoulder arm was very painful. The ER doctor said the arm was not or bruised, and was not worried about it. After treated and sent home, the next week the shoulder was very painful. I went returned to Er. I saw. Dr. McLane, med officer in charge. He ordered an xray, said there was no tears or fractures. When I was referred to Black hills orthopedics and ENT, the specialist saw that I favored my arm upon physical exam of my knees and arm. He ordered an MRI. That week, his staff said the rotor cuff was turn, fell out of the shoulder. I was setup for surgery in January 2016. Dr. McLane could have ordered an arm scan as I was told there is a scan machine in the hospital. He is a Locum. We can save \$\$\$\$\$\$\$\$ of dollars by recruiting regular physicians, who are willing to live and work in Eagle Butte. We need to get rid of locums.

CEO, Charles Festes Fischer, has no MEDICAL BACKGROUND, only a cop background. He is incapable of running our EBIHS. He does not know medical terminology, or can't recommend patients for preferred care referrals, and has to rely on other staff to do that. He denies me, and others, 3rd party billing dollars. I have Medicare and Medicaid. He sends me denial letters first on this issue, so when I see a specialist, his staff tell me IHS has already told them, they will not pay 3rd party billing. Or, I get a letter from the CEO, before I go to my first visit stating that too. This is wrong. I believe this CEO had no clue what our Treaty with the U.S. government states on quality healthcare for all full-blood Indians. The CEO and IHS has failed me, and all other enrolled tribal members, by sub standard health care. The wait in between injuries and getting referred to a specialist is way too long. Specialists from Rapid City and Pierre SD have told me, the IHS physicians send us out too late, and under medicate severe cases of pain in many instances, where I and my relatives have been referred out. Or, they've misdiagnosed us. We need regular, stable doctors who live in town, on site, not family nurse practitioners or physician assistants. The current CEO, Charles Festes Fischer, has to be fired, as he is incompetent and unqualified to run our IHS: And count his unqualified relatives and friends who he has hired currently.

Nepotism, tribal council representatives have played politics and the health committee members, related to the CEO, have allowed AAO to hire Charles Fischer over the objection, and Motion by Resolution from the tribe, to reject his application and readvertise that position has been ignored by the health committee and AAO.

The CEO has allowed our laboratory department to hire and train anyone without a certification instead phlebotomists. One employee told me all she had was a degree from black hills state university; she is working on job learning how to draw blood. She poked me 5 times and drew about 1cm because she couldn't get anymore. She said she maybe able to work with it? She left bruises that took a week to heal. This is risking my life, I'm glad she didnt create an air bubble with my system.

Incident in ER, an EMT was sent to draw my blood. She said I was her 7th person she was learning to draw blood, OJT, this is unacceptable. She couldn't draw me and hurt me. Finally, she went to get help. Robin lebeau, RN, came in and quickly drew my blood. I was scared and glad Robin helped.

PRIVACY HIPPA: When new staff mainly doctors arrive they are told this family is addicted to pills, etoh, etc.—this causes and presets these new doctors to become biased against patients. My niece called me up to hospital because they wouldn't give her any pain relief. I witnessed the staff forcing her to sign a pain contract to get a toradol shot just to get her out of the hospital. When Dr brant, med officer in charge, came into room, he said to me I know you're not addicted to meds. This

was after I asked to see him. I said a physicians assistant told my niece that “all Clowns” (our traditional ladt name) were drug addicts. He never disciplined Commander Fish, PA, who made the statement. This is an example of staff/nursed telling new staff breaking the HIPPA laws as written, violating patients to be treated without prejudice.

TORT CLAIMS: IHS needs to offer their employees due process. My daughter in law was not offered due process when she filed a complaint against her supervisor for sexual harassment. Her supervisor’s boss was present when he disciplined her after she filed her complaint. That is not due process. I filed a complaint against CEO, their timely responses from the local IHS TO AAO WERE disregarded, and Edwin chasing hawk, AAO, said they were backlogged in dealing with complaints but he would pull mine, and respond. This is sooo wrong.

PAIN CONTRACTS: I was referred to the ACLU website. I read on that page the current pain contracts forced by staff to have patients sign them before they give them pain relief were illegal. I told our local tribal health committee. They assigned peg bad warrior, attorney, to check into the legality, as our relatives and member ate forced to sign them. I’m still waiting for their response

Physical therapy: This department do not answer their phone calls or return calls. They work with one patient at as time. No in else can be in that room full of equipment and can comfortably hold 6–10 patients pet hr. There are lots of equipment and space. They’re not earning their salary, kind of like bankers wages and hours. I had rotor cuff surgery on January 20, 2016, my first appt. Is Feb. 19, 2016, the specialist is spercless at how IHS has deals with patient. Therapy is important to regain full use of my arm. My sister had similar surgery, due to no local therapy spots. Asap, she lost 30 percent use of her arm. Please get us more pt time, change it for the better.

Employees, we need more Indians who can speak our language. Were out the unqualified and those who are not ¼ Indian blood but claim Indian preference. We need to use our tribal preference with the mandatory lakota language required.

FETUS REMAINS: Ensure that all aborted fetuses are given a chart, and wait until moms are not drugged up before signing their fetuses sway to be burned up at Bismark.ND. It happened to my niece who still has nightmares and is seeing a psychiatrist for them and on meds.

We need you to put a moratorium on all IHS hirings here so no more nepotisms’ will continue.

Why was Cheyenne River never investigated when Charlene In the woods aka Red.Thunder was the Area doctors for AAO, in 2010, along with all other 17 tribe back in 2010? We had these problems then, they’re worse now. Thank you,

Thank you for your time. Please review my testimony and help us get quality healthcare. Please get rid of Charles Festes Fischer, unqualified and incompetent. Give us more funding to recruit better doctors and a CEO who is qualified. Please get rid of unqualified Tribal health CEO, whose degree is in bugs, animals, prairie dogs as in biology; she has no experience in the medical field to run our tribal health department.she is filling position with unqualified tribal council’s children or relatives. Her name is Julia Thorstenson.

PREPARED STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD (NIHB)

Introduction

Chairman Barrasso, Vice Chairman Tester and Members of the Committee, thank you for holding this important hearing on “Re-examining the Substandard Quality of Indian Health Care in the Great Plains.” On behalf of the National Indian Health Board (NIHB)¹ and the 567 federally recognized Tribes we serve, I submit this testimony for the record.

The federal promise to provide for the health and welfare of Indian people was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation’s obligations to the Tribes and the spe-

¹ The National Health Board (NIHB) is a 501(c) 3 not for profit, charitable organization providing health care advocacy services, facilitating Tribal budget consultation and providing timely information and other services to all Tribal Governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. Because the NIHB serves all federally-recognized Tribes, it is important that the work of the NIHB reflect the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. The NIHB is governed by a Board of Directors consisting of representatives elected by the Tribes in each of the twelve IHS Areas. Each Area Health Board elects a representative and an alternate to sit on the NIHB Board of Directors.

cial trust relationship between the United States and Tribes that was created through treaties, executive orders, statutes, and Supreme Court case law. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 U.S.C. § 13) legislatively affirmed this trust responsibility. To facilitate upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to American Indians and Alaska Natives (AI/ANs). Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people, but has been routinely plagued by underfunding and mismanagement.

In passing the Affordable Care Act (ACA) (P.L. 111–148), Congress also reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). As part of the IHCIA, Congress reaffirmed the duty of the federal government to AI/ANs, declaring that “it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”²

But the promise made by the federal government and renewed by Congress over five years ago has not been kept. The issues identified by recent reports from the Centers for Medicare and Medicaid Services (CMS) indicate as much. In the last year, several hospitals serving Tribes in the Great Plains region of IHS have lost, (or received threats of revocation) their ability to bill CMS. This not only severely hampers the critical 3rd Party Revenue on which these facilities depend, but it also raises serious questions about the quality of health care in the Great Plains Region. These recent developments in the Great Plains region have exposed a systemic lack of quality care being provided in at least two hospitals being run by the Indian Health Service. At the Winnebago Indian Hospital, Pine Ridge Indian Hospital and the Rosebud Indian Hospital the deficiencies in question are deplorable, and simply unacceptable. The incidents exposed by these investigations are evidence of a complete failure by the IHS to provide safe and reliable health care for American Indians and Alaska Natives (AI/ANs) and in turn, an abrogation of the government’s trust responsibility toward the Tribes.

“For decades and generations, IHS has had a notorious reputation in Indian Country, but it is all we have. It is all we have to count on. We don’t go there because they have superior health care. We go there because it is our treaty right. And we go there because many of us lack the resources to go elsewhere. We’re literally at the mercy of IHS.”

–Victoria Kitcheyan, Treasurer, Winnebago Tribe, February 3, 2016

But the issues identified by these reports are not limited to the Great Plains Region. NIHB hears similar stories from almost all regions where there are IHS-operated facilities. NIHB has received reports from other IHS Service Areas of patient misdiagnosis and subsequent death, lack of competent providers, and continued failure to provide safe and reliable healthcare for our people. This must change.

As you are well aware, in 2010, this committee commissioned a report titled: “In Critical Condition: The Urgent Need to Reform the Indian Health Service’s Aberdeen Area.” This report discussed the substandard health care services and widespread mismanagement in the region. Five years later here we are again. The hearing on February 3, 2016 felt like déjà vu, from the hearing held in 2010. The issues in the so-called “Dorgan Report” included:

- IHS using transfers and reassignments to deal the employees with a record of misconduct or poor performance;
- Substantial diversions and reduced health care services;
- Mismanagement of the purchased/referred care dollars; hospitals at risk of losing their CMS accreditation;
- IHS providers treating patients with expired state licenses or other certifications; and the use of contract health providers (locum tenens).

It is clear from the February 3rd hearing and testimony that these exact same issues are still very present in the IHS system six years later. The time for reports and additional research has passed. It is time to change the system; we must do better to provide health services to the First Peoples of this nation.

In the next several weeks, NIHB will be convening a special task force to come up with solutions and policy recommendations with the goal of reforming the systemic challenges of the IHS. This includes policy recommendations for long-term,

²25 U.S.C. § 1602.

sustainable reform of IHS. However, we also are eager to work with the Committee, building on the findings in this hearing, to enact interim solutions for IHS to ensure that the care our people receive is the care that they are entitled to and deserve. This hearing should mark a watershed moment for Tribal health; a time when Congress decided to say “enough” to the inadequate health care in Indian Country. That is when real change happens.

Health Statistics for American Indians and Alaska Natives

The findings in the CMS reports described in this hearing should not come as a surprise when considering the state of health for AI/ANs. Devastating impacts from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. American Indians and Alaska Natives continue to suffer from a variety of health disparities when compared with the rest of the U.S. Population. While some statistics have improved for American Indians and Alaska Natives over the years, they are still alarming and not improving fast enough or on a regular basis. In 2003, it was reported that AI/ANs have a lower life expectancy of almost 6 years less than any other racial/ethnic group. While the group still has a lower life expectancy than any other group, it is now 4.8 years less. In some areas, it is even lower. For instance, “white men in Montana lived 19 years longer than American Indian men, and white women lived 20 years longer than American Indian women.”³ In South Dakota, in 2014, “for white residents the median age was 81, compared to 58 for American Indians.”⁴ Twenty-five percent of AI/AN deaths were for those with ages under 45. This compared with fifteen percent of black decedents and seven percent of white decedents in 2008 who were under 45 years of age.⁵

Across almost all diseases, AI/ANs are at greater risk than other Americans. For example, AI/ANs are 520 percent more likely to suffer from alcohol-related deaths; 450 percent more likely to die from tuberculosis; 368 percent more likely to die from chronic liver disease and cirrhosis; 207 percent greater to die in motor vehicle crashes; and 177 percent more likely to die from complications due to diabetes.⁶ Infant mortality rates for AI/ANs is 8.3 per 1,000 live births, a decrease of 67 percent since 1974. However, AI/ANs still have a higher rate compared to the U.S. all rate of 6.6.

Most statistics have shown no improvement over the last decade to the detriment of American Indian and Alaska Native people. In 2003, AI/ANs were 204 percent more likely to suffer accidental death than other groups, and it has now risen to 240 percent. Our youth continue to be 2.5 times more likely to die from suicide than other Americans.⁷ Suicide rates are nearly 50 percent higher compared to non-Hispanic whites, and are more frequent among males and people under the age of 25. These staggering suicide statistics remain disturbingly unchanged from the 2003 report.

According to CDC data, 45.4 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. AI/AN children have an average of six decayed teeth, when other US children have only one.⁸ There must be a comprehensive change to prevent another decade from going by and countless American Indians and Alaska Natives becoming victims to a broken, under resourced health system.

Mismanagement/Accountability at the IHS

Of grave and immediate concern is the quality of care being provided to Tribes in the Great Plains and other IHS-operated facilities. The rampant disregard for human life that has occurred at these hospitals amounts to, as Chairman Barrasso stated at the hearing, “malpractice” and is nothing short of criminal. Victoria Kitchyeen, the Treasurer for the Winnebago Tribe, poignantly noted at the hearing: “It’s been said in my community that the Winnebago Hospital is the only place you can legally kill an Indian. It is 2016 and our people are still suffering at the hands of the federal government. Kill the Indian, save the IHS sounds appropriate.”

America is too great a nation to live with this status quo any longer. NIHB has heard reports of patients giving birth on hospital’s bathroom floor; patients with a highly contagious disease not being isolated; patient death as a direct result of med-

³ “The State of the State’s Health: A Report on the Health of Montanans.” Montana Department of Public Health and Human Services. 2013. p. 11.

⁴ “2014 South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators.” South Dakota Department of Health. 2014. P. 62.

⁵ Trends in Indian Health 2014 Edition.” U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health Support, Division of Program Statistics. 2014. p 63.

⁶ *Ibid*, p 5.

⁷ *Ibid*, p 5.

⁸ Indian Health Service FY 2016 Budget Request to Congress, p. 78.

ical staff not knowing how to respond to medical crisis; and frequent misdiagnoses (or lack of any diagnosis at all) of critical illnesses. NIHB spoke with one person living on the Rosebud Sioux Reservation who told of a patient who presented with typical stroke symptoms and was told to go home with just an aspirin. It was 12 hours before the patient was actually treated in Sioux Falls (4 hours away) because the Rosebud Indian Hospital's Emergency Room (ER) was placed on "diversion status" in December 4, 2015 due to the unsafe nature of the hospital.

Since the "diversion" of the ER, the situation has gotten even worse. Patients with emergency needs are being sent to other area hospitals 40 to 50 minutes away. These hospitals cannot handle the patient load and the individuals are often turned away. Others are forced to drive to Rapid City (3 hours) or Sioux Falls (4 hours) for care. And if they are fortunate enough to receive care, they do not have the means of returning home because they were brought by ambulance. Individuals at risk of suicide also have nowhere to go. Off-reservation service providers do not have the cultural training necessary to treat patients from Rosebud.

One individual from the Phoenix Area reported to NIHB that her mother was treated for a urinary tract infection by the Whiteriver IHS Hospital. When her condition did not improve, the patient's family was reportedly told by IHS medical staff: "What do you want me to do with her, she is an old woman?" After several more days, the patient was transferred to another facility in Gilbert, Arizona, and found to have pneumonia, numerous kidney stones in her gallbladder, two blood clots in her left arm, and a serious blood infection from the previous urinary tract infection. The patient passed away just a few days later.

Over the summer, NIHB heard from two young people on the Navajo Nation, that their grandmother went to the local IHS who sent her home several times telling her she had migraines. Yet, when she went to another hospital off the reservation, she was diagnosed with brain cancer. But again, it was too late to save her life. We see this theme again and again. One patient from the Cheyenne River Sioux Tribe told NIHB that, "Medical providers do not listen to their patients and do not include patients' information at times when making a diagnosis."

The response to these claims by the IHS and HHS leadership has also been frustrating for Indian Country. Tribal leaders have consistently complained about a lack of communication between CMS, IHS and the Tribes. Little has been done to correct the problems. This is likely no surprise given the outward attitude of IHS leadership. As Chairman Barrasso called out at the hearing, one senior IHS official recently remarked: "If you've only had two babies hit the floor in eight years, that's pretty good."

Accountability measures are enforced sporadically at best, and often managers have little training or are filling several positions at once. When issues do arise, it is unlikely that an employee would be let go. They just get transferred somewhere else. Unlike in the private sector, where the number of patient visits impact the overall physician pay, IHS medical staff just make a salary and there is no incentive to go above and beyond to meet the needs of patients. In the 2010 Dorgan report, it was discussed that IHS routinely transfers or reallocates employees at all levels with a history of misconduct and we still hear about this today. It is unclear what actions IHS has taken to terminate problem employees from the three service units who have been threatened with the loss or have already lost CMS accreditation.

How many more people have to die before AI/ANs can access quality health care? What will it take for the U.S. government to fulfill its promise of providing safe and reliable health care to Indian Country?

Lack of Communication between Tribal Leadership and the IHS

Inconsistent communication between IHS officials and local leadership continues to be a major challenge for the Tribes when it comes to management of hospitals on their land. For the Tribes who have been involved in the CMS certification issues, Tribal leadership has requested that they be informed on a weekly basis about progress from IHS. But, according to local Tribal staff, the Tribal government has not received adequate updates from IHS. It is our understanding that CMS also has regular discussions with the IHS on the issue, but has not involved the Tribal government in any of these conversations.

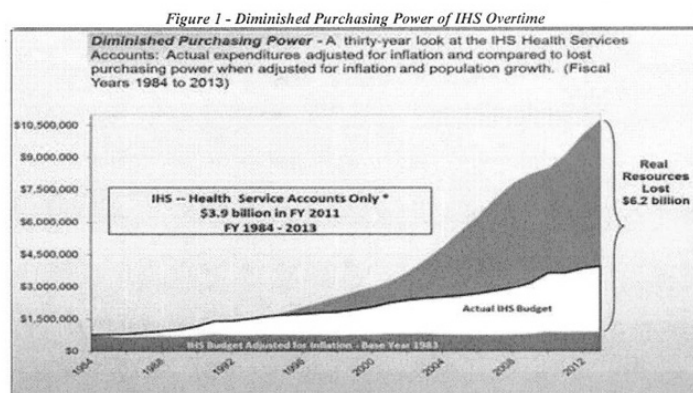
However, all the Tribal leaders present in the hearing discussed a lack of consultation by IHS on issues at certain service units. One Tribal leader present at the listening session noted that his Tribe found out about the loss of CMS accreditation at their hospital on the local news. Mr. William Bear Shield with the Rosebud Sioux Tribal Council noted, "There's still continuing to be practices. . . that doesn't give us any hope that things are being taken seriously [by IHS]. There needs to be more direction. . . they need to be more actively involved in helping us get our ER services back open."

One suggestion offered by several of the Tribal leaders present at the hearing was that Tribal leadership should have voting positions on hospital governing boards. It was reported during the hearing, that Tribal leaders only serve as ex officio members and the voting members typically consist of IHS area staff. Tribal leaders also reported that they found out about deficiencies or key decisions affecting hospitals on their reservations after decisions had already been made.

These claims should not be taken lightly. Even though IHS operates a facility, it is by no means an excuse to exclude Tribal leadership from hospital decisions. The elected Tribal leadership has a duty to ensure the health and well-being of their people, and without substantive engagement from IHS and other federal agencies, it is impossible for these leaders to do that. Someone must be there looking out for the people in each of these communities, and it is imperative that Tribal leadership be given an active and formal role in the hospital governance.

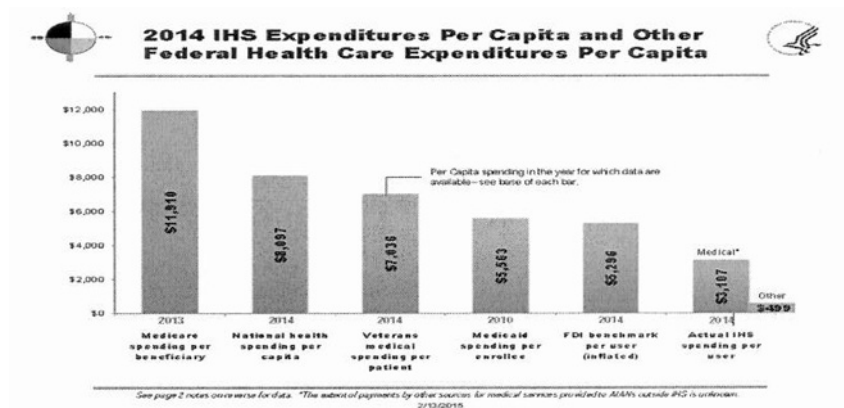
Budget Disparities for American Indian Alaska Native Health

The quality of health care provided is underscored by the low quality budget that IHS receives each year. NIHB understands that federal discretionary budgets are tight, but there are many things that just cannot be achieved with the amount of funds available. The treaties that Tribes signed are not discretionary and should not be held hostage to unrelated political battles in Washington. It is shameful and dishonorable that the United States refuses to live up to its treaty and trust responsibilities. Congress must make funding of the Tribal health system a priority. NIHB and Tribes have consistently asked for budgets each year that would bring IHS up to the same status as other American health facilities. Right now, this is \$30 billion. To begin a phase in of this amount over 12 years, we are requesting \$6.2 billion for IHS in FY 2017.



It is true that IHS budgets have increased over the last several years. However, most of these increases have gone to provide for full funding of Contract Support Costs after the decision by U.S. Supreme Court in *Salazar v. Ramah Navajo Chapter* (2012), requiring that these costs be paid in full (CSC is currently \$717 million, an increase of 62 percent since FY 2004). Other important increases have been made to Purchased/Referred Care Services (currently \$914 million, an increase of 48 percent since FY 2004). But it is important to note that inflation and population growth have played a big part in the diminished purchasing power of the IHS. For example, putting FY 2004 funding in 2015 dollars, the overall increase to the IHS budget would only be about 4 percent, yet the IHS patient population has grown by about 27 percent.

Per capita spending for AI/ANs also continues to lag far behind other Americans. In 2014, the IHS per capita expenditures for patient health services were just \$3,107, compared to \$8,097 per person for health care spending nationally. Compared to IHS calculations of expected cost of Federal Employee Health Benefits, average IHS per user spending in 2014 was only 59 percent of calculated full costs. It is also important to note that the IHS spending per capita on actual healthcare services was only about \$1,940 in FY 2014. The actual percentage varies widely between IHS areas, with some funded at much less than 59 percent of need.



New health care insurance opportunities beginning in 2014 and expanded Medicaid in some states may expand health care resources available to American Indians and Alaska Natives. However, these new resource opportunities come with a cost for billing, collections and compliance, and are no substitute for the fulfillment of the federal trust responsibility. With the funding gap already reaching upwards of \$25 billion, even if 100 percent of these were recouped and put into services, the huge budget gap and associated health disparities will remain.

Indian Health Care Improvement Act

In 2010, the Indian Health Care Improvement Act (IHICA) was permanently enacted as part of the Affordable Care Act. This landmark legislation was hailed as a great victory for Tribes, as renewal efforts were over 10 years in the making. Specifically, the renewed IHICA:

- Updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled.
- Establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

This historic law has meant many great new opportunities for the Indian health system, but not all provisions have been equally implemented or at all. With the passage of the ACA, the American health care delivery system has been revolutionized while the Indian health care system continues to wait for the full implementation of the IHICA. For example, mainstream American health care increased focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs. This is now a standard practice as a result of the ACA but not for Indian Country. Tribes fought for over a decade to renew IHICA and it is critical for Congress and the Administration to ensure that the full intentions of the law are realized.

To provide context for how much of the law has not been implemented, the following provides several categories of programs that have not been implemented and funded:

- 1) Health and Manpower—67 percent of provisions not yet fully implemented.
 - Includes: establishment of national Community Health Aide Program; demonstration programs for chronic health professions shortages.
- 2) Health Services—47 percent of provisions not yet fully implemented
 - Includes: authorization of dialysis programs; authorization of hospice care, long term care, and home/community based care; new grants for prevention, control and elimination of communicable and infectious diseases; and establishment of an office of men's health.
- 3) Health Facilities—43 percent of provisions not yet fully implemented
 - Includes: demonstration program with at least 3 mobile health station projects; demonstration projects to test new models/means of health care delivery.

- 4) Access to Health Services—11 percent of provisions not yet fully implemented
 - Includes: Grants to provide assistance for Tribes to encourage enrollment in the Social Security Act or other health benefit programs.
- 5) Urban Indians—67 percent of provisions not yet fully implemented
 - Includes: funds for construction or expansion of urban facilities; authorization of programs for urban Indian organizations regarding communicable disease and behavioral health.
- 6) Behavioral Health—57 percent of provisions not yet fully implemented
 - Authorization of programs to create a comprehensive continuum of care; establishment of mental health technician program; grants to for innovative community-based behavioral health programs; demonstration projects to develop tele-mental health approaches to youth suicide; grants to research Indian behavioral health issues, including causes of youth suicides.
- 7) Miscellaneous—9 percent of provisions not yet fully implemented
 - Includes: Provision that North and South Dakota shall be designed as a contract health service delivery area.

Clearly, more must be done to ensure that the promises made by this law are actually implemented. Otherwise, Indian Country will continue to operate with a health system designed for the 20th Century, not a modern health delivery system. The passage of this seminal law, and then subsequent failure to appropriate funds to carry it out represents just another broken promise to Indian Country.

Recruitment and Retention at IHS

At Rosebud, the IHS Area Director claimed that the hospital had a need for 22 doctors but only had funding for 11. YET, there were only 2 full time physicians at the hospital. NIHB's Board Member for the Billings Area, Charles Headdress, Vice Chairman for the Assiniboine and Sioux Tribes of the Fort Peck Reservation, reported he had to wait three years to get a dental appointment. NIHB has heard countless reports of patients showing up at the beginning of the day for just a handful of emergency appointments—even if this means waiting outside in the cold. To make matters worse, the use of contract physicians makes it impossible for patients to form a trusting relationship with their medical providers, further exacerbating distrust in the system.

While we understand that it can be challenging to recruit medical professionals to remote areas, it is critical that IHS and HHS employ all tools at their disposal to do so. For example, increasing the ability of IHS to use Title 38 salary authority would help. We also must expand the ability of IHS to offer student loan repayment with already appropriated funds by passing S. 536—The Indian Health Service Health Professions Tax Fairness Act. In addition, Congress must make investments in reservation housing so that people working in IHS facilities have a place to live. It is also critical to provide support for schools so that the families of medical providers will have access to adequate educational opportunities.

But most importantly, we must make IHS a desirable place to work. Time and again, NIHB hears from physicians who leave IHS and cite the obstacles to working at these poorly-operated facilities on a daily basis. One of the most common reasons physicians leave is because they can't practice medicine with the resources available. Too many of them have had their hands tied by budget constraints and other bureaucratic obstacles.

Conclusion and Policy Recommendations

"Congress needs to be willing to put that investment into [IHS]. It is not asking too much. We make up 2 percent of the entire population of this country. We are the genocide survivors. It is not a big ask for this country to fund schools, health, our judicial systems at a level that allows us to live functional healthy lives."

-Jerilyn Church, Executive Director, Great Plains Tribal Chairmen's Health Board, February 3, 2016

Thank you for holding this important hearing on the substandard quality of healthcare provided by the IHS. It is clear that the federal government is not living up to its trust responsibility. From underfunding to employee accountability, to recruitment and retention, NIHB calls on this Committee to enact solutions that will change the course for Indian health services.

Sadly, we knew about many of these issues six years ago when the Dorgan Report was released, but are still dealing with the same issues. We call upon this committee to be the leaders in making this change.

As noted above, NIHB will be working in the coming months to coordinate a task force that will develop recommendations on how to improve the IHS. However, NIHB makes the following interim policy recommendations that will help improve the quality of care at the Indian Health Service:

- Fully fund the IHS at \$30 billion. In FY 2016 Tribes are recommending \$6.2 billion for IHS in order to start a 12-year phase in of this \$30 billion
- Enact Advance Appropriations for the Indian Health Service which will enable IHS to operate budgets that are more predictable and sustainable
- Enact legislation that would require all Medicare-participating providers to also accept Medicare Like Rates for referrals from the IHS
- Require Tribal leadership on IHS-operated hospital governing boards, and provide training for those Tribal leaders. It is critical that Tribally elected officials are a part of key hospital decisions
- Support the use of Dental Health Aide Therapists in Tribal communities by repealing Section 119 of IHCA which will bring oral health access to Tribal communities.
- Enact the Indian Health Service Health Professions Tax Fairness Act (S. 536) which would allow IHS to fund more student loan repayment within existing funds

Please see the attached NIHB 2016 Legislative and Policy Agenda which also contains additional policy recommendations to improve Indian health. We look forward to working with you on these and other proposals as we work towards our joint goal of improving the health of American Indians and Alaska Natives.

2016 LEGISLATIVE AND POLICY AGENDA—JANUARY 21, 2016

Founded by the Tribes in 1972, the National Indian Health Board (NIHB) is dedicated to advocating for the improvement in the delivery of health care and public health services and programs to American Indians and Alaska Natives. To advance the organization's mission, the NIHB Board of Directors sets forth the following priorities that the NIHB will pursue through its legislative and policy work in 2016.

Phase in Full Funding for Indian Health Services and Programs for American Indians and Alaska Natives in the Indian Health Service (IHS) and Beyond

Each year the National Tribal Budget Formulation Workgroup to the IHS works diligently to synthesize the priorities identified by Tribes in each of the health care delivery Service Areas of the IHS into a cohesive message outlining Tribal funding priorities nationally. These priorities are the foundation and roadmap for the work that NIHB does on behalf of Tribes in pursuit of much needed funding for health care services and programs for American Indians and Alaska Natives (AI/ANs). In addition to advocating for these national Tribal priorities, NIHB will call on Congress and the Administration to:

*****NOTE: Specific Recommendations to be updated with the Tribal Budget Formulation Workgroup's recommendation after the national meeting on Feb 11–12.*****

- Phase in Full Funding of IHS—Total Tribal Needs Budget of \$29.7 Billion Over 12 Years
- Present a 22 percent increase in the overall IHS budget from the FY 2016 President's Budget request planning base for a total of \$6.2 billion
- Advocate that Tribes and Tribal programs be permanently exempted from sequestration
- Provide an additional \$300 million to implement the provisions authorized in the Indian Health Care Improvement Act (IHCIA)

Enact Mandatory Appropriations for the Indian Health Service

In addition to fully funding the Indian Health Service, NIHB and Tribes are committed to seeing IHS treated as 'mandatory' spending. The federal trust responsibility toward the Tribes is not an optional line item, and it should not be treated this way during the annual budgeting process. To reaffirm its commitment to the Tribes, IHS funding should be treated as mandatory spending so that fulfillment of the U.S. government's treaty responsibilities is not a victim of unrelated political battles.

Seek Long-Term Renewal for the Special Diabetes Program for Indians at \$200 Million

NIHB is asking Congress to pass legislation by this year to renew funding for this vital program for at least 5 years at \$200 million per year. The Special Diabetes Program for Indians (SDPI) has not received an increase in funding since 2002; the program has effectively lost 23 percent in programmatic value over the last 12 years due to the lack of funding increases corresponding to inflation. Few programs are as successful as SDPI at addressing chronic illness and risk factors related to diabetes, obesity, and physical activity. SDPI has proven itself effective, especially in declining incidence of diabetes-related kidney disease. The incidence of end-stage renal disease (ESRD) due to diabetes in American Indians and Alaska Natives has fallen by 29%—a greater decline than for any other racial or ethnic group. Treatment of ESRD costs almost \$90,000 per patient, per year, so this reduction in new cases of ESRD translates into significant cost savings for Medicare, the Indian Health Service, and third party payers.

Secure Advanced Appropriations for the Indian Health Service

NIHB is asking Congress to enact advanced appropriations for IHS. If IHS had received advance appropriations, it would not have been subject to the government shutdown or automatic sequestration cuts as its FY 2014 funding would already have been in place. Adopting advance appropriations for IHS results in the ability for health administrators to continue treating patients without wondering if—or when—they have the necessary funding. Additionally, IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when the results of Congressional decisions funnel down to the local level.

Seek a Legislative Fix of the Definition of Indian in Affordable Care Act

NIHB is asking for a legislative fix of the “Definition of Indian” in the Patient Protection and Affordable Care Act (ACA). The “Definition of Indian” in the ACA are not consistent with the definitions already in place and actively used by the Indian Health Service (IHS), Medicaid and the Children’s Health Insurance Plan (CHIP) for services provided to AI/ANs. The ACA definitions, which currently require that a person is a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act (ANCSA) corporation, are narrower than those used by IHS, Medicaid and CHIP, thereby leaving out a sizeable population of AI/ANs that the ACA was intended to benefit and protect. Congress should:

- Enact legislation that would clarify the definitions in the ACA to align with other definitions used by federal providers

Promote Better Public Health Outcomes for AI/ANs through Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) is the nation’s public health agency responsible for the public health of all populations, however, their actions on American Indian and Alaska Native health have not demonstrated a firm commitment to fulfilling the trust responsibility that the federal government has to maintain the health and well-being of Tribal citizens. The CDC’s past efforts, although lauded and appreciated, have been indicative of a both a ‘helicopter’ and ‘band-aid’ mentality—serving often to micromanage Tribal health programs and only seeking to solve symptomatic issues, rather than improving whole health systems. Efforts, more specifically funding streams, have been temporary and have only served to draw fleeting attention to bigger and broader issues. The funding creates fruitful and effective programs within the Tribal communities (i.e. traditional foods, motor vehicle safety, HIV capacity building), however these programs are woefully dismantled upon the termination of the funding. This only reinforces a lack of long-term and sustainable commitment to American Indian and Alaska Native communities. The funding is not sufficient enough to create systemic change, embed a community consciousness aligned with public health goals, re-align programming and governance to longer-term public health strategies, and address tribal priorities. There needs to be a significant increase to the CDC’s bottom line budget, and then that increase used to:

- *Create an American Indian and Alaska Native public health block grant* administered through the Tribal Support Unit within the Office of State, Tribal, Local and Territorial Support.

- *Create flagship funding for Tribal health departments* for key public health issues in Indian Country. State health departments receive multi-year funding from the CDC for such issues as HIV, hepatitis C, diabetes, cancer, and sexually transmitted diseases. These funds are used to establish the state's own programming and presence around these issues. Tribes should be permitted the same opportunities through their own flagship awards.
- Each institute, office or center operating significant programmatic outreach at the community level should create *standing funding streams dedicated only to federally recognized American Indian or Alaska Native Tribes*.
- The CDC should *work directly with the CDC Tribal Advisory Committee meeting to establish subcommittee that will actively seek out Tribal input during the internal budget negotiations and formulation*. It is important that Tribal input is reflected in the budget that CDC prepares for the White House's initial proposal and all subsequent revisions.

Achieve Medicare-like Rates for the IHS

NIHB is requesting Congress to extend the Medicare-like rate cap on Purchased and Referred Care (PRC) (formerly Contract Health Services) referrals to all Medicare participating providers and suppliers. The IHS-operated PRC program alone would have saved an estimated \$31.7 million annually if Medicare-like Rates applied to non-hospital services. These savings would result in IHS being able to provide approximately 253,000 additional physician services annually. On December 5, 2014, IHS released a proposed rule that would amend the IHS PRC regulations to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital based services that are either authorized under such regulations or purchased by urban Indian organizations. The National Indian Health Board, along with multiple Tribes and other Tribal organizations submitted comments supporting the Proposed Rule as long as any regulation is flexible enough to allow Tribes to opt out of the regulations requirements if they so choose. While NIHB is generally supportive of the proposed rule, it recognizes that the proposed rule has no enforcement capability. As a result, NIHB is still calling on Congress to pass legislation to extend the Medicare-like rate cap on PRC.

Seek an Exemption for American Indians and Alaska Natives from the Employer Mandate Requirement

The Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, states that all employers with 50 or more employees must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule even though they are not specifically listed in the language of the statute. Yet, AI/ANs are exempt from the Individual Mandate to purchase health insurance. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself. NIHB has reached out to members of Congress to educate them on this important issue and it has garnered some interest and support. However, given the political climate, NIHB believes that a regulatory fix would be more likely to succeed than a congressional one. However, NIHB continues to advance both strategies in 2015.

- The Administration should *exempt AI/AN employees from the Employer Mandate* through a regulatory fix
- If the Administration can't exempt AI/AN employees from the Employer Mandate altogether, *Tribal consultation needs to occur on how to mitigate the impact that the Employer Mandate has on Tribes*
- *Congress should explicitly exempt AI/AN employees from the Employer Mandate* to purchase health insurance under the ACA

Improve Recruitment and Retention of Medical and Health Professionals at the Indian Health Service

Like most rural health providers, IHS has difficulty recruiting and retaining medical staff at many of its sites. As a result, patients experience very long wait times, and serious illness is often left untreated. Congress and the Administration must do more to ensure that providers are seeking out the IHS as a desirable place to work. Recommendations include:

- Securing tax exempt status for IHS student loans
- Engaging in formal Tribal consultation on how to better recruit and retain medical staff

- Shortening hiring times for medical professionals
- Increasing funding to build staff housing on reservations
- Create specialized residency programs within IHS to attract a service provider corps with more diversified professional expertise
- Increase professional development opportunities for existing staff

Enact Special Suicide Prevention Program for AI/ANs

AI/AN communities grapple with complex behavioral health issues at higher rates than any other population. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma. According to the Substance Abuse and Mental Health Services Administration, suicide is the 2nd leading cause of death—2.5 times the national rate—for AI/AN youth in the 15 to 24 age group. Tribes have noted that federal support seems to increase whenever there is an acute crisis, but then dwindles over time, preventing long-term, sustainable improvement in mental and behavioral health systems. The Attorney General’s Advisory Committee on AI/AN Children Exposed to Violence, describes the foundation that must be put in place to treat and heal AI/AN children who have experienced trauma: “We must transform the broken systems that re-traumatize children into systems where [AI/AN] tribes are empowered with authority and resources to prevent exposure to violence and to respond to and promote healing of their children who have been exposed.”* NIHB recommends that:

- Congress should *enact a program to target suicide prevention program for Indian Country* that would be modeled off of the Special Diabetes Program for Indians
- *Create an American Indian and Alaska Native mental health block grant* to be administered by the Substance Abuse and Mental Health Services Administration
- Congress and the Administration should *require that states engage in meaningful Tribal Consultation with Tribes* within their borders in order to receive any funds under the Mental Health Services Block Grant
- *Increase appropriations across the federal government* for Tribal behavioral health programs and empower Tribes to operate those programs through Tribal Self-Governance contracts
- Congress *pass statutory language supporting traditional and cultural healing practices* in any national mental health reform legislation

Repeal Language in the Indian Health Care Improvement Act Limiting the Use of Dental Therapists in Tribal Communities

Tribal communities suffer from some of the worst oral health disparities in the United States. AI/AN children have an average of 6 decayed teeth, while the same age group in the U.S. population overall has only one. For over a decade, Tribes in Alaska have successfully employed Dental Health Aide Therapists (DHATs), who have expanded oral health services to over 40,000 Alaska Natives. These safe and effective mid-level oral health providers deliver basic and routine services (i.e. cleanings, fillings, simple extractions, oral health education, sealants, etc.) to communities who do not have access to a regular dentist. However, when Congress passed the Indian Health Care Improvement Act in 2010, language was included that would limit the use of DHATs outside of Alaska within the Community Health Aide Program unless a state legislature approves. NIHB believes that this is a direct violation of the principle of Tribal sovereignty, and that Tribal governments, not state legislatures, should dictate who is able to deliver care in their community. Therefore, we recommend that:

- Congress should *repeal Section 119 of the Indian Health Care Improvement Act* which bans the expansion of Dental Health Aide Therapists (DHATs) to Tribes in the lower 48 within the Community Health Aide Program at the Indian Health Service unless approved by a state legislature
- Congress should *pass legislation that would express support for the use of DHATs* in Tribal communities outside of Alaska

*U.S. Department of Justice. (2014) “Attorney General’s Advisory Committee on American Indian and Alaska Native Children Exposed to Violence: Ending Violence so Children can Thrive,” p. 7.

Expand Tribal Self Governance at the Department of Health and Human Services

For over a decade, Tribes have been advocating for expanding self-governance authority to programs in the Department of Health and Human Services (DHHS). Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696—Department of Health and Human Services Tribal Self-Governance Amendments Act—that would have allowed demonstration projects to expand self-governance to other DHHS agencies. This proposal was deemed feasible by a Tribal/federal DHHS workgroup in 2011. Therefore, in 2016, NIHB recommends that Congress:

- *Expand statutory authority for Tribes* to enter into self-governance compacts with HHS agencies outside of the IHS.

Improve Enrollment through the Federal and State-based Insurance Marketplaces

NIHB is committed to working with CMS to set goals for enrollment and measure progress towards those goals. It has been estimated that about 460,000 AI/AN are eligible for tax credits or premium assistance yet only about 24,000 AI/AN have enrolled. There are a number of ways to increase enrollment of AI/ANs.

- *Funding for enrollment assistance for the I/T/U.* Navigator grants have been limited to only a few regions in the country; and the rules associated with Navigator grants make them unattractive to some Tribes and Tribal organizations, which are in the best position to do outreach, education, and enrollment assistance. NIHB needs to work with CMS to consider alternatives for funding for enrollment assistance that is specifically designated to reach the I/T/U.
- *Change the rule for AI/AN in family plans.* A regulatory decision was made in the first year that everyone on a family plan would get the least generous cost sharing reduction that anyone qualified to receive. NIHB will recommend that a family plan includes one person who is eligible for Indian-specific cost sharing reductions, then others who are in the tax-filing unit who are eligible for the Indian Health Service will get the same cost-sharing reduction as the person with Indian Status.
- *Access to analytics to manage enrollment for AI/AN.* To manage the problem of increasing enrollment requires a system of reporting and analyzing enrollment data in a regular and consistent way that allows us to better understand the impediments and the approaches that are successful. NIHB and TTAG have made recommendations about the most useful types of information and how they can be retrieved from existing data files and we intend to follow up with CMS until we receive access to the data that we need.

AI/AN-Specific Call Centers

NIHB has reported to CMS numerous times that AI/ANs continue to experience poor assistance when contacting the marketplace call center for help. Issues range from technicians having no knowledge of the Indian-specific protections like exemptions and tax credits, to technicians being rude and having no patience to walk elderly consumers through the troubleshooting process.

Because AI/AN consumers continue to receive such poor customer service we have suggested before and continue to suggest that the Center for Consumer Information and Insurance Oversight (CCIIO), in CMS, *establish an AI/AN-specific call center to respond to questions and provide technical assistance to AI/ANs*, as well as enrollment assisters such as navigators and certified application counselors. We also believe that an AI/AN-specific help desk would be better equipped and more sensitive to the needs of AI/AN consumers.

Support Increased Oversight of QHPs

CMS put into regulations the provisions in the 2015 Issuer Letter requiring Qualified Health Plan (QHP) Issuers to offer contracts to all Indian health care providers that operate in the QHP's service area and to do so by including the QHP Indian addendum with "good faith" payment provisions. However, not all QHP Issuers are complying with the requirement. Depending upon the region of the country, some QHP issuers are offering contracts, but in other regions, QHP issuers do not appear to be offering contracts to Indian health care providers. NIHB is advocating and working with CCIIO to provide better oversight in federally facilitated marketplaces (FFM) states and that the contract requirement be extended to state-based Marketplaces to ensure Indian Health Care Providers are included in plan networks in those states.

For a variety of reasons, an I/T/U may be unable to join the network of plan providers or chose not to do so. In any case, if the I/T/U is an out-of-network provider, AI/AN will continue to seek the I/T/U for many of their health services. CMS should ensure that:

- *Marketplace plans make accurate and timely payments to the I/T/U for services to people enrolled in the Marketplace plans, and that the cost sharing reductions for AI/AN are handled properly at the time of service.*

Meaningful Use of Electronic Health Records

Meaningful Use (MU) of electronic health records (EHR) requires both changes in technology and changes in business practices. For a variety of reasons, this has been difficult to accomplish in many places within the I/T/U. Now Indian health providers are threatened with reduced revenues for lack of progress on MU. In addition, many I/T/U facilities are small and located in extremely rural areas where it is difficult or impossible to attract and retain the kind of personnel who can understand, implement and manage the new requirements for reporting that result in Medicare payments being reduced. NIHB will advocate for exemption to these requirements.

Support Medicaid Expansion and 100 percent FMAP Policy

Medicaid Expansion is a shared partnership between states and the federal government. Under Medicaid, AI/ANs are eligible for a 100 percent federal match (also known as 100 percent FMAP), meaning that the money spent by a state Medicaid program is fully reimbursed by the federal government. Medicaid reimbursement is a significant source of third party revenue that is essential to supplementing the limited resources of the Indian health system. In states that have expanded Medicaid, like Washington, as much as \$2 billion has been added to the Indian Health System. A recent White House report estimates that 5,200 deaths could be avoided annually if those 16 remaining states that have stated that they are not expanding Medicaid continue to do so. NIHB must continue to advocate and provide technical assistance for those states that wish to expand Medicaid.

In addition, CMS recently proposed updating its policy concerning the circumstances under which a 100 percent federal match can be applied. CMS proposes expanding the match to include services furnished outside an IHS or Tribal health facility. This would have substantial benefits to Indian Country and the revenue generated from expanding the federal match could be used to expand Medicaid in the state, as South Dakota has proposed. NIHB will continue to advocate for this expansion and provide all necessary technical support.

Public Health Infrastructure Workforce Development

AI/AN communities have some of the largest public health disparities in this country, with disproportionately higher rates of depression, suicide, HIV, motor vehicle accidents, other accidental deaths, sexually transmitted diseases, viral hepatitis, substance use, tobacco use, and cancer when compared to other reported races and ethnicities. Indian Country does not have the established public health infrastructure that exists within state governments or even local or country systems. This lack of infrastructure and accompanying workforce will only continue to perpetuate the disparities, and quite possibly compound them. The recent movement to accredit the public health operations of health departments has proven quite successful but uptake has been slower in Tribal communities, primarily because the lack of public health infrastructure makes public health accreditation seem unachievable. An effective public health system, especially the practices of disease surveillance and prevention, can save hundreds of thousands of dollars in health care costs to Indian Health Service, Veteran's Administration, Medicaid, and third party payers. In order to bolster the public health infrastructure and workforce of Tribes, NIHB recommends:

- *IHS create targeted capacity building to Indian Health Service medical providers on the integration of public health and behavioral health services into clinical settings.*
- *Congress re-instate the CDC's National Public Health Improvement Initiative (NPHII) which was discontinued in 2015, as this funding was solely for the purpose of strengthening gaps in public health services or systems, as identified by the funding recipient. However, the re-instatement of this program should include a Tribal set-aside, as data clearly indicates that not only are health disparities greater, but the infrastructure is weaker within Tribal communities than their non-Tribal counterparts.*
- *Indian Health Service create a health education certification program for Tribal and IHS employees.*

- That Congress require the *Indian Health Service and the CDC to report to Congress every two years how it supports the creation and effective implementation of the ten essential services of public health* within AI/AN communities.

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES, INC.

The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) is pleased to provide the Senate Committee on Indian Affairs with the following testimony in pursuit of solutions to the systemic challenges facing the Indian Health Service (IHS) and Tribally-Operated facilities. Following the unacceptable and devastating failures of the Indian Health System in the Great Plains, that is in part responsible for the unfortunate loss of lives, it was vital that the Committee investigate the state of Indian health care regionally and beyond. USET SPF thanks the Committee for hosting the hearing on the quality of health care within the IHS Great Plains Area and the subsequent listening session on “Putting Patients First: Addressing Indian Country’s Critical Concerns Regarding Indian Health Service.”

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine.¹ Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the IHS, which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-Operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638.

We echo the comments of many Members of the Committee, as well as witnesses, highlighting the financial obstacles facing the Indian Health Service and Tribal Nations, as they seek to provide quality health care to American Indians and Alaska Natives (AI/AN). While the issues surrounding the deplorable conditions in the Great Plains are multi-faceted, much of the problem can be attributed to the persistent underfunding of IHS. With this in mind, USET SPF is hopeful that Congress will take necessary actions to fulfill its Federal Trust responsibility and obligation to provide quality health care to Tribal Nations, including providing adequate funding to the IHS. In addition, we urge this Congress to introduce and approve no-cost legislation that will stabilize and extend the limited resources of the IHS.

Uphold the Federal Trust Responsibility and Obligations to Tribal Nations

As this Committee is well aware, many of the systemic inequities in the Indian Health System and strikingly high health disparities² in Indian Country result from the chronic underfunding of the IHS budget. The IHS is the primary agency tasked with ensuring the federal government fulfills its promise to provide health care to AI/AN. However, the IHS is consistently underfunded, meeting just around 59 percent of the demonstrated financial need to deliver care to AI/AN patients. As a result, IHS health expenditure per capita for patients is just \$3,099, which is approximately 61.7 percent less than health spending for the total U.S. population at \$8,097 per capita.³ Although Congress has appropriated additional funding for IHS in recent years, the costs of health care continue to increase. Current levels of funding are barely able to meet non-medical inflation rates and is completely unable to meet the medical inflation rate. As a result, major barriers to accessing care exist due to the lack of resources in the Indian health system. These barriers lead to poor health outcomes and severe health disparities.

Through the permanent reauthorization of the Indian Health Care Improvement Act, “Congress declare[d] that it is the policy of this Nation, in fulfillment of its spe-

¹ USET member Tribes include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

² Tribal Nations face disproportionately high rates of mortality from diabetes, major heart disease, chronic liver disease and injuries, when compared with all other races in the United States (U.S.).

³ Indian Health Service “Year 2015 Profile” December, 2015.

cial trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.⁴⁷ As long as the IHS is so dramatically underfunded, Congress is not living up to its own stated policy and responsibilities. USET SPF urges this Committee to consider carefully the level of funding for IHS it will support as it makes requests of appropriators for Fiscal Year (FY) 2017 and beyond. Fulfillment of the Federal Trust responsibility, both from a fiduciary and moral perspective, means fully funding the Indian Health Service.

Extend PRC Resources by Passing Legislation to Extend Medicare-Like Rates Payment Methodologies to Non-Hospital Services

One of the most severely underfunded line items within the IHS budget is the Purchased/Referred Care (PRC) account (formerly known as Contract Health Services). PRC resources allow Indian Health programs to purchase care that is furnished by outside, non-Indian health care providers (non-IHCPs) in the private sector. PRC funding is essential for AI/AN patients to access primary care, specialty care, and other services not readily available at their Indian Health Facility. At current funding levels, many IHS and Tribally operated programs are only able to cover Priority I⁵ services to preserve life and limb and are often unable to fully meet patients' needs at even this restrictive PRC service category. In FY 2015, IHS estimates that it denied 132,000 necessary services to AI/AN patients due to lack of funds.

Compounding and contributing to this challenge are the rates PRC programs pay to non-IHCPs. Non-IHCPs routinely charge, and expect to be paid, full-billed charges to PRC programs. According to an April 2013 Government Accountability Office (GAO) report, federal PRC programs paid non-contracted physicians two and a half times more than what it estimates Medicare would have paid for the same services. The PRC program may be the only program in the federal government that pays rates above the Medicare rate. Neither the VA nor the DOD pay full billed charges for health services furnished by outside providers. Nor do insurance companies, including those with whom the federal government has negotiated favorable rates through the Federal Employee Health Benefits program. IHS and Tribally-Operated Health Programs' regular payment of full billed charges is both a major barrier to accessing necessary care for AI/AN patients, and an inefficient use of taxpayer dollars.

The 2013 GAO report concluded that paying a Medicare-like Rate (MLR) for services purchased by PRC programs would allow the IHS to provide approximately 253,000 additional physician services annually. Payment under this rate would have resulted in hundreds of millions of dollars in new federal health care resources being made available to AI/ANs in 2010 alone. Furthermore, the implementation of this payment mechanism would be achieved at no cost to the federal government.

Over the past year, IHS has been working to implement a regulation that would provide Tribal Nations with the option to apply MLR to their PRC programs. The rule, however, does not include an enforcement mechanism, namely, conditioning participation in the Medicare program on the acceptance of MLR. A lack of enforcement could lead non-IHCP to refuse to AI/AN patients due to the decrease in payments. Particularly for USET Tribal Nations that reside in areas with few specialty care providers, this rule could create additional barriers to accessing health services. This is why legislation is necessary. The Administration, in its FY 2017 Budget Request, recognized the need for legislation over regulation, stating in its Congressional Justification, "unlike the legislative proposal, the regulation cannot require that providers participating in Medicare accept the capitated PRC rate from IHS."

USET SPF urges this Committee to support and work toward the passage of legislation extending MLR to non-hospital services that includes an enforcement mechanism to ensure AI/AN patients' continued access to care. Doing so would be a more efficient use of taxpayer dollars, dramatically improve AI/AN patient access needed care, and be an important step toward improving the health inequities between AI/AN and the U.S. population.

Provide Advance Appropriations for the Indian Health Service

In addition to the more efficient spending of IHS dollars, Congress should work to ensure funding is received on time by approving legislation that would authorize advance appropriations for IHS. Advance appropriations is funding that becomes

⁴⁷ 25 U.S. Code § 1602

⁵ For a breakdown of IHS Medical Priority Levels see: http://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care.

available one year or more after the appropriations act in which it is contained, allowing for increased certainty and continuity in the provision of services.

On top of chronic underfunding and drains on precious dollars, IHS and Tribes face the problem of discretionary funding that is almost always delayed. In fact, since FY 1998, there has only been one year (FY 2006) in which appropriated funds for the IHS were released prior to the beginning of the new fiscal year. The FY 2016 Omnibus bill was not enacted until 79 days into the Fiscal Year, on December 18, 2015.

Late funding has severely hindered IHS and Tribal health care providers' ability to administer the care to which AI/AN are legally entitled. Budgeting, recruitment, retention, the provision of services, facility maintenance, and construction efforts all depend on annual appropriated funds. Many of our USET SPF member Tribal Nations reside in areas with high Health Professional Shortage Areas and delays in funding only amplify the challenges with salary and hiring of qualified professionals which are systemic across the IHS System. IHS and Tribal facilities must continue to operate while Congress engages in philosophical debates about federal spending. However, they are forced to do so at a severely reduced capacity. In a world where it is not unusual to exhaust funding before the end of the Fiscal Year, surgeries are delayed, services are reduced, and employment is in jeopardy.

Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle. When it became clear that our nation's veterans were not able to receive the quality health care earned in the protection of this country due to funding delays, advance appropriations were enacted for the Veterans Administration (VA) medical care accounts. Advance appropriations serve to mitigate the effect of delayed and, at times, inadequate funding for the VA. As the only other federal provider of direct health care and a consistently underfunded agency, IHS should be afforded this same consideration and certainty. USET SPF urges this Committee to support legislation that would extend advance appropriations to the IHS.

Conclusion

As the February 3rd hearing revealed, the chronic underfunding of the IHS has life or death consequences for many of the AI/AN patients from our USET SPF member Tribal Nations. Any loss of life resulting from failure to fulfill trust responsibilities and obligations is unacceptable. The rationing of care through the PRC program, and major obstacles with the recruitment and retention of providers are examples of the direct result of Congress' failure to meet its Trust responsibilities and obligations to adequately fund the IHS. In recognition of the political climate that enables the underfunding for Indian Health Care, we offer the preceding solutions to extend and stabilize IHS resources. We hope that Members of the Senate Committee on Indian Affairs will join us, and others in Indian Country, in advocating for the introduction and passage of these two common-sense proposals, in addition to increased funding for IHS.

We thank the Committee for holding both the hearing and the listening session to examine the quality of care delivered through IHS. USET SPF is a willing partner in your efforts to address systemic problems at IHS and improve the health outcomes of AI/AN patients.

PREPARED STATEMENT OF JAY HOULE, SISSETON-WAHPETON OYATE TRIBAL MEMBER

Dear Senate Committee,

I normally do not speak out about much, but this issue is getting out of hand. Healthcare in the Native American world is sliding downhill out of control. Referrals to private providers that were paid for 5 years ago are now being denied. I know not all referrals will be paid for, but many are serious health issues than are at minimum uncomfortable, not to say extremely painful and/or life threatening. At the personal level, my wife has a hernia and a bone spur on her spine, both of which have had the referral denied, so she must try to handle the pain with medication and lifestyle adjustment because physical therapy is not recommended.

This nation can spend HOW MUCH money on other countries and their citizens but cannot spend that much for the first people of this continent. I do not claim to understand the complexities of Washing, D.C. and the leaders of our nation. I do know that not many Native Americans are willing to raise a voice and comment. I pray that you will find a solution to this issue soon. Thank you.

PREPARED STATEMENT OF DOMNIC L BROWN, OSAGE TRIBAL MEMBER

I was employed at the Rosebud Indian Health Service and what I had seen is the patients would have appointments for specialist, but they would end up with the medical bill. The Rosebud Tribe Members, don't have insurance, because they don't have jobs, they should not be punished by not being sent to Specialist or having to be responsible for the Medical bill, that they can't pay. The Indian Health Service should pay all these bills and whether they have medical insurance or not.

I have sat in on the meetings when they go through the referrals and it was yes or no who would get sent out and that isn't fair, what happens the person that doesn't get sent out for medical attention and they die, oh well? It is sad.

They open clinic up on Sundays. because of the patient load we were seeing during the week, so they have Sunday Clinic and then only see 10 patients, the could see more than 10 patients with 2 physicians. Then the patient is prescribed medicine, but they can't pick it up because the pharmacy will not open up on weekends. Then why have clinic if patients can't receive there medicine?

I had slipped on the ice March 31, 2014 and I had bruised my ribs really bad and my ankle was hurt as well. I worked for the Hospital and my ankle was always swelling up so bad that I couldn't walk and was missing work, due to I could barely make it to my bathroom at my home, I was continuously seeing the doctor and they told me that it was just fractured, never offered me to be sent to a specialist, so I took myself to Rapid City Black Hills Orthopedic and had an MRI, within a week, I was in surgery, my inner ligaments were torn apart and had to have my whole ankle reconstructed on August 8, 2014, this is how long I had to deal with the pain and suffering and was out of work for 90 days, and was denied advance leave, was told that I should have saved my leave for something like this, will I used my leave to stay home and see the doctors, because of my ankle. I was punished and was off work without pay. This is how they treat there employees and that is why they have a large turnover. The management do not care about the employees or patients, they just make sure that they look good and not get any blame for things that are wrong doing.

I hope this gives you some light on what goes on at Rosebud Indian Health Service, and hope to hear from you on your opinions on what I have discussed today I don't expect much to happen, I just needed to speak my mind today. I am a Desert Storm Veteran, and from the Osage Tribe. I enjoyed helping the Rosebud Tribe Members while I was there and want to go back and work for the Indian Health Service, at least I showed some compassion, other workers don't, they don't care.

Thank you.

 PREPARED STATEMENT OF JACQUELINE ARCHAMBAULT, CHEYENNE RIVER SIOUX TRIBAL MEMBER

Hello, My name is Jacqueline Archambault, I live on the Cheyenne River Sioux Tribe, Eagle Butte, SD. I am submitting a statement in behalf of my daughter and grandson. I hope you are able to view the attachments.*

She is unable to submit her statement on her own as her work place won't allow her to use the computer for personal use. So, I as her parent and grandmother to her son, I am submitting from my email.

I hope you can help us, as my grandson got the poorest health service from the IHS in Eagle Butte, SD.

He had to go without a cast on his right leg for 10 days, because the IHS said, his right leg showed no fracture, but he still would not walk on it. My daughter kept taking him back to IHS and they kept saying it was not broke. So, I kept telling her to take him back. On Friday, March 4th, 2016 they finally saw the fracture, but the soonest they can refer him out was in five days, which was March 9th. He went to Black Hills Orthopedic and Spine Center, Rapid City, SD Then they place a cast to his right leg and he had a compound fracture.

I am so disguised with IHS that they could not help my grandson, who had to suffer for 10 days w/out a services and be in pain.

I told my daughter to file a law suit on IHS but that is probably not an opinion. But I think the IHS needs to get qualified x-ray technicians and physicians to make the right diagnosis on the patients. This way to much for us people to suffer.

My daughter, LaToya F. LaPointe always has the x-rays on disk.

I hope you help her and her son. He didn't have to suffer this long.

*The information referred to has been retained in the Committee files.

PREPARED STATEMENT OF ALEXIS JONES, REGISTERED NURSE, BSN

To Whom It May Concern;

I started at the Fort Thompson Indian Health in September of 2014. Upon continuation of working here, there have been many issues that have progressed or have happened during my employment.

One incident that occurred was with the schedule change due to an employee leaving and closing at 4:30 p.m. on Wednesdays. After reviewing the schedule I noticed there was an employee (Abby Bacon) who did not have any late shifts. I was switched to take her late shifts and was shifted to another charge nurse day. After noticing the changes I went to the Acting DON, Robert Douville and asked him why this was. He said Abby was going to the school to do immunizations and that she runs reports for the CEO. I asked him why nobody else was trained or asked to do those reports. He said he that it was set up before he got there and he was going to ask the CEO.

He asked me if I would be willing to do the reports and I said I would be away from Mcfee and that would take me away from patient care. I really enjoy seeing my patient's and doing my job that is why I am here. Running any kind of reports takes away from patient care. We are the busiest area in the facility. Providing immunizations is a busy job as well and should be prioritized over running reports.

Running reports or doing any other task will be helpful in providing growth for the individual and for the facility to provide better care. Growth to expand one's knowledge in the facility should be offered to everyone. During my employment here I asked my supervisor (Abby Bacon) at the time and CEO (Bernie Long) if I could attend a Health Care conference. After discussing with CEO, he said that they would be able to pay for the registration fee and I would have to pay for the rest. I would have been responsible for my hotel and travel. Due to lack of funding I was unable to go.

A few months ago a co-worker of mine who is now gone, attended a wound care workshop in Texas. All of hers was paid for and she also earned comp time. I thought this was really unfair and why was hers prioritized more than mine. Especially being a Native American, as a facility on reservation you would want your employees to grow and to be more educated.

My reasoning behind going was I provide complex care to a wide variety of patients. I felt as though my reasoning was just as important if not more important. I felt as though there was no justification behind their decision. Decisions that are being made affect everyone including our patient's.

Another issue that affects this facility is the amount of Commissioned Corp officers. The management of this facility has been mostly Commissioned Corp officers. Earlier in the year if you were to review the chain of command for the nursing staff it was all completely Commissioned Corp officers. During the last year that I have been here, we have had 4-5 acting DON's. We did have one permanent supervisor when I first started who was Native American and she left only after a few months. A co-worker and I are both Native American and she has over 5 years of experience and I have been a nurse for 3 years and have not been offered an opportunity to be acting DON. Every acting DON has been a Commissioned Corp officer. I don't think I deserved the opportunity due to lack of experience, but my co-worker did and she has Indian preference. Indian preference is a law that the facility must abide by. This facility or any other facility should promote the natives and encourage them to stay and provided opportunities for advancement or education.

Also with the amount of commissioned corp officers one would think that extended hours would be provided and that they would be able to provide that. They are on call 24/7. Some of the officers do the same amount of work we do and get paid 2-3x as much as we do.

The same co-worker also applied for another position in the facility. This position is a nurse who helps out in behavioral health. The nurse who worked there was actually detailed from public health and was of Caucasian descent. She has been there for an extended amount of time. An unusual event occurred where they actually advertised for the position. My co-worker applied for it amongst others, come to find out she didn't get the position. She again is Indian preference and the lady of Caucasian descent was offered the position. This goes to show that favoritism and pre-selection occurred during this event.

My co-worker and I were fed up one day with the amount of nepotism that occurs in this facility and how being a Native American in this clinic works against us. We addressed the tribal council during our lunch period. We were a few minutes late coming back from lunch. After administration found out where we were at they started an investigation against my co-worker, and not I. I felt this was an act of retaliation against her. I even went to the compliance officer and asked him why

she was being investigated. He said he thought I was being addressed as well. After that I left it alone.

During a personal conversation with Bernie, I had mentioned I thought about leaving and he told me I should. I said there was no opportunity and that as a young nurse I wouldn't gain that here. I guess at that moment I realized I would forever be at a dead end road here in Fort Thompson.

Bernie, along with other administration staff have a great deal of unprofessionalism. I must say with the gentleman from Spirit Lake was sent from Aberdeen to collect statements from the employees regarding Bernie Long, there was an overhead page for the providers to report to the conference room. That is where the provider's were asked to write statements on Bernie's behalf. This is the most crooked move I have ever heard of. No CEO should even have to beg for any kind of statement. That is something you earn along the way.

Lastly, I would like to mention the uncomfortable environment and the amount of stress the nepotism has created. A few months ago our supervisor had a hired a friend of the one of the nurses at as a new clinical nurse. Only after a few weeks of being there she put in her notice and quit due to a hostile environment and was effective immediately. The working conditions are unfavorable due to most because there is so much favoritism and gossip. We should not have new nurses coming on board and quitting due to a hostile environment. Any signs of hostility should be addressed immediately by our supervisor.

The everyday decisions of this facility have made me explore other options outside the reservation. I feel there are no opportunities for me to grow here. As a graduate from the Retention for Native American Nurses at UND, I always wanted to come home and help the people. This is not what I pictured coming home. It has been so hard coming to work every day. As a young nurse in IHS, this has been the most unprofessional and complex facility I have ever worked at. This affects the people we care for and ourselves as providers.

Thank you.

PREPARED STATEMENT OF DONNA M. (WATERS) SALOMON, OGLALA SIOUX TRIBAL
MEMBER

Good afternoon to the Honorable Senators of the United States Senate Committee on Indian Affairs!

My name is Donna Marie (Waters) Salomon. I am an enrolled member of the Oglala Sioux Tribe of the Pine Ridge Indian Reservation. I am a lifelong resident of Bennett County in the state of South Dakota. My parents are Leroy Thomas Waters and Emma Nelson-Waters; both of whom are enrolled members of the Oglala Sioux Tribe. I am the eldest daughter of ten siblings. When my father was hospitalized; I was duly recognized by my family as the authorized representative to make all medical decisions on our dad's behalf. Later on, my older brother Phillip Waters and I were officially recognized by tribal court order to have guardianship for my dad. Based on my personal experience during my father's hospitalization, I am here today to present supporting testimony for the critical need for respiratory care services for our tribal membership on the Pine Ridge Indian Reservation and quite possibly for the Great Plains Region. Attached are copies of my correspondence that I have written in the Year 2013 that are relevant to my testimony of today.

I will begin my testimony with a brief narrative of the accident and the subsequent health care treatment as provided for my father while he was under the care of the Pine Ridge Indian Health Service and conclude with recommendations. I really want to outline the subsequent health care treatment portion because I believe it is imperative for you to realize the type of treatment that we, as Oglala Lakota people, face while we are at our lowest point in life.

On May 11, 2013, my 84 year old father Leroy Thomas Waters was critically in a one vehicle care accident on the Pine Ridge Indian Reservation. He was transported via tribal ambulance and admitted at the Pine Ridge Indian Health Service (IHS) Emergency Room Unit. He was transferred on the same day to the Rapid City Regional Hospital (RCRH) in Rapid City, South Dakota. On May 30, 2013, he was transferred from RCRH to the Advanced Care Hospital (ACH) in Billings, Montana. Upon our insistence, the Pine Ridge IHS Hospital finally transferred my dad back to the Pine Ridge on the Mission Flats area, near Pine Ridge, South Dakota where he finally lost his fight for life on July 27, 2013.

Lack of Follow-Up and Patient Advocacy:

The "Episode of Care" for our Dad went into effect at the time of admittance of our Dad on May 11, 2013 and remained in effect throughout the transfers and continued medical care at the RCRH and onto ACH of Billings and even up to the time of death of our father. Yet, during this period of time, May 11-July 27, 2013, the Pine Ridge IHS neglected to provide and afford quality health care services to our father.

- During our Dad's hospitalization, the Pine Ridge IHS Hospital Administration rarely initiated any consultations with our family. If any contact was made, it was usually initiated by my family or myself to discuss the medical care, condition and services needed for our Dad.

- When RCRH determined that Dad would need to be transferred to another medical facility because RCRH believed that he would need "...a higher level of acute nursing care...". Pine Ridge IHS never contacted us nor tried to advocate on his behalf.
- During the period that Dad was hospitalized at the ACH in Billings; the Pine Ridge IHS still did not follow-up nor provide advocacy services for our father. If there were any contacts with the Pine Ridge IHS, again it was mostly initiated by myself and my siblings.

As a result of the lack of follow-up and advocacy, the following did happen while our Dad was hospitalized at the ACH in Billings and although it was called to the attention of the Pine Ridge IHS administration, our requests were assistance went unheeded:

- We saw extreme positive changes in the health care services provided to our father from the first day of admittance at the ACH of Billings. The physicians and specialists, nursing staff, physical therapist, respiratory care service providers, dieticians all seemed to be a very dedicated team to assist in the recovery process for our father.
- As time went on, my father became infected with a MRSA infection and was put on isolation (Methicillin-resistant *Staphylococcus aureus*). I found out that there was another patient across the hallway from our Dad's room who was diagnosed with MRSA a week before our Dad was infected. This infection greatly weakened our Dad and the powerful medicines that were used to treat the infection may have caused the decline of our Dad's health. Once infection was identified, I noticed that aside from the basic nursing care that was administered to our Dad; there were no other medical services being done for him; such as, minimal physical therapy...so in an effort to keep his muscles supple as he was on complete bed rest, I had to do "range of motion" exercises with him as no one else was helping him.
- Prior to Dad being infected with MRSA, his health condition was improving:
 - The neck braces were removed.
 - The trach tube was decreased by 2" and swallowing tests were showing improvements.
 - The tube in his lung was removed.
 - Internal organs were working fine.
 - Oxygen needs were minimal.
- During this time, our Dad repeatedly requested to be released and taken home. We conveyed his requests to the Pine Ridge IHS Hospital and were denied each time.
- At or around July 12, 2013, ACH of Billings medical staff informed us that they could no longer provide medical care to our father and that we would have to bring our family together to make the decision to discontinue the respirator/ventilation system services for our father.
- On or around July 16, 2013, all my siblings and mother traveled to Billings, Montana to meet with the ACH of Billings medical staff to simultaneously hear the news about our father and that we would have to make the final decision to discontinue the respirator/vent system. After the consultation with the medical staff, we held a conference call with the Pine Ridge IHS Hospital administration and again we were told that they did not have the necessary medical staff and equipment needs to receive our father.
- Physicians and Specialists for ACH of Billings operate on a rotating schedule and it was during this time that a "new" physician rotated in on schedule and after checking my Dad, he informed us that Dad's internal organs (kidney, liver, heart, lungs) were all doing well and that his lab tests were okay. After hearing this report, I pursued the qualifying reason why ACH of Billings were encouraging us to discontinue and terminate his respiratory/ventilation services and was "shocked" to find out that it was

due to the 45 day limit allowed by Medicare for "long-term acute medical care". I immediately contacted the Pine Ridge IHS Hospital administration to inform them that we were being forced to make an unnecessary decision to terminate lifesaving medical needs for our father. I requested IHS to pay for the health care services needed for my Dad and to help get him home. During this discussion, IHS informed me that a quick review of his file showed that our Dad was also covered by Medicaid therefore his medical services were covered. ACH of Billings checked and received confirmation that our father was indeed Medicaid eligible therefore the necessity of discontinuing medical care and services was no longer necessary. Shortly after this meeting was over, we returned to Dad's room and found Dad sitting up and surrounded by the nursing staff and various therapists all administering the type of medical care that he should have been getting.

- Sadly, by then our father's health had already deteriorated to the point that he could no longer even attempt to stand up or sit in a shower chair without almost 100% oxygen. He constantly motioned to us to take him home.

Family Forced to Advocate and Conduct Outreach Services:

Due to the Pine Ridge IHS Hospital Administration's lack of advocacy for our father; our family requested ACH of Billings discharge staff to assist us in advocating and conducting our own outreach to other administrations and agencies to assist us in our futile efforts to get our father to a hospital closer to our home:

- We contacted our Tribal Veterans Service Officer on the possibility of getting our father to be admitted to one of the area Veterans Administration; such as Ft. Mead VA Hospital in Sturgis, SD or the Black Hills Health Care System in Hot Springs, SD. Sad to say, but the VA Hospitals could not receive our father as they did not have respiratory services.
- We contacted the RCRH but they too could not receive our father as they could not provide the respiratory services.
- The only other possible locations that had respiratory care services were in locations that were approximately over a 6 hour drive proximity to Pine Ridge, SD; such as: Denver, Colorado; Omaha, Nebraska; Minneapolis, Minnesota, etc.
- I wrote letters to the Bureau of Indian Affairs and sent courtesy copies to the US Senate Committee on Indian Affairs, Great Plains Tribal Chairman's Association, US Department of Health and Human Services, Oglala Sioux Tribal Officials to inform them of our father's situation and requested their help to get him home.
- I wrote a letter to US Senator Tim Johnson (SD) who was on the US Senate Committee on Indian Affairs regarding but not limited to a request for specialized services.
- I presented copies of my letters to the Montana/Wyoming Tribal Leaders Council in Billings, Montana and they supported my efforts and forwarded my letters to the national offices of the Bureau of Indian Affairs and to the US Department of Health & Human Services offices.
- I asked a former Tribal President at the time, John Yellow Bird Steele, to see if he could get the Pine Ridge IHS Hospital administration to bring my dad home. He was denied. He even asked a physician on call about bringing my dad to the Pine Ridge IHS parking lot, discontinue his tracheotomy and respirator, then bringing him into the hospital to provide comfort care. The physician on call denied the request.
- During the next two weeks, we continued our outreach services to get our dad transferred to a facility closer to home. We even asked if IHS could contract respiratory care services with a contractor in Rapid City and we would move him to a residence and help to take care of him. The Advanced Care Hospital

indicated a willingness to train some of our family members with the basic methods of trach care and oxygen care so that we could take care of him at home if a care provider could oversee this. IHS denied our verbal request.

IHS REFUSES TO HONOR FATHER AND FAMILY WISHES TO RETURN HIM HOME:

On or around the last week of July, 2013; as before, the ACH of Billings began to suggest that it was time to consider sending our father to alternative health care facilities such as a nursing home or a hospice. By then I knew that the Medicare/Medicaid services for the type of "acute long term care" that our father needed was nearing its limits. Our father's physical condition was also very weakened by then from all the various medicines that he was taking; that I knew it was just a matter of time before it was too late to honor our father's desire to go home.

- On July 26, 2013; Dr. Fen, ACH of Billings, informed our father that his condition was getting worse; that lab tests indicated that our father's kidneys were shutting down and that it would be just a matter of time before the liver and heart would shut down. After we translated this to our father in our language, our father indicated his refusal and that he again motioned for us to take him home.
- Once again, we contacted the Pine Ridge IHS Hospital administration and had Dr. Fen explain to IHS that my father's internal organs were shutting down and that he desired to go home. He further explained that he was willing to release him on the condition that there would be a Receiving Physician to accept him. Pine Ridge IHS administrator Alan Davis and Dr. Mitchell were on the conference with us and after they were told of my father's condition; they both strongly recommended the transfer of our father to the Billings hospice where he could get comfort care until he expired. Needless to say, this angered us so much that we almost carried our father out of the ACH of Billings and headed home with him. Dr. Fen advised us that our father would not make the trip by car as he was 100% reliant on oxygen and that it would be advisable to take him home by air ambulance. We were so distraught that we prepared our van for transport: one of my brothers who is a certified electrician said he would get a air tank and hose to administration oxygen to Dad. My sister and I who are CNA's knew we could keep Dad comfortable. My other sister and brother agreed to drive. When Dr. Fen realized that we were serious about taking our Dad against all odds, he convinced us to try contacting the IHS again.
- We contacted our Tribal President Darryl Brewer and various other tribal council members and they too contacted IHS Administrator Alan Davis.
- Finally, Mr. Davis agreed to transfer our father home by air ambulance and that he would have a Receiving Physician on hand, but he was adamant that he would not provide a registered nurse to fly with our Dad; and that they could not accept my father at the Pine Ridge IHS Hospital as my father would still be hooked up to a ventilator/respiratory system.
- Given that we had no alternative and knowing that my father's life was in danger; plus honoring his desire to go home, we agreed that he would be taken to his home on the Mission Flats and that we would be with him to the end.
- Dr. Fen seemed very concerned about the possibility of a lack of an attending physician at our father's home and gave me a prescription for medicines to administer to my father to keep him comfortable in the event that the Receiving Physician did not administer comfort care for him.
- Upon my return to the ACH of Billings after getting the prescriptions, the Discharge Planners informed me that they received a call from the Pine Ridge IHS Hospital administrators that they changed their mind about accepting my dad and that he should be transferred to a nearby hospital for comfort care.
- Once again, we were on the phone with tribal officials and once again, we got another call from Mr. Alan Davis, Pine Ridge IHS Hospital administrator that they would receive my father under the same terms as before.

- By then, all my family members had begun their travel from Billings, Montana to Pine Ridge, SD so they could be on hand when we got home. ACH of Billings hospital staff, Dad and I waited and waited for several hours. Finally the Discharge Planners came in and informed me that they called the Pine Ridge IHS Hospital to check on the flight schedule and they were informed that there was no flight schedule as it was up to the ACH of Billings to make the arrangements for the air ambulance and the flight schedule. This was news to the Discharge Planners and they were not told who would pay for the air ambulance services if ACH of Billings were responsible for setting this up. Again, I called the Pine Ridge IHS Hospital and they finally confirmed that they would pay and gave the information to the Discharge Planners.
- Finally, the air ambulance team arrived around 7:30 pm on July 26, 2013 and Dad and I left Billings, Montana and headed for home. As we took off and headed south, I reached around the seat and hugged my Dad and asked him if he was happy and he nodded yes. He was fully conscious and very happy to know that he was finally on his way home.
- At approximately 11:00 pm, we finally arrived at Rushville, Nebraska at approximately 11:00 pm, which is approximately a 25 minute drive to Pine Ridge, SD. We were met by two Pine Ridge IHS Hospital personnel: Dr. Mitchell, receiving physician and Mr. Jason Lootens, Social Worker. Dr. Mitchell asked if I had the prescription for my Dad and I confirmed that I did. He told me to hold onto it. After Dad was loaded into the tribal ambulance, he was still fully conscious and happy to see my siblings and other grandchildren that were also there. Dr. Mitchell allowed some of them to go inside the ambulance and welcome our father home. That was the last time that any of us got to see our Dad in a conscious state.
- Dr. Mitchell and one ambulance attendant rode with our father in the ambulance on the way to our father's residence on Mission Flats, SD (located about 3 miles north of Pine Ridge, SD). I don't know what Dr. Mitchell did to my father in the back of that ambulance for those 15 minutes of ambulance drive time but when we got to our father's house, our father was unconscious and never recovered from whatever was done to him.
- At approximately 12:30 am, Dr. Mitchell advised me to give my Dad his prescription. I looked at my Dad but he didn't seem to be uncomfortable or in any state of agitation. So I barely give him less than a third of the medicine prescribed.
- At approximately 2:00 am, I was surprised to see Dr. Mitchell and Mr. Lootens approach me as I didn't notice that they were still there. Dr. Mitchell mentioned that they were leaving and that if anything happened, that I should call the Pine Ridge IHS Hospital. I looked at Dr. Mitchell and noticed that he appeared to have been crying. He said he now realized how important it was for us to get our father home to be with his relatives, to have this type of closure with his relatives in order for us to help him prepare him and us for his journey; and that had he known how important it was, he would have agreed long before to bring our dad home. Needless to say, I almost slapped his face but I didn't because I knew that my Dad would not have approved to treat anyone in a bad way even though, that same person treated us with disrespect by taking my Dad's last chance to realize his last wish to see his home.
- At approximately 3:27 am on July 27, 2013, our beloved father left this world and began his spiritual journey.
- Later that morning, the Sioux Funeral Home came after our dad and took his body. Not even half an hour or so, Sioux Funeral Home called us to inform us that we had to go in to talk to the funeral home director to decide the wake and funeral services asap as they were unable to take him to the hospital morgue at the Pine Ridge IHS Hospital because the refrigeration units were broken down.

CONCLUSION:

My testimony a living testament of the actual treatment that we receive at the hands of those in power within the Indian Health Service, who are entrusted to administrator quality health care to the members of the Oglala Sioux Tribe but fail to carry out their duties.

My father was a humble man and lived his life in a simple manner. He never sat back and waited for others to provide food, shelter and clothing for himself or his family. He was a self-taught carpenter and built log homes for his family. He learned to track and hunt wild game to feed his family during hard times. He taught us to grow big gardens and can and store the garden produce so that we would have food even in the winter. He was a spiritual man and took us to worship the catholic religion as well as participated in the Lakota ceremonies. He learned and showed us to use the natural plants and medicines to heal our bodies. He believed in the goodness of others and

I am humbly requesting your kind consideration to thoroughly investigate the Indian Health Service as to why we, who rely on the Pine Ridge IHS Hospital administration:

- Find out the actual number of patients who were transferred out of our Pine Ridge IHS Hospital to hospitals elsewhere who cannot be taken back to the Pine Ridge IHS Hospital because the hospital does not have the qualified medical staff nor medical equipment necessary needed to treat patients who are on respiratory care services.
- In today's day and age, why we cannot have respiratory care services at the Pine Ridge IHS Hospital. Our tribal members, especially our tribal elders, are very troubled to realize at their time of passing to the spirit world, that there is a spiritual and physical disconnect to their tribal homelands. They want nothing more than to be embraced back into the familiar surroundings so that they can accept the impending passage to another world. In the case of my father: he wanted to be home as we had ceremonies to be done to help him to enter that spiritual world. That is in line with our cultural practices and belief system.
- Do not have the necessary medical equipment necessary to administer respiratory care services at the Pine Ridge IHS Hospital.
- Do not afford the nursing staff the required training and certifications necessary to administer respiratory care services. The ACH of Billings was willing to train our family members, many of who have no educational background in health, to administer trach care in the event that my dad would be sent home. Why can't our nursing staff at Pine Ridge IHS Hospital be trained to administer respiratory care service, if people "off the streets" can be trained to do so?
- Do not have a certified Physician or Specialist in respiratory care services. At the least, why do we not have a Specialist or a Respiratory Team who can provide contracted specialized care as needed. When our dad was hospitalized in Billings, Montana and we were requesting for him to be taken back to the Pine Ridge IHS Hospital informed me that there were four (4) other tribal members who were in similar situations and hospitalized in Denver, Sioux Falls and Minneapolis. Sad to say that I do know for certain that our Chief Oliver Red Cloud, Chairman of the Black Hills Sioux Nation Treaty Council, was the one who was hospitalized in Denver. Much like my Dad, he too was transferred from RCRH to Denver and although he pleaded to be returned home for his final days, the Pine Ridge IHS Hospital denied him his last wish and he died in Denver on July 4, 2013. I'm pretty certain that the other three also did not make it home. Since then, as people hear of our Dad's experience, they too come forward and share like experiences with their loved ones who wanted to come home and lost their lives "out there" because the Pine Ridge IHS Hospital denied their final wish because of the lack of medical equipment and certified staffing.

I believe that we, one the Pine Ridge Indian Reservation, are not the only Tribe within the Great Plains Region to need this much needed respiratory care services. We no longer need to hear excuses as to why Indian Health Service cannot provide respiratory care services!

PREPARED STATEMENT OF STEPHANIE L. WATERS, OGLALA SIOUX TRIBAL MEMBER

I am writing this statement on behalf of my brother Phillip Waters, who was diagnosed with Prostate cancer at the Rapid City Cancer Institute in February 2013.

On February 7th, 2013, Phillip was in pain, due to his left leg was so swollen and could barely move around. I went to see him and I tried to help him make an appointment at the Kyle Health center, but due to no openings for appointments that day and the earliest next available date would be the next week Tuesday, 12th of February, 2013, he was scheduled in for that day.

On Tuesday, I picked him up and drove him to the clinic and assisted him to check in. I also had an appointment for myself that day. He was called in to see the doctor. I did not go in with him, because I was called in shortly to get seen for my appointment.

After I was finished with the doctor, I went to the waiting room and I noticed that he was not there. I waited for him for about half hour, but still no sign of him. I had asked another person if she saw him, but she said that he never came out from the back since they called him. She was waiting for a ride to come after her. So I began to worry about him, because I knew that he needed assistance due to his leg and could barely walk. I asked the receptionist if he was finished, because usually the visits aren't very long. Then she said she would check and then he was not in any room, so we started to look for him. We found him in the back waiting room. He said that he was told to get labs done and that he was still waiting for them to call him in the lab. I asked him if anyone was in the lab, and he said "no, nobody went in there and they didn't call me. He didn't know that he supposed to walk in if no one else was in there. So I explained that to him and he said if knew that was what he supposed to do he would have been done already, he didn't know that because he never went to the clinic.

When he came out of the lab, I asked him if he needed to meet with the doctor, so that we could go a short distance to the doctor's room to get the results backs from the x-ray and the lab work. He told me that he was done and that they call him to give him the results, because it was getting late and that they were going to close at 5 p.m. I thought that was strange, but he already had his meds for the pain from the pharmacy and that he was tired and needed to elevate his leg because it was painful.

I asked him what the doctor said about his leg and what was causing the leg to swell. He said, "they didn't get my results and when they look at the x-rays they will call me. She prescribed tramadol for pain and call me tomorrow for on the results".

Almost a week had past, when I received a call from the Kyle clinic. The receptionist Darla told me that they were unable to contact Phillip, and that he had an appointment at the Rapid City Cancer Institute on Thursday.

Phillip's 1st visit to the RC Cancer Institute was on February 20th, 2013 with Dr. Swartz. He was seen at the Kyle IHS clinic by Beverly Hill, who requested the referral for him. Dr. Swartz diagnosed him with metastatic Prostate Cancer. His treatment plan was set at that time. He was prescribed oxycodone for pain, and that he would no longer need tramadol for the pain. This is where we found out that he had a broken leg. Dr. Swartz ordered x-rays and lab work because he said that their institute had not received the results or the x-rays he had done at the IHS clinic. He showed us the breakage and reviewed the x-ray to see if he would require surgery if the bone was top of each other. Luckily, he didn't have to have surgery because he informed us that it was a clean break. The treatment and appointments for the cancer was to be every 3 months.

On June 20th, 2013, Phillip and I went to Ontario, California, to seek out medical care at the City of Hope Cancer Institute. We contacted the institute to get information about the care/cure for the cancer and how to get into the institute. They informed us that they would work with him and that we had to get a referral purchase order from the IHS within our tribe and they would meet with us to set up the plan for the cure for the cancer.

He contacted the clinic in Kyle and they gave us the contact number and name of the person who issued the referral for him from Pine Ridge Hospital. When he contacted the contract office at Pine Ridge, he was told that he had to come back and request the referral and that they would have to take it to committee for this process and then wait to get the approval, then go forward.

Phillip was not covered by Medicare or Medicaid, because the guideline said that he would have be 65 or older to qualify or wait 1 year to become eligible for coverage, due his age, and that it would be in November of 2014. Also he was not eligible for SSI benefits at that time either.

After our month search, we felt hopeless and shattered and came home to Allen, South Dakota. We knew that it would be impossible to make another trip, due to the wait time for the referral process from IHS contract office. We were running out of time before the cancer would succeed and strength would be a major factor.

After we came home, 5 months later, Phillip's kidney started to affect him and problems with health issues were now playing part and taking its toll on him. He had surgery at Rapid City regional, after he went to Pine Ridge Hospital emergency room and had been referred out to RC Hospital, due to right kidney failure.

He was given oxycodone for the pain and was supplementing ibuprofen due to the time frame for the severity of pain. He was told that he could alternate the ibuprofen in-between the 4 hours, if he needed more pain medication. Over the 22-month period, he took the ibuprofen to supplement the pain inflicted upon him, and as a result, the ibuprofen took effect on his right kidney, which resulted in a shutdown, which required a quick surgery and a catheter was inserted through his back. After this incident happened, another doctor said that he was not to take ibuprofen, as a supplement, so he did not know why Phillip was told to take ibuprofen in between the 4-hour period for the pain. The ibuprofen was part of the cause his right kidney to shut down.

During this time, we had a family meeting and decided to get in touch with Dr. Mark Jackson from the Aberdeen Area Indian Health Office, Aberdeen South Dakota. Phillip gave his consent for Dr. Jackson to review his medical history in February. After Dr. Jackson reviewed his history, he was going to referred him at the clinic in Sioux Falls. Phillip did agree to be recommended for his referral to Sioux Falls Hospital. Phillip never made that trip to seek care there, he passed away March 23, 2014.

I believe that when a person is strong in strength, when a life is on the line of believing in cures for sickness, and where there is a willingness on a positive role, we need to take the advantage of helping families find cures for sickness.

I wish that IHS had provided the referral request and processed for my brother at his request to help extend his life and significantly improve the quality of his life, by working for him and our tribal members like Phillip's health care. Each person is entitled to choose health care across the nation. I only wished that IHS would have honored and respected my brother's request for the health care choice to the City of Hope Cancer Institute for his care to extend some years of his life.

Ridge Hospital in Pine Ridge, South Dakota provide the immediate referral health care process for people like Phillip and other tribal members where severe health sickness calls on outside health facilities other than Rapid City Hospital in Rapid City, South Dakota. We made this decision to seek outside care and were placed on a time frame where the acts of processing a referral and the purchase orders are slow in responding to help seek immediate care for outside medical care.

People like my brother Phillip, who have no health care insurance and who don't have any type of health insurance coverage because of state requirements where age plays a factor or simply have to wait for 1 year, should be placed immediately on Medicaid or Medicare coverage.

Phillip did have to wait for social security benefits for 1 year after he was diagnosed with cancer. They cannot work because of the severity of pain inflicting on them, so they cannot provide the insurance financially, due to having no income.

Phillip did have a job and supported himself with his living expenses, until his health experience with cancer and the toll it took on him. He was not covered by any insurance and it is a great necessity for the need for immediate health coverage when people have a severe sickness where they are unable to financially cover themselves.

His vehicle broken down and no longer owned one, due to the lack of transportation and the travel to the health facilities for care, we experienced a hardship. We needed money for food, gas, lodging. His diet needs were not met, due to this reason. He could not sit up for long periods of time, as result of the pain level that he endured, so over the months and the distance to travel to the cancer facility, we had to save up for the lodging expenses.

These are just some of the expense hardships that we experienced and I only wished that assistance from the Tribe was up to an amount reasonable, instead of \$75.00 to Rapid City to cover the expenses of a medical trip outside for the cancer patients. This assistance began the last 6 months of his life.

Cancer is a fast moving sickness and the time frame for extensive immediate care, so the Indian Health Service here needs to act fast when referrals are requested by the patients to go outside of Rapid City medical facilities be taken as a priority and immediately processed.

Thank you for the time to read and listen to this statement on behalf of my brother Phillip Waters. He wanted to start an awareness for cancer to the people in our tribe and our local community and to help people get the resources available to meet their needs.

PREPARED STATEMENT OF TAMMY RAE GOODWIN, SISSETON WAHPETON OYATE
TRIBAL MEMBER

I am an enrolled member of the Sisseton Wahpeton Oyate and I receive services at the local IHS clinic. Woodrow Wilson Memorial Healthcare Center located in Sisseton, South Dakota. I believe this facility is another example of the governments genocide of native peoples. Abundance of misdiagnosis, accusations of being a drug

seeker, no confidentiality, drug use of employees, etc. I do not have medical insurance so I'm stuck with what care I receive at IHS.

I am not a person whom I consider doctor runners, I only go when absolutely necessary for my basic medication. I have arthritis, diabetes, COPD, avascular necrosis in my hands, PTSD, anxiety, along with other mental health issues and have recently applied for SSI Disability.

On December 17, 2014 I went to Acting Director Gail Williams to voice a complaint of employees not following confidentiality guidelines and she listened to my concerns involving specific individuals and said someone from the HIPPA office would be contacting me. No one ever did and she was removed from office or resigned due to other issues going on in administration.

The receptionist involved with intake and making appointments would report to the Director of a domestic violence shelter I worked at, of which this IHS employee was the one on the Board of Directors for the shelter, would report to the director under her, employees of the shelter when they would go to see the doctor and what it was for. Example, an employee went to IHS for a physical necessary for treatment she was going to attend for codependency issues. One day the Director of the shelter asked me if I knew this employee was going to go to treatment. She said, "I didn't know she was drinking again." I knew she was going to treatment but how did the Director know about this when I know this employee did not speak to her about it. It wasn't hard to figure out where the information derived from. This employee still works at IHS.

In April of 2015 I went to see the doctor for other issues and while he was typing on the computer, I showed him my left hand with a swollen, red knuckle and mentioned how much it hurts. He looked up from his typing and said "yeah, you irritated something," and then resumed typing and didn't try to look at it again. In frustration, I left. In June of 2015, I returned to clinic to see about getting some relief from the pain in my left hand and was told by a nurse, "You can't just come in here and ask for a pain pill." Again nothing was done. There was no xray or examination made of the left hand and now I'm accused of drug seeking because of addictions in my past. I have been sober now for five years.

In September of 2015, again I returned because the PA that I was seeing in the past, returned to the facility. She immediately sent me to xray and had images taken of my hand. This is when I received the diagnosis of Avascular Necrosis, which I'd like to add is normally found in the hips and knees, hence the total joint replacement. I have it in my left hand with one knuckle totally collapsed and now it's also affecting my right hand with other knuckles dying off. Within two days, my referral was approved and I was sent to an orthopedic surgeon. When I asked about my knuckle, he stated there wasn't anything he could do about that but he was going to do the carpal tunnel surgery. He stated I needed to see a doctor that specializes in hand surgery because I needed a total knuckle replacement surgery and he didn't do that. On December 9, 2015 I had the carpal tunnel surgery and I guess it was a success, but it didn't change the pain in my hands one iota. By then the PA I was seeing, transferred to another facility and another new doctor took her place. I asked for pain meds to be refilled and was told no, the surgery was a success and there was no more pain in my hand. Without looking at my hand, or the doctor looking at my file, she was able to make this decision. Again, accused of drug seeking. During December, we got a doctor from the east coast who likes to come help out the natives during his vacation. When I visited with him, he was actually kind of excited and he logged onto the New England Journal of Medicine and even there, there is no mention of this affecting the hands. Well now it's in both my hands. The major cause of this is alcohol usage and steroid use. I was an alcoholic for many years and due to asthma, and now COPD, I have been inhaling steroids for approx. 30 years. Who knew? Now this doctor has returned to his normal practice and I'm stuck with the ignorance left at IHS with a diagnosis that many are not familiar with and have absolutely no experience with. In layman's terms—I'm fucked. Please excuse me for saying that but there are no other words to express my sadness and fear of the unknown of what's going to happen now. Where can I turn to get relief from the pain now, without getting accused of drug seeking. I'm sure just looking at me, I look fine.

This is only ONE example of what I've gone through, and continue to go through. I have been going to IHS since around 1965.

The being accused of drug seeking is really what irritates me the most. I only wanted a pain pill to take when the pain is incredibly bad, I am very active and live on a farm so there is always things to do. Even though I'm in pain daily, there are critters here that depend on me and land to work. I seek relief from the pain occasionally. Just a break. If I was drug seeking, I would go out to our housing project and pick up what I think I need, not go to IHS. THEY are the one's that

lead people back to their addictions. Since I no longer choose to go that route, YOU tell me what I can do.

This leads me to my last statement. The first question the nurse asks is: On a scale of 1 to 10, what is your level of pain today? Now I just say a random number in their scale because my level of pain is off their chart, and nothing will be done anyway. It's an insult for them to ask me that question. One thing that sort of tickled me was when I told the PA I didn't consider myself an doctor runner, she looked at me with big eyes and said "I would never accuse you of that, with your diagnosis other people would be in here everyday screaming for a pain pill." That's kind of when it was determined my high pain level is different than other people.

I appreciate having an outlet to voice the things I have stated because no one else listens. I only pray the disability is approved soon and medicaid kicks in so I will be able to see real doctors in a real hospital/clinic. IHS genocide is working.

I have been unemployed for a year now, I'm 57 years old and homeless as described by peoples opinion. I live in an abandoned camper on a Caucasian friends farm in a machine shed. I am grateful to have a roof over my head and able to keep my animals. I have no problem living this lifestyle because I know how to live without electricity and running water quite comfortably. I am resourceful, I am a woman and I am Dakota.

PREPARED STATEMENT OF EVELYN ESPINOZA, RN, BSN, ROSEBUD SIOUX TRIBE
HEALTH ADMINISTRATOR

Dear Honorable members of the Committee,

My name is Evelyn Espinoza. I am an enrolled member of the Rosebud Sioux Tribe and a registered nurse. Currently I serve as the Health Administrator for my Tribe. I am also a consumer of our Indian Health Services as is my family. I would like to take this opportunity to share with you my experience with the Indian Health Services in my current role.

I began working for the Tribe on Sept. 30, 2014 as the Tribal Health Administrator. I entered this position after taking a year off from work and with just under 10 years of experience working for the Indian Health Services. The second week into this role, I went to Washington, DC where I had the opportunity to meet faceto face with the then Director of IHS, Dr. Roubideaux. I provided her and her staff in detail our concerns. I shared with her real life examples of substandard care being delivered at our facility. I spoke very directly that practices needed to change or lives were going to be lost, our certification with CMS would be lost, and we would lose services. I provided the agency with our expectations and what we wanted to see in the future. At the top of our list, next to safe, quality care, we asked to be involved. I asked to help, to be included in the decisionmaking for our facility and to have our input respected and acted on. I stressed the importance and critical need for the IHS and the tribe to work together, to create a healthy and trusting working relationship where we are both moving in the same direction accomplishing our common goals. She agreed with me, committed to actionable steps, but unfortunately, the follow thru did not occur.

During the same visit we had the opportunity to meet in person with our SD Senators Thune and Rounds and Representative Noem. We met as a group and our tribal delegation met individually with each. We informed these officials of our same concerns. We shared real life examples. We asked for their support and we asked for the same from them as we did IHS. We asked to be involved, for our feedback to be considered and acted on. We voiced frustration with the "tribal consultation" practices and felt like it was not meaningful, rather felt like a dictatorship. We voiced frustrations about the lack of response and communication from IHS. Actually we all had this in common. IHS did not only disregard the tribe but also their leadership. To this day, I do not understand this.

This visit I write about was the first of many held over the past year and a half. Our tribe has met regularly with local, regional and national IHS leadership. We have met with HHS leadership and CMS. The OIG came recently for a visit. Despite all these meetings and telling our story over and over, reliving the traumatic events repeatedly, demanding to be involved, to help, nothing changed and we continue to not have a voice. Infact, for our facility, we have steadily been declining and the decisions continue to be made for us not in collaboration with us.

It is a very stressful situation for me, for my tribe, for my relatives. I have the responsibility to advocate for and protect our tribal people. It is as if I am being held down against my will and forced to endure abuse after abuse and no matter what I do, how hard I fight back, what approach I take, I cannot get out of this choke hold. We are forced to watch our relatives around us suffer, die prematurely, or take

their own lives to escape this hopeless environment. What is going on in our community, with our healthcare delivery system is inhumane, its criminal and cannot be allowed to go on any further. How many people have to lose their lives to change how medicine is being delivered by the IHS?

While there is an obvious need for additional funding, there is absolutely no reason other than poor leadership and mismanagement to account for our current situation we are living through today. A brief timeline of the last 6 months includes multiple false reassurances provided by IHS leadership. We have been told over and over "things are under control." In fact, 2 weeks after the Winnebago Hospital lost their Medicare Provider agreement on July 23, 2015, I asked the Acting CEO of our hospital what they were doing to prepare for our CMS survey and how I could help. He told us they were prepared, they didn't need any help, things were on track. On Nov. 4, 2015 an accrediting body known as DNV hired under contract with IHS, came and surveyed our facility and noted we had the best survey we had in the past 8 years. They found very minimal concerns. A week later on Nov. 8, 2015 the OIG visited and the CEO of our hospital sent an email out saying "congratulations staff, we impressed the OIG, we impressed DNV, CMS bring it on!" On Nov. 16, 2015 CMS arrives. On Nov. 18, 2015, CMS placed our emergency services in immediate jeopardy, stating they found situations in our ER that posed an immediate and serious threat to any individual seeking care there. On Dec. 6, 2015 our Emergency Services were diverted and continue to be.

This diversion is not only affecting tribal members, it is negatively affecting ALL our community members regardless of race who are in need of emergency care. Furthermore, it is negatively affecting our surrounding communities and those small hospitals picking up the added patient load. They do not have the manpower and resources to keep up and as a result are starting to make mistakes that puts their accreditation at risk. This has a ripple effect on so many.

As a young woman growing up, I did not have the privilege of knowing where I came from and who I was as a young Lakota woman. Those teachings left when my mother left this world. I was taught otherwise by good intended people deciding for me what they thought was in my best interest. It was not until later in life I learned about my ancestors. How amazing of a people we are, what amazing gifts we have and what an amazing way of life I work toward everyday to get closer to. Many events that have taken place over the past 200 years created this "perfect storm" we live in today. The most important thing I have realized is only I can change what I do and only you can change what you do. So I ask you all to self reflect, be honest and sincerely hear and feel what I am saying. We have all had different experiences in our lives that mold the way we think and react. But I have searched and searched and I can not find anything that supports the lack of courtesy and respect that exists in our leadership today at all levels. We either can choose to continue with the same status quo and same practices or we can choose to change how we lead, how we treat one another, how we protect one another. I am respectfully asking each of you to put politics aside and look at our situation from your human side. I want for each of you the same as I want for my relatives. I do not expect anything less than you expect for your loved ones. For any of this to change in a meaningful way and sustain the changes, we have to all change what we are doing. We have to respect one another and move forward together with this in a good way. I thank you from the center of my heart for your advocacy, support, time and energy. I eagerly look forward to working together and using each other's strengths to strengthen each other's weaknesses.

Lila Wopila Tanka (Thank you very much),

PREPARED STATEMENT OF DARLENE M. WILCOX, PH.D., LP, LICENSED CLINICAL
PSYCHOLOGIST

Hello,

I have been working with IHS for almost 10 years as a Mental Health professional. I am writing this as a Oglala Lakota/Sioux tribal member. I started out working at the Pine Ridge IHS service unit as a Mental Health Specialist in 2006.

When I started there, I worked in an hostile environment. Behavioral Health staff did not get along. My supervisor treated me terribly, even though I was a tribal member and had worked really hard to be a psychologist. (I graduated from UND, Grand Forks, ND in 1999. I was a member of the Indians Into Medicine program and Indians into Psychology Doctoral Ed. (INPSYDE) program.) I tried to go through the union about my poor treatment by my supervisor but I was discouraged from going through with this process by a union representative.

While at Pine Ridge I.H.S., I worked long hours, did walk ins and was on call at least 10 times per month. Many times, I would get called in to ER, 2 or 3 times per night. I was then expected to report to work at 8am and do a regular shift. I worked hard and studied long hours to become a licensed psychologist.

I transferred to the Fort Defiance, AZ, Adolescent Psychiatric Unit. It was the only Adolescent Psychiatric Unit within IHS. While there, it was a wonderful experience, to work with a whole team of mental health professionals; 2 psychiatrists, 2 clinical psychologists, 3 Social Workers, 2 Teachers, 2 Psychiatric nurse practitioners, Art Therapist, 3 traditional, Navajo medicine people, social service aides, one Behavioral Health Chief, as well as working with outpatient, mental health staff. We worked with 12 youth per 6 week cycle, in between cycles, we had program development type of activities, trainings and healing ceremonies for staff to prevent burn out and also protection ceremonies were done for staff.

While there at Fort Defiance, AZ we were invited to go to my reservation, the Oglala Sioux Tribe at Pine Ridge, SD, to present on the Adolescent Psychiatric Unit. I traveled to Pine Ridge and Rapid City, SD and we met with many OST tribal organizations, I.H.S at Pine Ridge, the Oglala Sioux Tribe. They were very interested in starting a Adolescent Psychiatric Unit at the Pine Ridge IHS service unit. We were also invited to attend a local, Sundance ceremony. We attended and we were very much honored and blessed for being there.

As follow up to these invitations, the Fort Defiance Indian Hospital invited the Oglala Lakota Nation to go to Fort Defiance, AZ to view the Adolescent Psychiatric Unit. A few of the tribal members, Pine Ridge high school counselors and Dr. Garcia, psychiatrist at Pine Ridge IHS did go to Fort Defiance Indian Hospital to visit and view the Adolescent Psychiatric Unit. They were taken into ceremony immediately and the Navajo Nation representative, the Fort Defiance CEO and board members and Adolescent Psychiatric Unit met with the SD visitors. The Oglala Lakota delegation were treated like royalty. The SD group talked about the problems they faced on a daily basis on the Pine Ridge reservation. A special ceremony was held for the SD staff that went to AZ.

As the result of these initial meetings, the Fort Defiance Indian Hospital, sent their business and billing staff to Rapid City, SD to provide the tribal and IHS service unit, valuable information on how to start their own Adolescent Psychiatric Unit. Fort Defiance Indian Hospital at that time, was making almost 9 million a year from federal, pass through monies and third party reimbursements for the Adolescent Psychiatric Unit. It cost 3 million to pay for the staff, so actually they made a profit of \$6 million per year. The Fort Defiance Indian Hospital benefited tremendously from the Adolescent Psychiatric Unit.

What stopped this endeavor from happening was the Behavioral Health leadership in 2010–2011, at the Aberdeen Area office. My Navajo supervisor, the Behavioral Health Chief (2011) heard from the Behavioral Health Director at IHS Headquarters: “She said Aberdeen Area, was very upset with Fort Defiance, Adolescent Psychiatric Unit, for going to Pine Ridge to present on the adolescent psychiatric unit—because Aberdeen Area office had plans of their own, to build a psychiatric unit at Rapid City.” I said “As an Oglala Lakota tribal member and Clinical psychologist, my tribe, the Oglala Lakota and Pine Ridge IHS and our Lakota traditional and spiritual healers and elders invited us. We didn’t go there on our own, or because I am an Oglala Lakota/Sioux tribal member, they invited us and they want information to help the youth there.”

I have worked at other IHS service units in the Great Plains Area, I have had positive and negative experiences. I have always have had a good relationship with my patients and tribes I have served.

We do have educated, tribal people who are health professionals. We also have a lot of non-Indian, health professionals, who want to do things their way. I was informed by the tribal attorney that he has almost enough tribal people from the Crow Creek Sioux Tribe to file a class action, law suit again Fort Thompson Health Center, administration for discrimination against tribal employees.

At Fort Thompson, they went through 7 or 8 Behavioral Health Directors within 5 years, about 7 acting before I started working there. I was met with a lot of resistance. There was a psychiatric nurse, who was acting before I started and she refused to attend my meetings, she was very non-compliant. I asked the CEO for help with this matter. He ignored me and let the psychiatric nurse get away with her unprofessional behavior. I left and heard later, the psychiatric nurse was again, acting, BH director. She had gotten into trouble for writing a prescription for her sister (non-native), her sister stole her prescription pad and wrote her self prescriptions. The SD Attorney General prosecuted the psychiatric nurse, she received a misdemeanor and was not disciplined by IHS and she is still the acting BH director.

At Sisseton, SD, I witnessed and heard about a Clinical Director (2012–15), who chased away, most of the American Indian, medical doctors. She wrote them up for reasons that did not pertain to their practice. I applied there for a clinical psychologist position, she cancelled the position and it was reported to me later that she mentioned my name in a medical staff meeting that she did not want to hire me because I was using Indian Preference. She did that to another, American Indian woman psychologist who also applied at a different time.

I worked at the Kyle Health Center, from 2013–2015, during the suicide epidemic. What IHS HQs, did to address the issue, was to detail, mental health staff who were not able to work with the more complex cases. (CPS issues, developmental issues), they also detailed psychiatrists to administer medication via tele-psychiatry. I was the only psychologist working on the Pine Ridge, SD reservation for 2 years and 2 months. There was no housing there for me at Kyle Health Center. I had to commute 87 miles one way, each day to get to work. I also worked four, 10 hour days; I left my home at 6am each morning, I did not return home until 7:30 p.m. or 8 p.m. each night, depending on the weather. When I left there I was wore out, I was so tired from the long commute each day.

In the short time I was there, I was able to complete over 100 psychological evaluations, I referred them to a psychiatrist, psychiatric nurse practitioner for their medication if they needed to be on medication. When IHS detailed all the psychiatrists via tele-behavioral health, less than 10 percent needed to be seen by the tele-psychiatrists. Some of my patients did not want to be started on psychotropic medications, they wanted to get help via natural remedies; exercise, diet, traditional and cultural ceremonies, talk therapy.

What the communities wanted was more mental health professionals who were able to go out to the cultural and spiritual camps, schools, district buildings, to do talking circles, grief groups, make home visits. They wanted activities for the youth such as jobs, educational opportunities, sport activities, safe houses for youth and elders.

I do not see the Behavioral Health consultants meeting with the elders, community people to obtain their ideas for the youth on the reservations. The consultants tried to push their philosophies and ideas on to the Indian people. Their ideas did not apply to a rural area.

My reasons and rewards for working long hours and traveling long distances; is that I love my people. I committed myself to my people at a very young age, to get educated, to help my people in every way that I can. This is why I am here. You need to offer more incentives to the tribal, medical and mental health I.H.S. workers to help them buy their own houses so that they can stay and work on their own reservations. For those medical staff that have to commute, you need to develop a transit system so that they can ride it to work.

You need to do the reservation wide, community needs assessments, you need to listen to the tribal voices. You need to have the respect and compassion necessary to hear those voices. Honor the people who do a good job. Hire the traditional and cultural healers at the Great Plains Area IHS service units, so that they can provide ceremony to the patients and staff like the Navajo Nation does. They provide healing services and they are able to do business so well, they are making a profit, so that they can continue to improve and expand their services.

Thank you for your time and attention.

PREPARED STATEMENT OF BRENT R. PHILLIPS, PRESIDENT/CEO, REGIONAL HEALTH,
INC.

Regional Health, the health care system providing care to western South Dakota, respectfully submits this statement for the record. We commend the Senate Indian Affairs Committee for holding the Oversight Hearing on "Reexamining the Substandard Quality of Indian Health Care in the Great Plains." The hearing properly included testimony of IHS and tribal representatives. We submit this statement because the American Indian population under discussion is also part of our community and are welcome in our hospitals and clinics. We see ourselves as an important stakeholder in this public policy discussion.

Regional Health serves American Indian patients in the IHS Great Plains Service Area that includes the Pine Ridge Indian Reservation, Rosebud Indian Reservation and the IHS Sioux San hospital. Regional Health collaborates with the Oglala Lakota Nation, Rosebud Sioux Tribe, IHS and independent physicians and caregivers to help deliver health care to our most vulnerable populations. Our organizational purpose is "Helping Patients and Communities Live Well".

Underfunding is a barrier to the ability of Pine Ridge and Sioux San to provide a range of services and equipment to serve American Indian patients. Based on historical results, the current IHS model of health care delivery is untenable and without a substantial bureaucratic overhaul is not sustainable.

As we see it at Regional Health, the options to cure the substandard delivery of American Indian health care in the Great Plains are: 1) reinvent the existing IHS health care delivery model for efficiency and transparency, including fully funding the delivery of care; or, 2) engage all stakeholders in creating something completely different – some type of disruptive innovation that will radically reimagine the delivery and quality of health care. Whatever the choice, Regional Health is willing to partner with all stakeholders to bring innovation and solutions that improve health care access and outcomes in a fiscally sustainable manner within a revision of the current model or through an entirely different delivery model.

Currently Regional Health serves as the safety net healthcare organization for all American Indians in Western South Dakota. When IHS funding runs short, or access is limited Regional Health takes care of the needs of the community with little to no reimbursement. In 2014, the IHS reimbursement for services to Regional Health was far below the actual cost of care for American Indians living in Pennington County (home of Regional Health). Actual cost to deliver the care was \$16.7 million with actual reimbursement of \$2.7 million. This disparity impacts our ability to provide access and care for all citizens of Western South Dakota. Regional Health seeks a true partnership with the tribal leaders, Great Plains, IHS, and Congress to address the entire situation and develop a plan that addresses the concerns rather than shift the burden to another party.

Tribal population served:

The Pine Ridge Reservation, located in south western South Dakota and northern Nebraska, is one of the poorest counties in the United States. Approximately 49% of the 28,000 residents live below the Federal poverty level. The infant mortality rate is five times higher than the national average and adolescent suicide rate is four times the national average. The Pine Ridge Health Facility is a 110,000 square foot inpatient hospital with an outpatient clinic, dental clinic, and a surgery suite. It is located 90 miles from Rapid City, South Dakota and travel time to Rapid City Regional Hospital is an hour and one half when weather conditions are good. The remote location and lack of transportation creates a barrier to access to health care both in and off reservation. Recruiting physician and other caregivers to Pine Ridge is exacerbated by a lack of housing, and underfunded medical facilities, educational system and economic development.

The Sioux San hospital is located in Rapid City and, pursuant to federal treaty obligations, is intended to provide health care to approximately 10,800 American Indians in Rapid City and surrounding area. The nine bed hospital has a staff of 14 physicians and four mid-level practitioners who provide inpatient and outpatient adult and pediatric and prenatal care. The inpatient census averages 0.5 patients per day.

The capacity and competencies of both IHS facilities are not sufficiently funded to provide the quality services necessary to fulfill the federal responsibility for American Indian health care.

Patient Needs:

The 2015 Helmsley report "Focus on South Dakota – A Picture of Health" states that "less than half (43.3%) of the American Indian survey respondents have a primary care provider compared to 80.9% of non-American Indian respondents." The need for and access to health care is established in the report subpopulation health profile section. The percent of American Indians told by a doctor that they have serious health conditions includes: diabetes (26%); heart disease (9.6%); asthma (15.2%); depression (25.7%); anxiety (29.1%). These categories are all higher than the corresponding percent reported by non-American Indians. Additional areas of underserved needs identified by utilization analysis and other methods include: orthopedics; dialysis, obstetrics and neonatal intensive care, and, dermatology. Behavioral health services are acutely needed.

Option 1: Revise current IHS care delivery model:

American Indian health needs indicate that the acuity increases due to the lack of early access to health care in appropriate settings. Under the current IHS delivery model Regional Health is willing to partner with IHS to establish appropriate settings and services within existing or newly established IHS facilities. The improved access will reduce acuity, care in inappropriate settings, and reduce the cost of delivery of care. American Indian population will be served and patients will be benefited by the provision of services in their communities where they have family support.

The services that can be improved or established through embedded contracted physicians and advanced practice providers include: primary care; emergent services/emergency department; behavioral health; general surgical; orthopedics; endocrinology; cardiology; nephrology; dermatology; wound care; specialty consults; diabetic care and dialysis; infusion; imaging; medication management; pharmaceutical; obstetrics, gynecology and prenatal care; physical therapy; chronic condition management; and more. The continuum of care will reduce the long term cost of care and improve outcomes.

Regional Health currently contracts with IHS for Medical Clinic Services in Pine Ridge. The services include: Endocrinology; Cardiology; Nephrology; Orthopedic; Pediatric; and, Transitional services. The services are provided between two and five days per month at Pine Ridge depending on contract. Due to funding shortages, the IHS recently notified Regional Health that the contracted services are scaled back. The result is less access and delayed health care services for patients with serious health conditions. Delayed care results in more chronic and acute conditions that present to the Regional Health Emergency Department when the conditions could have been effectively treated in less costly non-acute or clinic environments. The care provided by Regional Health Emergency Department is predominately uncompensated. The uncertainty caused by IHS contract scale backs also create economic barriers to Regional Health's ability to recruit and retain the specialists necessary to serve Pine Ridge patients.

Option 2: Innovation of new delivery models:

The second option - engaging in disruptive innovation - requires a fresh look at the delivery of health care to American Indians. The process would require creative collaborative partnerships between all stakeholders: Tribes, IHS, CMS, tribal healers and caregivers like Regional Health. Community involvement of patients, providers and governments will identify needs and innovative models of culturally sensitive and high quality services. The delivery of home and community based support services for patients, families and caregivers can be established. Stakeholders can partner to achieve economies of scale; recruitment, training and retention of qualified caregivers; technical support and analytics; financial and operational assistance; and, quality improvement. Telehealth and telemedicine partnerships can improve the delivery of behavioral health, medical and clinical service access.

An innovative look at the delivery of American Indian health care must consider transferring the American Indian care delivery from IHS to CMS. It is an existing program that can meet the care delivery obligation on a national basis through an existing bureaucracy. CMS is a program and performing under a transparent and clear regulatory process. All U.S. Hospitals and physicians are familiar with CMS program requirements and reimbursements. Utilization of CMS will improve access and outcomes for American Indians and it will encourage more providers to serve American Indian patients. The burden of health care access will be relieved, the continuum of care will be improved, and paperwork and administrative red tape will be reduced.

As a major health care provider in the Great Plains Area, Regional Health offers to engage in innovation, partnerships, and pilot projects to improve the delivery of health care to American Indians.

PREPARED STATEMENT OF JANE DILLDINE, SUPERVISORY GENERAL SUPPLY
SPECIALIST, PINE RIDGE IHS HOSPITAL

Good morning,

I am a 29½ year employee with Exceptional Service at the Great Plains Area, currently serving as the Supervisory General supply Specialist at the Pine Ridge Service Unit. Prior to transferring to the Pine ridge Service Area, I serve as the Supply Management Specialist at the Area Office.

Since transferred to Pine Ridge in 2003, I have been discriminated against, retaliated against, I have been placed on extended Administrative Leave, Transferred to the Wanblee Health Center, given letters or reprimand, directives, suspensions and currently one step away from being removed from service. Yet, during all the years that I have work for IHS including the years at Pine Ridge, the lowest PMAP rating I received was "Achieved More Than Expected Results."

In January 2014, on the day I returned from the first suspension, I was in a meeting with one of my staff that was requested by my supervisor Duane Ross. The em-

ployee had also filed an EEO complaint against Mr. Ross. During the meeting Mr. Ross confronted us for comments made to a EEO Manager. Mr. Ross stated "You need to know that what you state to EEO is not confidential" and "Why did you say that I said 'employee' could be fired". The only statement I made during this meeting was that I stood by any statement I made to EEO. I was then suspended again because Mr. Ross reported that I called him a liar.

This suspension was upheld by the Deputy Area Director, even though Mr. Ross admitted the he asked us these questions and both my statement and the employees statement which was provided stated the no one called him a liar. In my response I stated my belief that the suspension was in retaliation for my EEO Activity. The Deputy Area Director did not conduct a investigation into my allegations.

In 2014 I received the "Achieved More than Expected" Results and in 2015 I received the Achieved Outstanding Results. If this is how the Great Plains Area treats their Outstanding employees, how do they treat their "average" employees. Is it any wonder that the Area cannot recruit or retain highly trained and qualified staff. And why there are so many vacancies in Critical Positions throughout the Area.

I am, in my own humble way, asking you to read my story (see attached) and consider it during your investigation and hearing on the Great Plains Area Office.

I authorize the Senate Committee access to my personnel record and any documents that would be needed to verify any statements I made in the attachment.

Thank you in advance for your consideration.

Attachments

Life at IHS before and after the Senate Committee of Indian Affairs
 Titled: In Critical Condition: The Urgent need to reform IHS – Aberdeen Area
 September 28, 2010
 Jane (Tiger) Dilldine

Focus on the last five (5) years(2005 thru 2010):

Investigation: Increasing number of EEO complaints and Agency Grievances, Transfers, Administrative Leave, Doctors and Nurses with expired licenses; several facilities on the brink of losing Accreditation/Certification.

Investigation: 176 Employees placed on administrative leave – past 5 years from 8 Hours to 8 months
 Pine Ridge: 23 employees, average length of time – 2.2 weeks

Jane Dilldine, Pine Ridge IHS Service Unit – Placed on Administrative Leave from Oct. 15 - Dec 6, 2004

Investigation: Between 2002 and August 2010 -- 364 Reassignments; 235 Details; 31 Transfers
 Additional documents suggest that employees who file EEO Complaints were more likely to be detailed/Reassigned. Investigation: 11% of Reassignments – Filed EEO Complaints, 8% Placed on Administrative Leave prior to Reassignment.

Jane Dilldine, Pine Ridge IHS Service Unit -- Filed EEO Complaint April 4, 2004, Reassignment letter received October 15, 2004, Reassignment to Wanblee Health Center effective December 6, 2004.

Aberdeen Area Office from 2000 to July 23, 2010 – 222 formal and informal EEO Complaints
 Pine Ridge: 28 -- Primary Reasons: Gender Discrimination, Reprisal, And Retaliation.

From 2000 to July 23, 2010: Jane Dilldine filed four EEO Complaints, Reasons: 1st EEO Complaint: Gender Discrimination; two following: Reprisal/Retaliation/Hostile Work Environment, Management Officials: William Pourier (3), Sophia Conroy (2).

From July 23, 2010 to Present: Jane Dilldine filed six EEO Complaints, Reasons: Reprisal, Retaliation and Hostile Work Environment.

Hearing: Why someone is working in a circumstance where you see multiple EEO Complaints adjudicated against someone and they are still on the payroll.

Of the ten EEO Complaints filed by Jane Dilldine: Management Official: Duane Ross (6), Sophia Conroy (1), Wehnona Stable, (2). Duane Ross and Sophia Conroy not only still on payroll but have been promoted up to Administrative Officer and Deputy Chief Executive Officer. The Chief Executive Officer position is now vacant and it's likely that Sophia Conroy will be promoted to the CEO position and Duane Ross will be promoted to the Deputy CEO position.

EEOC Case No. HHS_IHS0187-2010 Settlement Agreement signed May 11, 2010.

#10 The CEO of the IHS Pine Ridge Service Unit agrees to that Ms. Sophia Conroy will never be designated as Acting Supervisor over the complainant, Jane Dilldine for as long as complainant remains at Pine Ridge Service Unit.

Several times since this date, Sophia Conroy has been in my chain of command and has served as an Acting Supervisor.

Work record: Jane (Runnels/Tiger) Dilldine

Prior to coming to Pine Ridge, I had 17 years of exceptional service with IHS at the Aberdeen Area Office. Which included awards received serving on the IHS HQTRS Workgroups that updated the IHS Manual Chapters for Records Management along with the workgroup that updated the IHS Records Disposition Schedule; Property Management and Supply Management chapters, I also served on the workgroups that created the Self-Assessments for these three programs.

At the time I was hired at the Pine Ridge HIS Hospital, I had the same property certification that the IHS HQTRS Property & Supply Management Officer held.

When the issues at Pine Ridge are discussed (such as expired items, invoices on hold) with Leadership, I explain to them what the IHS policy states and how to assess the service unit in meeting these policies along with how to correct the issues. Yet, Leadership (mainly Duane Ross and Sophia Conroy) makes the decision not to follow these policies.

In 2010, I was asked to create a Corrective Action Plan on the invoices on hold. This plan included ensuring each department identified an employee to serve as the Contracting Officer Representative. Then monitor the purchase orders, ensuring that invoices are paid and in providing closeout statements as required by the Federal Acquisition Regulation. This corrective action plan was not followed through on.

To date the service unit still has issues with invoices on hold.

In March of 2012, Ron Cornelius, Area Director sent out a Circular No. 2012- Supply Managements Control of Supply Items that have Expiration Dates; that stated: Once the department signs for the supply items, the responsibility for that item is transferred to the ordering department,. Yet my supervisors Duane Ross, Sophia Conroy and Wahnona Stabler directed me to create a policy that would go against this circular.

To date the service unit continues to have issues with expired supplies.

During the last five years I have de-obligated over 7 million dollars: 2011 \$1,937,133.48; 2012-1,283,498.17; 2013-2,473,170.68; 2014-704,413.54; 2015-1,064,831.31. In 2012, I serve on as a Team Leader in the Area Closeout Project.

Since being at Pine Ridge, I have been given directives, letters of warnings, placed on extended administrative leave, transferred and suspended. I am now a 29 1/2 year employee and I am one step away from being removed from service by Leadership at the Pine Ridge Hospital.

Yet, all during my years at HIS including the last five years as Pine Ridge my lowest rating received was the 2014 PMAP rating from Duane Ross and it was "achieved more than expected". For 2015 my PMAP Rating was Achieved Outstanding Results. My staff in the Property & Supply Department has also received outstanding PMAP Ratings.

Case Number	TYPE	Basis	Issues	Management Officials	Date	Closed Agency
No Number Given	Informal	Sexual Discrimination-Gender,				
IHS-006-05 - EEOC Case	Formal	Hostile Work Environment	Disparate Treatment,	Sophia Conroy	4/4/2004	Lost 2X
No. 320-2005-00270X		Reprisal/Retaliation, Sex;	Non-Sexual Harassment	William Pourier	11/2/2004	2/17/2005
		Female				
HHS-IHS-1455-2008	Informal	Reprisal/Retaliation	Training	William Pourier	7/2/2008	10/8/2008
HHS-IHS-0187-2010	Formal	Reprisal/Retaliation	Reassignment Directed,	Sophia Conroy, William	11/16/2009	5/11/2010
			Assignment of Duties	Pourier		
HHS-IHS-0118-2011	Formal	Reprisal/Retaliation, Sex;	Assignment of Duties,	William Pourier, Duane	1/21/2011	1/5/2012
2011-00172X		Female	Disciplinary Actions,	Ross		
			Reprimand, Disparate			
			Treatment			
HHS-IHS-0255-2011	Informal	Reprisal/Retaliation	Disciplinary Action	Duane Ross	4/1/2011	4/11/2011
			Reprimand			
HHS-IHS-0213-2012	Formal	Reprisal/Retaliation	Non-Sexual Harassment	Duane Ross, Weinona	2/12/2014	2/19/2015
413-2015-00049X				Stable		
HHS-IHS-0462-2012 - EEOC	Formal	Reprisal/Retaliation	Non-Sexual Harassment,	Duane Ross, Weinona	10/17/2012	9/6/2013
Docket No(s): 443-2013-			Appointment/Hire	Stable Sophia Conroy		
00106X						
HHS-IHS-0249-2013	Informal	Reprisal/Retaliation	Non-Sexual Harassment,	Duane Ross	4/29/2013	5/29/2013
			Disciplinary Action,			
			Reprimand			
HHS-IHS-0474-2014	Formal	Reprisal/Retaliation	Non-Sexual Harassment,	Duane Ross	10/20/2014	
			Disciplinary Action,			
			suspension, Training,			
			Assignment of Duties,			
			Disciplinary Action			
			Reprimand, Other			

THE LIES THEY HAVE TOLD:

Wehnona Stabler, CEO Pine Ridge at the time, No Longer In Federal Service

HHSIHS-HIS-0462-2012, Page 70, Affidavit signed/dated January 18, 2013

Q: Were you made aware that Complainant had filed prior EEO Complaints?

A: No

HHSIHS-2013-2012: page 2 Appeal Affidavit signed and dated October 3, 2014

Q #14: Do you know whether Complainant has engaged in prior EEO activity? If yes, please describe...

A: Yes. The day I arrived at Pine Ridge in July 2011, Mr. Pourier told me about a locked file cabinet. In the file cabinet he maintained congressional inquiries documentation of union issue and folders about EEO Issues. He referred to Jane Dilldine as the "famous filer". Mr. Pourier is no longer in federal service.

Sophia Conroy, Deputy CEO, Pine Ridge

HHSIHS-0462-2012, page 75, Affidavit signed and dated January 24, 2013.

Q: Were you made aware that Complainant had filed prior EEO Complaints?

A: No

HHSIHS-2013-2012: page 2 Appeal Affidavit signed and dated October 3, 2014

Q #14: Do you know whether Complainant has engaged in prior EEO activity?

A: Yes

Q#15: If so, when? Nature and subject of her complaint?

A: In 2012, she filed a complaint and I was named. The complaint was HHSIHS-0462-2012. I signed the affidavit in January 2013. It covered several of the same issues listed above.

Also, I was aware of an earlier EEO Complaint where she was assigned to another location and then returned to Pine Ridge. I do not recall the date or the circumstances of this earlier complaint but it was before the above complaint. I was not a named official. EEOC Case No. 320-2005-00270X, IHS-006-05.

NOTE: Ms. Conroy does not mention EEO Complaints listed below:

No number given: Two Copies Lost by Pine Ridge Hospital – William Pourier, CEO

Dates of allegation-February 23, 2004 thru May 2005 – Filed April 4, 2004

Basis: Sexual Discrimination – Gender and Hostile Work Environment

Allegations- Disparate treatment from Supervisor Sophia Conroy Deputy Administrative Officer

Responsible Management Official: Sophia Conroy

Settlement Agreement dated July 7, 2014 verifies Sophia Conroy's presence during the ADR.

[Agency lost file, but I still have my unsigned copy given to me (and Ms. Conroy) during the ADR, missing file was documented in EEOC Case No. 320-2005-00270X, IHS-006-05; settlement included: Reassignment back to PRSU.

Case No. HHS-IHS-0187-2010,

Dates of Allegation: October 16, 2009 thru November 16, 2009

Bases: Retaliation and Hostile Work Environment

On October 16, 2009 thru November 16, 2009 Issues relating to Performance Improvement Reports, receiving reports, standardization committee and supervisory duties.

Responsible Management Officials: William Pourier, Sophia Conroy

Settlement Agreement signed May 11, 2010 via ADR with Mr. Pourier

D. The CEO of the IHS Pine Ridge Service Unit agrees to that Ms. Sophia Conroy will never be designated as Acting Supervisory over the complainant, Jane Dilldine for as long as complainant remains at Pine Ridge Service Unit.

CURRENT CASE: HHSIHS-0474-2014: Exhibit F4 page 245, signed and dated on May 11, 2015

#13: A: Yes, #14 When I was contacted by the EEO Counselor in 2012. There were two cases in 2012. Case HHSIHS-0213-2012 & HHSIHS-0462-2012. NOTE: Sophia Conroy Again does not mentioned the two case above and does not state that she knew of case since 2005 as stated in Affidavit signed October 3, 2014.

Note: During mediation Mr. Cribari not aware of the settlement agreement EEOC Case No. 320-2005-00270X, IHS-006-05. May not have information on the topics of the first EEO ADR Settlement agreement either.

Duane Ross, Administrative Officer: Supervisor -- August 2010 thru Present
See January 26, 2015 re: Affidavit -- Additional Items 230-239 two pages:

HHSIHS-0118-2011: Affidavit: signed dated April 25, 2011

Page 57 (page 1 of affidavit) #5 When did you first learn of Complainant's EEO Activity

A: December 2010, before that I knew since 2008 that she had filed an EEO Complaint.

HHSIHS-0462-2012: Affidavit signed and dated January 18, 2013

Page 55 (page 2 of affidavit) Q: Were you made aware that Complainant filed Prior EEO Complaints:

A: I knew she had filed prior complaints because she filed one against me previously. Does state that he knew since 2008 like previous affidavit.

HHSIHS-0213-2012: signed and dated October 8, 2014

Page 2, #14: Do you know whether Complaint has engaged in prior EEO Activity #15 Is so, when

A: Yes. Probably 2010 I became aware of a complaint. Ms. Dillidine has been reassigned to a different location and come back. The CEO at the time, Mr. Pourier told me that due to an EEO Settlement, Ms. Dillidine was returning to the Service Unit and restored her full responsibilities. I was returned to PRSU 2006.

CURRENT CASE: HHSIHS-0474-2014, Affidavit dated March 13, 2015:

Page 4 #13: Do you know whether Complainant has engaged in prior EEO Activity; #14 If so when....

A: Yes A: Once or twice in the past she had EEO complaints against me. Those are the ones I know of for sure.

15: What were the nature and subject of Complainant's complaint(s)

A: She said I retaliated for prior EEO Complaint, and hostile work environment. I believe they were settled at the area office level.

Page 5 CAP: Jane to go to each department and help them set up a system so they can monitor their supplies
This conflicts with Supply Audit Information

Page 6; #15 I've been asking her for months and months "have you gotten with Roberta Jacobson to line up the training? This conflicts with a statement on page 5: When I realized Jane and her staff did not have the training. I went to Pharmacy Supervisor, Roberta Jacobson, if she would be willing to provide the training.

Page 7, #18: The property and supply department was responsible for the expiration dates of all supplies in the Omnicell machine. It was their responsibility to make sure nothing expired in those machines. It is in their PDs.
Page 7 #20: Her staff was always responsible for monitoring the expiration dates of the supplies in the Omnicell machine. This conflicts with PRSU Policies and Circular 2012.

Page 8 #26 IHS Policy responsibility of Nursing supervisors

A: The nursing supervisors were told the same thing she was told. They all agreed and complied

AGREE TO WHAT: P&S responsible for monitoring the Expiration dates. Of course they would agree

Page 9, #29 She wanted to have a meeting. She said "What do you want me to do exactly? But this was explained during the July 21 -- Random Check of Departments. What kind of clarification do you need to check for expired items?

Page 9, #30 Paragraph 1: But we did it anyway. I said we will set up a meeting to show you and your staff how to use the Omnicell machine. Paragraph 2: On August 28, 2014 Request Dr. Weber if OK to do training, Roberta -- Paragraph 3: Afterwards we went upstairs to do a spot-check example in Acute Care Department.

Omnicell Training September 5, 2014; Supply Audits September 29, 2015

Page 9 #30 -- paragraph 4: I thought that was all fine and dandy until it was late August, [stated 8-28 above]

Paragraph 7: Erica Gourneau and I had a meeting with her re: expired items on 9-29-14. She did her first audit on September 30, 2014. Page 10, 1st Paragraph: The next month she started during them, so I didn't make a big deal about it. It was something new, so we eased into it. She's been doing it ever since.

Page 10, #33 Regarding, Threatened her with Insubordination and breaking the chain of command.

What she was doing, she was calling the area office to see if we could make her do that. The area office called Allen and said she was calling. I said, "You know there is a chain of command her and you can get in trouble for that. If I can't solve your problem go to Allen next" Did not document date of this statement to me or whether it was via Email, Face to Face, etc.

Page 13 #48 States provide copy of 8-28-14 meeting to me on Sept 2, 2014. I did not receive until EEO case. No document was provided to showing when given to me and/or Supply Technicians

Page 14, #58: states: I have never received anything from Jane claiming she was harassed: I have no record of her notifying me by phone, email or other wise of any act of harassment. Signed Request for Official Time (8-23-15)

Douglas Factor for 1 week suspension:

Page 417 #4. She does have a problem with getting along with fellow supervisors. Conflicts with PMAP No comments about her or her department.

This continue disruptive behavior by a supervisor leads me to not have confidence in their ability to carry out their official responsibilities. This also conflicts with PMAP (Achieved More than Expected

#8 This offense can cause reputation damage to IHS if we are placed on another U or lose out ability to bill. Leads investigator to conclude "Expired Items cease U Status and CMS failure. When more dire items on U.

AFFIDAVIT dated 5-12-15 Additional Items:

Page 4, Q 10. I supervise 100 people. This conflicts with Organizational Chart, includes all employees not just supervisors.

Page 4, #16 I get between 200-300 emails a day.

Page 5, #17 All she did was cut and paste what she is supposed to do and said "I did 100%. This conflicts with Self-Assessment that I submitted.

Page 5, #19 Mid Term Review, you have no concerns about her performance. A: Nothing really, I conveyed my concerns to her at the time. Conflicts with Mid-Term Review comments

PREPARED STATEMENT OF VERNON MILLER, CHAIRMAN, OMAHA TRIBE OF NEBRASKA

Good morning esteemed members of the Senate Select Committee on Indian Affairs. My name is Vernon Miller and I am Chairman of the Tribal Council of the Omaha Tribe of Nebraska. I was elected to the Tribal Council in November, 2013 and appointed by the Tribal Council as Chairman in 2014 and again in 2015. Prior to my election, I was a High School Business Teacher at Omaha Nation Public Schools for 8 years. We are a federally recognized tribe living on the Omaha Reservation in northeastern Nebraska and western Iowa. Our total land area is approximately 307 square miles with a population of approximately 8,400.

I'm here to discuss the Omaha/Winnebago Hospital, located on the Winnebago Reservation. The reason I emphasized the word "Omaha" is because over the past several months that the Omaha and Winnebago Tribes have dealt with the deficiencies caused by IHS at the Omaha/Winnebago Hospital, my Tribe has become frustrated because the hospital is consistently yet mistakenly referred to as the "Winnebago Hospital"; thus, much of the focus has been on the Winnebago Tribe. Our Reservation is south of and adjacent to the Winnebago Indian Reservation. The land that comprises the Winnebago Reservation was part of our reservation until-out of our compassion for the Winnebago, who had been forced out of Wisconsin-we sold it to the U.S. Government for the use of the Winnebago in 1865. Thus, the two tribes have a long history of sharing, and we simply want it recognized that the Hospital shares our name.

I've addressed procedure; now, substance. First, I'll provide some background, followed by the historic record of failures by IHS at the hospital. Next, I will discuss some of the egregious deficiencies of the Hospital that in July 2015 resulted in CMS terminating the Hospital's ability to collect third party billings from Medicare. Finally, I will conclude with a synopsis of the progress of the IHS since July 2015.

By way of background, the Omaha/Winnebago IHS Hospital serves over 10,000 Tribal members living in the States of Iowa, Nebraska and South Dakota. The Hospital is a 13-bed facility staffed with 4 Physicians, Emergency Room, Pharmacy, Lab, Inpatient Clinic, Radiology, Urgent Care and Social Services. When fully staffed, the Hospital employees about 250 employees. Medicare & Medicaid provides almost 17% of its \$21 million dollar annual budget.

The Hospital has a long, documented record of failures. I urge you to read a report issued by Senator Byron Dorgan in 2010 entitled "In Critical Condition: The Urgent Need to Reform the Indian Health Services' Aberdeen Area", which was a report made to this committee (111th Congress, 2d. Sess.) (Dec. 28th, 2010). The report cited substantial accreditation and EMTALA issues; lapsed provider licenses, certifications, registrations and privileges; and, serious performance issues among senior level management employees. Five years later, it's grown worse.

CMS Surveys conducted in April, 2014 and May, 2015 pointed out that deficient practices and medical errors were allowed to continue; that ineffective oversight may result in serious harm, injury and death; and, that the Hospital staff and governing body failed to provide adequate examination to patients, medical care to a critically ill patient, ER screening and stabilizing treatment.

The prediction of the CMS Survey's proved true: as a consequence of IHS' negligence, there have been five patient deaths at the Hospital since 2011; four of those deaths, since April 2014. This sad track record led to the unprecedented termination of the CMS Medicare Provider Agreement in July of 2015, leaving our Tribe and the families of what I refer to as "victim-patients" to believe that no one from IHS heeded the report or surveys.

Specifically, the Omaha Tribe learned, from first-person accounts, surveys and CMS reports from 2004, 2014 and 2015 that as of July 2015:

- **There was a lack of specific admission criteria.** What criterion existed was vague and misleading. For example, the scope of services stated that ultrasound services were available. But they were not. The hospital could not even determine whether it offered telemetry. The criterion vaguely defined or identified the types of patients and conditions the hospital is capable of safely caring for. We've learned that this- combined with a constantly rotating staff of temporary physicians in the Emergency Room- is a contributing factor to the alarmingly high rate of transfers of patients to other hospitals. Indeed, this factor has proved to be not only dangerous, but costly as well. In short, the Tribe has incurred a substantial increase in costs associated with emergency transfer of patients.
- **The Emergency Department was seriously deficient.** We've learned that the obstetric skills of providers were questionable; so too, was the thoroughness of the credentialing process for ED Doctors. Indeed, the ED was not functioning under a qualified physician. There was a lack of communication within the ED, likely complicated by the fact that members of the ED staff were not oriented to the hospital. There were delays in documentation, an alarmingly high number of medication errors; and, the ED staff was found to lack hygienic and sterilization skills.
- **The Medical Staff lacked basic skills.** In general the nursing staff lacked skills in obstetrical care, general ED skills, pediatric care and medical-surgical nursing fundamentals. There was no evidence of crisis prevention training of the Staff. Examples of deficiencies ranged from not completing a patient's vital signs at discharge, to a serious lack of knowledge as to how to interpret fetal monitoring strips. Dentists were performing medical screenings. Emergency Room Doctors failed to document patient transfers and were often found not to have oriented to the hospital. A Doctors' credentials were expired. Incident reports showed a high number of medication errors.
- **Many of the policies and procedures of the hospital were out of compliance.** Significantly, the hospital's restraint and seclusion policy required extensive revision because the policy in place could result in serious injury. There was no evidence staff was trained in basic crisis intervention. There was scant evidence staff was analyzing patient quality indicators. The timing of medical record entries was often out of order, and there was insufficient discharge planning for patients.
- **The physical facility itself has several deficiencies.** For example, those seeking Emergency Services had trouble finding them, as when entering the hospital through the walk-in entrance to the Emergency Department from the outside, the location of the ED Triage area was not readily evident.

The Hospital did not properly monitor medical gas alarms, generator and fire alarms. Fire alarms and sprinklers found to be faulty at testing often were not replaced for as long as two months. There was an abundance of expired supplies. Numerous rooms that required certain levels of airflow and pressurization were not maintained.

- **The Administration and Governance of the Hospital was Incompetent.** Most tellingly, *there was no evidence that the Medical Executive Committee had performed a review of patient deaths!* There was a lack of oversight of emergency services by the governing board. There was little to no follow up with patients who filed grievances. If a patient received a response, it was uninformative and vague. Perhaps most vexing-as evidenced by the fact this summary is based on findings over the course of several years- is that Governing Body meeting minutes and quality assessment and performance improvement reports did not reflect that the hospital had taken any action to improve performance improvement in the areas where it had identified opportunities to improve.

After the termination by CMS in late July of 2015, IHS hired a consultant to develop and implement a Corrective Action Plan ("CAP"). The consultant discussed this plan with the respective tribal councils. On September 23, 2015, the first CAP provided to the Tribes identified 93 deficiencies broken down into categories: red, meaning incomplete; yellow, in progress; green, complete. The first CAP showed that approximately 85% of the deficiencies were in the red. The last CAP, dated January 6, 2016, reflected that 50% were green; 40% yellow; and, 10% red.

On the one hand, modest progress had been made; on the other, the deadlines set forth in the original CAP have fallen behind in key areas. The hospital continues to lack data to measure improvement in care. To date, there is no peer review of medical staff; and, the flow of information to the Hospital's governing body is questionable. With regard to leadership, despite the joint resolution of the Omaha and Winnebago Tribes calling for the removal of Aberdeen Area Director Ron Cornelius and Chief Medical Officer Mark Jackson, those individuals remain as part of the problem rather than solution. For example, despite the promise of transparency by Mr. Cornelius and IHS, they have blocked efforts by both Tribes to be involved in communication between IHS and CMS.

Moreover, the most critical issue remains unresolved; that is, to recruit, contract and train qualified Emergency Room physicians and staff. This continues to affect the health, safety and welfare of our tribal members; and, to add insult to injury, is hurting our tribal members financially. In short, because the physicians and staff lack orientation and training, they often transfer emergency patients out of the ER via life flight rather than ambulance. Subsequently, when third party payers learn that such transportation was unnecessary, they refuse to pay, and bill the patient in amounts up to \$25,000. The Tribe has turned these bills over to IHS but has yet to learn whether they will honor them.

I urge this Committee to take action. Bear in mind, IHS ignored Senator Dorgan's report, the CMS surveys and personal stories of employees and patients. Another report from another Senator to this Committee won't heal our people. Listen mindfully to the narratives of our people. Know that their motive is not to blame but to demand solutions. Call upon IHS to heal us.

Among those solutions must be an increase in funding to make up for lost Medicaid dollars. Also, the federal government must prioritize changing the cumbersome recruitment process of employees, the complexity of which results in discouraging applicants. We insist on accountability and communication by IHS. Critically, we need permanent, rather than contract Physicians and staff in our ER.

If anything, this Committee should be shocked by this fact: my tribal members are afraid to go the IHS Omaha/Winnebago Hospital. In sum, I remind the esteemed members of this Committee that the mission of IHS is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level." The Aberdeen area is failing in that mission; indeed, it has sunk the physical, mental, social and spiritual health of my people.

ATTACHMENT

JOINT RESOLUTION
OMAHA/WINNEBAGO
TRIBAL COUNCILS

***Resolving to State the Joint Interest and Intent of the Omaha and
Winnebago Tribal Councils Relating to the Indian Health
Services Direct Services Hospital on the Winnebago Indian
Reservation***

- WHEREAS, the Omaha Tribe of Nebraska is a federally recognized Indian tribe organized under a constitution and bylaws approved by the Secretary of Interior on April 30, 1936, pursuant to Section 16 of the Indian Reorganization Act of June 18, 1934; and,
- WHEREAS, the Winnebago Tribe of Nebraska is a federally recognized Indian Tribe organized pursuant to Section 16 of the Act of June 18, 1934 (48 Stat 984) (25 USC 476), as amended by the Act of June 15, 1935, (49 Stat 378); and,
- WHEREAS, pursuant to Article III, Section 1 of the Constitution of the Omaha Tribe of Nebraska, the governing body of the Omaha Tribe shall be known as the Tribal Council; and,
- WHEREAS, pursuant to Article III of the Winnebago Tribal Constitution, the governing body of the Tribe shall be the Tribal Council; and,
- WHEREAS, pursuant to Article IV, Section 1(a) of the Constitution of the Omaha Tribe of Nebraska, the Tribal Council has the authority, *inter-alia*, to negotiate with the Federal, State, and local governments on behalf of the Tribe; and,
- WHEREAS, pursuant to Article IV, Section 1 (a) of the Constitution of the Winnebago Tribe of Nebraska, and its inherent powers of self-

government, the Tribal Council is vested with the power to *inter-alia*, negotiate with the federal, state and local governments on behalf of the Tribe; and,

WHEREAS, the Omaha and Winnebago Tribal Councils find that the Indian Health Services ("IHS") has a federal treaty and trust responsibility to provide high quality health care to the Omaha and Winnebago Tribes and their members; and,

WHEREAS, the IHS operates a Direct Service Hospital on the Winnebago Reservation, commonly known as the Omaha/Winnebago IHS Hospital; and,

WHEREAS, as currently structured, this hospital serves in excess of 10,000 Indian people, including the members of the Omaha and Winnebago Tribes; and,

WHEREAS, since well before 2010, numerous studies, investigations and surveys conducted by the United States Congress and various federal agencies have documented serious and appalling deficiencies in the programs and services operated by the IHS in its Great Plains Service Area, including at the Omaha/Winnebago IHS Hospital; and,

WHEREAS, one such investigation, conducted by the Centers for Medicare & Medicaid Services (CMS) in 2014, documented 45 separate serious deficiencies at the Omaha/Winnebago IHS Hospital between April and November of 2014, and found that said deficiencies pose an immediate threat to patient health and safety; and,

WHEREAS, the CMS findings, combined with the IHS's failure to adequately address them, led CMS to terminate the Omaha/Winnebago IHS Hospital's ability to collect third party billings from Medicare effective as of July 23, 2015; and,

WHEREAS, even more importantly, these failures have been, and still are, jeopardizing the lives, health and safety of Omaha and Winnebago tribal members and the other Indian people who rely on this hospital for medical services; and,

WHEREAS, the loss of the Omaha/Winnebago IHS Hospital's Medicare billing capability will almost assuredly result in other third party payers refusal to pay for the services provided at that facility, further endangering its operating budget and the level and quality of services it is capable of providing; and,

WHEREAS, all of this demonstrates the IHS's flagrant disregard for its treaty and trust responsibilities to the Omaha and Winnebago Tribes, as well as a callous disregard for the lives, health and safety of the members of the Omaha and Winnebago Tribes; and,

NOW THEREFORE BE IT JOINTLY RESOLVED:

that the Omaha and Winnebago Tribal Councils hereby notify the Indian Health Service and its Acting Director Robert McSwain of their joint interest and intent in the following:

1. Management of the Omaha/Winnebago Hospital by IHS is not in the best interest of the Omaha and Winnebago Tribes.
2. The Omaha and Winnebago Tribes call upon the IHS to immediately supply the data necessary for the self-governance compact and to expedite the compacting process.
3. The Omaha and Winnebago Tribal Councils continue to demand that IHS immediately address each and every one of the shortcomings which exist at the Omaha/Winnebago IHS Hospital including, but not limited to: (a) those which have been noted in one or more of the Congressional and federal agency studies referenced in this Resolution; (b) those identified by past or present hospital staff or other health care professionals; (c) those identified by the Omaha and Winnebago Tribes; (d) those identified by the patients at the Omaha/Winnebago facility; and, (e) those which threaten the accreditation of the facility.
4. That the IHS should immediately provide qualified and permanent federal staff and the equipment, medications, money and expertise necessary to accomplish these tasks and to assure high quality medical care to all of the patients served at the Omaha/Winnebago IHS Hospital.
5. The Omaha and Winnebago Tribal Councils demand that any funds allocated by IHS to "corrective action plans"-all of which to date have failed-not come from funding for the IHS Omaha/ Winnebago Hospital.
6. The Omaha and Winnebago Tribal Councils request that IHS keep them informed of the progress the IHS is making on these specific objectives no less than weekly, and seek the full consultation of the Omaha and Winnebago Tribal Councils before all important decisions are made which have, or have the potential to have an impact on the health care the IHS provides or will provide to the Omaha and Winnebago tribal members; and,

BE IT FURTHER RESOLVED:

that because the failure of the Indian Health Service's previous corrective action plans resulted in the loss of the Omaha/Winnebago IHS Hospital's Medicare/Medicaid eligibility or accreditation, and a decrease in the level or quality of services provided to Omaha and Winnebago tribal members, the Omaha and Winnebago Tribal Councils call for the removal of the following IHS employees from the Omaha/Winnebago IHS Hospital: the Chief Executive Officer Randy Jordan; the Clinical Director; Director of Nursing Karen Reiser; the Emergency Room Director; the Administrative Officer; the Managed Care Director; and, any other employees and contractors responsible for this situation; and,

BE IT FINALLY RESOLVED:


that the Omaha and Winnebago Tribal Councils also demand the removal of Ron Comellius from his position as the IHS Area Director and Dr. Mark Jackson, Chief Medical Officer, Great Plains Area.

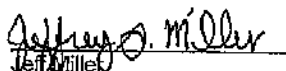
CERTIFICATION

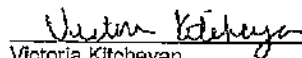
This will certify that the foregoing Joint Resolution was considered at a meeting of the Tribal Councils of the Omaha and Winnebago Tribes of Nebraska convened on August 12, 2015 and adopted by each Council by unanimous consent.

Dated: August 12th, 2015


 Vernon Miller
 Chairperson,
 Omaha Tribal Council


 Darla LaPointe
 Chairperson,
 Winnebago Tribal Council


 Jeff Miller
 Secretary,
 Omaha Tribal Council


 Victoria Kitcheyan
 Secretary,
 Winnebago Tribal Council

PREPARED STATEMENT OF HON. MARILYNN MALERBA, CHIEF, MOHEGAN TRIBE;
 BOARD MEMBER OF SELF-GOVERNANCE COMMUNICATION AND EDUCATION TRIBAL
 CONSORTIUM; CHAIRWOMAN, IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
 (TSGAC)

Introduction

On behalf of the Self-Governance Communication & Education Tribal Consortium (SGCETC),¹ I am pleased to formally submit this written testimony to support the

¹The Self-Governance Communication and Education Tribal Consortium consist of Tribal Leadership whose mission is to ensure that the implementation of the Tribal Self-Governance legislation and authorities in the Bureau of Indian Affairs (BIA) and Indian Health Service

Continued

ongoing efforts of the Indian Health Service (IHS). This testimony will highlight policy, legislative, budget, and administrative changes that would work to improve health care delivery for those that depend on medical and public health services from IHS, to raise their health status to the highest level possible and to ensure the success of the Indian Health Care System. I commend the Committee for hosting this opportunity to gather input from Tribal Leaders and Administrative officials to address critical concerns regarding the IHS.

Self-Governance is a Tribally-driven, Congressional legislative option that recognizes the inherent right of Tribes, as sovereign nations, to negotiate annual appropriated funding and assume management and control of programs, services, functions and activities that were previously managed by the Federal government. It allows Tribes to determine their governmental priorities, redesign and create new programs and services and reallocate financial resources to more effectively and efficiently fit the needs of their Tribal citizens and communities. The growth and success of Self-Governance, within the IHS is best documented by the 351 Tribes currently participating in Self-Governance compared to the 14 Tribes who initially signed agreements in 1992. Together Self-Governance and Title I Contracting Tribes represent 62 percent of Tribal governments who operate \$1.8 billion in healthcare programs each year.

Over the last two decades, Self-Governance Tribes have markedly improved the nation-to-nation relationship between the United States and Tribes. However, this success has required active engagement, cooperation and the collaboration of administrative officials across the Federal government, Congress, and Tribal Leadership. Improving patient care throughout the entire Indian Health Care System requires a similar approach. First, Congress must uphold its commitment to Tribal Nations by fully funding IHS. Without adequate funding the system cannot be expected to provide quality care to patients or to attract qualified, long-term providers and administrators. Second, the entire Federal system must work collaboratively to improve the conditions at Indian Health Service, Tribal and Urban (ITU) facilities within the Indian Health Care System. Lastly, Tribal Leaders must have a leading voice in decisions made regarding the health delivered in their communities.

SGCETC proposes Congress focus its work in three areas: (1) stabilize and increase funding to IHS; (2) encourage administrative flexibility and collaboration; and, (3) adopt effective communication and partnership with Tribal Nations.

I. Stabilize and Increase Funding to the Indian Health Service

Despite trust and treaty obligations to provide for the health care of the American Indian/Alaska Native (AI/AN) populations, Congress continues to severely underfund IHS without regard to meeting basic health care service needs for AI/AN and fulfilling requirements such as providing adequate health care facilities. Underfunding healthcare directly contributes to the poor health status and life expectancy of AI/AN. Within this overall context, SGCETC has identified the following top budget and related issues that would improve patient care by increasing appropriations and leveraging current opportunities:

Protect the IHS budget from sequestration. Despite the unprecedented increase of 29 percent in the past 4 years, funding levels for AI/AN healthcare remain dangerously low.² Tribal governments experienced severe budgetary cuts after the 2012 sequester—which resulted in a decrease to the IHS budget of \$220 million.³ These cuts had a devastating impact on direct services provided to AI/AN patients, with an estimated elimination of 804,000 outpatient visits and 3,000 inpatient visits. As Congressional members debate the FY 2017 appropriations, Self-Governance Tribes first, urge Congress to restore Tribal funding cuts and, second, to uphold the Tribal trust responsibility and amend the Budget Control Act of 2011 to exempt Tribal funding from future sequesters, budgetary reductions and/or rescissions.

Support Advance Appropriations for IHS in the FY 2017 Budget Request. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. Late funding creates significant challenges to Tribes and IHS provider budgeting, planning, recruitment, retention, provision of services, facility maintenance and construction efforts. Providing sufficient, timely, and predictable funding is needed to ensure the Federal government meets its obligation to provide health care for AI/AN people. Enacting advanced appropriations

(IHS) are in compliance with the Tribal Self-Governance Program policies, regulations and guidelines.

²National Congress of American Indians Policy Research Center. (2013). Geographic & demographic profile of Indian country.

³Native Care Act, H.R. 4843, 113th Congress (2013–2014) (2014).

will ensure more stable funding and sustainable planning for the entire Indian Health Care system by appropriating funding two years in advance.

End discretionary decisions within the IHS budget. Unlike other health programs such as Medicare and Medicaid, IHS is funded as a nondefense, discretionary line item, creating an inconsistent funding environment year-to-year and ignoring external factors that contribute to the recognized growing gap between IHS and other public health programs.⁴ Transferring the IHS budget to the mandatory side of the budget would adequately represent the trust and treaty responsibility due to AI/AN, while creating a consistent budget based on important factors such as population growth, inflation and evolving technology.⁵

Fully fund Indian Health Care Improvement Act (IHCIA) provisions related to patient care. Health reform represents a significant opportunity for Tribal and IHS programs to sustain, improve, and build innovative health systems in Tribal communities. However, to date, there are more than twenty-five (25) unfunded authorities in the Indian Health Care Improvement Act (IHCIA), each representing an unleveraged opportunity to increase and improve services for American Indians and Alaska Natives across the Nation. Therefore, successful implementation of the law is of great importance to Tribes and hinges on the full funding of the permanent reauthorization of the IHCIA and the overarching Affordable Care Act (ACA). The SGCETC respectfully requests funding increases to begin implementing the twenty-five unfunded authorities in IHCIA and countless others in the ACA.

Fully support the IHS Information Technology System. The Resource and Patient Management System (RPMS) is the decentralized health information system used to manage both clinical and administrative information in IHS healthcare facilities. However, due to budget constraints and demands to meet growing industry and government standards, IHS has not been able to commit resources to update RPMS in every Area. Failure to maintain this system properly has resulted in lost revenue to IHS and Tribal facilities across the country. A short term influx in funding to bring RPMS up to industry standards in every area could result in more streamlined care as well as increase third-party revenue to the Indian Health Care System.

Invest in Self-Governance Planning and Negotiation Grants. More than two decades of Self-Governance in IHS has shown that Tribal governments can and often do deliver better quality care in a more efficient and culturally competent manner, improving the health and welfare of communities significantly. Congress should increase its support for Tribes wishing to plan, prepare, and negotiate for Self-Governance programs. The easiest way to build the internal capacity for Tribes to make the transition into Self-Governance is to commit more Federal funds for planning and negotiation cooperative agreements. This year, due to inadequate funding, only five planning and two negotiation cooperative agreements were provided to a growing list of Tribes seeking alternative and innovative solutions to provide better care.

II. Encourage Administrative Flexibility and Collaboration

Ultimately, improving patient care requires more than the provision of adequate funding. We must also embrace and advance innovative and collaborative approaches to providing programs and services in order to achieve sustainable healthcare. The Administration can take action to improve its business practices, open additional streams of revenue, and leverage funding opportunities that already exist within the Federal government to provide quality care, expand services, and hire qualified providers and administrators. However, each of these solutions requires Federal agencies across the entire government to allow greater flexibility and collaboration. SGCETC offers the following solution to administratively improve patient care:

Expand the IHS-Veterans Administration Memorandum of Understanding to Include Purchase and Referred Care. When the IHS and the Department of Veterans Administration (VA) negotiated the first national agreement, required under the IHCIA, they only included reimbursement for direct care provided by IHS facilities. Failure to include Purchased and Referred Care (PRC) is a disservice to Veterans and does not adequately address the specialty care that is needed while imposing a financial burden on Tribal healthcare systems which provide eligible veterans care at its own expense. After two years of implementation and changes to the VA health care delivery, Self-Governance Tribes believe the time is right to revisit the reimbursement agreement and include PRC.

⁴Moss, Margaret. P Ed. and Malerba, Marilyn. American Indian Health and Nursing. Springer Publishing NY, NY pp. 323-336.

⁵White, J. (1998). Entitlement budgeting vs. bureau budgeting. Public Administration Review, 58 (6), 510-521.

Enact Medicare-Like Rates for IHS outpatient services for ITU facilities. IHS, Tribes and Tribal organizations currently cap the rates they will pay for hospital services to what the Medicare program would pay for the same service (the “Medicare-Like Rate” or “MLR”). Currently, this MLR cap applies only to hospital services, which represent a fraction of the services provided through PRC. In December of 2014, IHS proposed a rule to amend the current rule to apply Medicare methodology to all physicians, other health care professional services and non-hospital based services that are authorized for purchase by the IHS and Tribal PRC programs or urban Indian health programs. Tribes generally support the proposed rule with limited changes and provided recommendations to allow for the greatest flexibility. To date however, a final rule has not been published.

Previously, Congress also proposed legislative fixes to amend Section 1866 of the Social Security Act (SSA) to expand application of the MLR Cap. It would direct the Secretary to issue new regulations to establish a payment rate cap applicable to medical and other health services in addition to the current SSA cap on services provided by hospitals. It would make the MLR cap apply to all Medicare-participating providers and suppliers. Self-Governance Tribes support this legislative fix to leverage the limited resources provided to IHS, Tribal and Urban health programs.

Bolster the recruitment and retention of qualified providers and administrators. Recruitment and retention of qualified health providers and administrators is at the crux of improving patient care. IHS, along with Federal partners such as the Departments of Housing and Urban Development (HUD) and Agriculture (USDA), the Health Resources and Services Administration (HRSA) and others, must adopt a re-engineered business model that directly focuses on identifying the external factors and effective strategies that contribute to physician and administrator recruitment.

Additionally, Congress could take steps to approve legislation that would amend the Internal Revenue Code to exclude from gross income, amounts received under the IHS Loan Repayment Program and the Indian Health Professions Scholarships Program, which are currently a drain on the appropriations extended to IHS.

Support legislation to expand Self-Governance under a Demonstration Project within HHS, by amending the Indian Self-Determination and Education Assistance Act (ISDEAA). Title VI of the ISDEAA required the Secretary of Health and Human Services (HHS) to conduct a study to determine the feasibility of a Tribal Self-Governance demonstration project for appropriate HHS programs, services, functions, and activities (and portions thereof) in agencies other than IHS. HHS submitted the required report to Congress in March of 2003. The report concluded that the demonstration project was feasible. Although Congress has considered legislation to authorize a Self-Governance demonstration project, legislation to advance this initiative has not been enacted into law to date.

HHS has more than 300 grants specifically available to Tribal governments. Yet, Tribes are unable to fully maximize these opportunities because they are often short-term or one-time sources of funding. Additionally, these opportunities often focus on prevention or treatment of the same health issues, such as suicide, substance abuse prevention, heart health, or diabetes, but cannot be leveraged together to provide holistic health care to AI/ANs. Distributing funding through grants does not fulfill the trusty responsibility and does not lead to improved, long-term health status indicators. Expanding a model with a proven track record, such as Self-Governance, would continue to improve the nation-to-nation relationship and allow Tribes to leverage funding from across HHS to support preventative and direct care, to enhance substance abuse and behavioral health services, and to manage their health systems similarly to other public and private entities.

Tribal efforts to continue working on the expansion of Self-Governance was recently realized in the transportation reauthorization legislation. P.L. 114–94, the Fixing America’s Surface Transportation Act (FAST Act) made several important changes to the Tribal Transportation Program, most notably created a Department of Transportation (DOT) Tribal Self-Governance Program which extends many of the Self-Governance provisions of Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA) to DOT. The FAST Act also provides modest funding increases for the Tribal Transportation Program (TTP) and the Tribal Transit program as well as a number of technical changes to these programs. So why, after more than a decade of asking has HHS been so unwilling to advance the same opportunities for Self-Governance in HHS?

III. Adopt Effective Communication and Partnership with Tribal Nations

During its sixty-year history as an agency committed to improving the health of American Indians and Alaska Natives, IHS has had many successes and downfalls. Like any other public or private organization, IHS will require consistent and trans-

parent methods to evaluate and identify issues, to implement changes, and to respond to external, unknown factors. Instead of relying on Congressional action each time, the following recommendations should be adopted:

Utilize formal and informal communication methods to encourage community partnership with Tribal Leaders. Delivering proper health care in Tribal communities requires true partnership between Tribal Leaders and agency officials. Since the Clinton Administration, Presidents have reaffirmed the responsibility of Federal agencies to consult with Tribal governments before taking actions that affect their communities. Though Tribal consultation is an excellent way to establish a set of principles, direction, or directly respond to a proposal, this formal communication does not allow for regular exchange regarding issues that arise outside of the formal policy process. Tribal Leaders maintain a close pulse on their community and the effects of proper health delivery. IHS should adopt methods to efficiently and effectively exchange information with Tribal Leaders in a manner that allows them to identify issues earlier and respond more rapidly.

Institutionalize stakeholders throughout the Indian Health Care System. Another opportunity to tie Tribal communities to the performance of the Indian Health Care System is to regularly engage leadership in the administration and direction of local health facilities. IHS has adopted a process in other areas that allows Tribal Leaders and other experts to participate regularly in the governance of hospitals and clinics that impact the health of their citizens. Replication of this process would provide IHS with another avenue to hear from stakeholders and allow Tribes an opportunity to be part of the solution before issues negatively impact patient care.

Direct IHS to develop an annual report which shows how well the Federal Government has upheld its Treaty Obligations and Trust Responsibilities to Tribes. Reporting on achievements is critical to winning and maintaining support. If the “performance-based budgeting” uses statements of missions, goals and objectives to explain why the money is spent, then similar objectives, goals and measures should be tied to the United States government honoring the treaties and fulfilling the trust responsibility. While our budgets remain at the discretion of Congress to sequester, decrease and eliminate services, we have no tools to leverage the broken promises to Indian people. There should be equal standards of performance and results to hold the United States accountable for not upholding the agreements between our nations and not honoring its word.

Summary

In closing, SGCETC again thanks the Committee for the opportunity to submit testimony. We look forward to working with you to initiate positive changes that will improve the health and welfare of every Tribal citizen throughout Indian Country.

TO WHOM IT MAY CONCERN:

My name is Steve L. Garreau and I want to tell you about what happened to me at the Eagle Butte IHS ER back in 2015.

I went to the ER because I was having really bad nose bleeds and they would not stop. The ER doctor had them hold me down and she shoved a tube into the nostril that was bleeding and it was too big but she shoved it in any way and it hurt so bad. But after she had done this did she realize that it was too big and then she took it out and shoved a smaller one into my nostril. I do not normally holler from pain but when she shoved that big tube into my nostril, I hollered out in pain because it hurt that bad.

Now as a result of the damage done to my nostril I have periods when I lose my sense of smell in it and it tends to discharge more than usual and I have headaches.

They sent me to Rapid City and the ER doctor out there was really angry at what they did to me. He said that they tore up the inside of my nostril. He even wrote a statement about what they did to me. That statement is on file with Senator John Thune's office. A copy can be requested.

Sincerely,

STEVEN L. GARREAU

TO WHOM IT MAY CONCERN:

I am Melba Garreau I am 85 years old and I live in Eagle Butte, South Dakota. I have been neglected by the Ii-IS clinic. I have seen so many Doctors and PA it is only to repeat over and over my condition and never get no satisfaction and my health deteriorates. I have cancer and in this cancer and it is so bad I can't think straight. I have this lump in my mouth for 12 years now. I keep telling the doctor

and I continue to see the doctor on this lump but to no avail. They keep saying we will see you again all the time and then when it finally turned to cancer after a biopsy I've been really bad it came back again last month.

My health deteriorated back in 1978 when I got a lump in my left side bottom jaw and when I check to see a doctor they slide me along no one cares to care unless it's a matter of death. Well, a Dr. Carlson kept seeing me every 3 or 4 months. He would say it is not growing and releases me. This went on till it turned into cancer. I was sent to Minnesota University Hospital in Minnesota the doctor removed a part of it cause the cancer wrapped around my jaw GOD! I don't want anyone to go through what I did.

Finally a Dr. Gray sent me to Mayo Clinic, Rochester, MN. They did a major surgery and I can't eat just liquids am so hungry I am sad all the time.

The cancer came back aggressively had surgery and 6 weeks of radiation. I am now waiting for an appointment to go back to Rochester, MN at the Mayo Clinic if I am cancer free. I am very fatigued so I stay in bed all the time. I also had cancer in my breast in 1994 and 1996 because they didn't follow up on me.

Sincerely,

MELDA GARREAU

TO WHOM IT MAY CONCERN:

My name is Brenda (Clown) Veit I am 58 years old.

I kept going to IHS for over a year for my bones hurting. No arthritis I was told. My last visit was June 2015. My wrist was swollen and my bones were getting deformed. Still I was told nothing was wrong.

I finally went to the Women's Health and they completed breast exam and immediately referred me out. I was given biopsy and diagnosed with 4th stage cancer in August 2015. I have cancer in seven different areas.

If blood work were done they could have caught it. I now have terminal cancer with a diagnosis over a year left.

Sincerely,

BRENDA VEIT

TO WHOM IT MAY CONCERN:

IHS Incident on January 1, 2018

On December 29, 2015 I hurt my back while cleaning seeing that I couldn't solve the problem of Pain myself I went into the ER. at the IHS hospital in Eagle Butte, South Dakota on January 1, 2016.

I saw Dr. Mauricio Ferrel and he had an X-ray done on me. My pain level was at least a 9. While getting the X-ray the technician grabbed me by the ankles and pulled me down on the table to where he wanted me. Having had to hip replacements and the lower back pain this action caused me even more pain that made me cry. He could have told me to move down toward the end of the table instead of pulling me by the ankles I was in so much pain and I told the doctor what happened. I told him (the doctor) that you can't be pulling on a 78-year-old woman like that without something happening. Before leaving the hospital I was given a shot for pain but it did not help. The doctor refused to give me something else for the pain he explained that the hundred milligram of Celebrex that I am taking for my rheumatoid arthritis should be adequate. But it wasn't it drove me to see a doctor not connected with IHS to finally find relief.

Sincerely,

ARDIS LEBEAU WARCLOUD

TO WHOM IT MAY CONCERN:

For 27 months my husband had total hip replacement at Black Hills surgery. Since that time he has been having swollen legs, knees and feet, severe pain in hip/leg area.

He has been sent to Bismarck, ND, Sanford twice for misdiagnosed heart attack due to faulty CT scanner or blood test. Sanford has informed us that over ten patients were misdiagnosed for false alarm of heart attacks. We appreciate Eagle Butte IHS concern for my husband's heart but he was thoroughly tested and Sanford showed no blood clots either in legs, or heart, head nor chest areas.

As his spouse, I am the opposite in regards to heart attacks. I have been diagnosed with cardiovascular disease and I have had two heart attacks in Arizona in IHS. I was sent via ambulance to Casa Grande hospital for treatment. Due to high charges by ambulance I have not been able to get Eagle Butte IHS to pay for

\$1,800.00 ambulance fees, MRI and CAT scan due to a truck running into the driver's side of my van. As I tried to hold on to the steering wheel my right shoulder was torn from bone to ligament, collarbone cracked, and resulted in shoulder cuff surgery, when no other doctor at IHS could diagnose my need for a shoulder cuff surgery two years after the surgery, a specialist in bone/joint surgery diagnosed and performed a shoulder cuff surgery two years after the truck accident. I have been in severe pain since the accident which occurred in Casa Grande, Arizona. I have been doing physical therapy for two years until this last PT therapist told me he cannot help me any further because he has no training in how to use the neck-spine stretcher machine.

I was told that IHS cannot pay for my medical bills over 30 days. My medical bill occurred over 2 years ago. I had asked if they IHS can help me pay it but I was refused. I am requesting your assistance in having IHS pay this outstanding medical bill for me. Thank you for your attention into this matter.

Sincerely,

MONA GREY BEAR WALKS OUT

Concerning our IHS Health Facility at Eagle Butte, South Dakota. I would like you to know how much we appreciate this hospital. If not for this hospital, we would not have emergency or medical care for most people in this area. Had IHS not been here, I would have lost family members and friends to heart attacks, appendicitis, pneumonia, strokes, cancer, and car accidents. I am grateful beyond words.

We have a wonderful staff at our IHS. Of course, there are occasional exceptions, but nothing is perfect in this world. As a rule, our medical staff and doctors are exceptional, they do everything humanly possible to help as many as they can. The problem is their hands are tied much of the time, because of funding. Doctors are forced to provide healthcare on the basis of most life-threatening leaving much preventive care undone.

There are many stories and examples, but one that comes to mind is an 11 year old granddaughter. She was swinging when her flip-flop caught on something that turned her foot backward, and stabbed a large sliver into the arch of her foot. We removed the sliver, and soaked her foot in epsom salt, but she was still not able to put her weight on it, and was still complaining of pain, so we took her in, and she was given antibiotics and told to soak in epsom salt. It was x-rayed, but nothing could be seen. Two weeks later, it broke open and another piece of the sliver came out. We took her in, and were told to soak it more. Since that time, it has healed over, but there is a bright pink lump on her arch, since June 2014. It is unfortunate that her foot is not priority. I don't blame Doctors, I blame funding.

My cousin was a diabetic on dialysis. He had trouble controlling his blood pressure and blood sugar, and when his blood sugar was finally stable; his insulin changed to a lower cost insulin, which made him sick, and caused his blood sugar to fluctuate again. Doesn't make sense to me. I understand cost cutting, but I think it's costing more in the long-term.

It is too bad that people who have gone thru years of training, and have the ability to help others in need are stifled by pharmaceutical companies, insurance companies, and government budget cuts, which prevent them from doing what they have devoted a great deal of their lives of training to do. Unfortunately, that untrained people that control pharmaceutical companies, insurance companies, and government representatives, who have not taken an oath to save lives, have so much control over our health.

It is my intent in this letter to voice my concerns, and do also ask that funding that in previous years has been subject to budget cuts, be restored to our IHS facility. Surely, funding services that have been in place providing services to their patients is at least as important as paying representatives of the people to force us to pay more of our earnings to our insurance companies for health and drug insurance, and giving them control as to where, when, who, and how we can be treated; which medications we receive, and what cost. I don't often seek medical treatment, I have never been able to afford medical insurance, but if I do ever seek medical attention, I prefer a Doctor to an insurance agent, or a drug manufacturer.

Yours Truly,

GEORGINA J. RED BEAR

Please, Please, read the grievance below and remember the dates are wrong but major issue is I was in a middle of an emergency and just brought my brother home few hours prior to the leave request that morning prior to start of my tour of duty to transport him to the IHS Hospital/primary care provider to re-do his labs due

(hyperkalemia) and then re-assess him. Had that had happened like it should have I truly believe he would still be here. Everyone is telling me the opposite but he was only 47 and didn't my assistance prior to this incident. But because the supervisor had sent the upsetting text refusing my leave request my brother's attitude who was initially cooperative had took a turn and adopted the "I don't want to be a burden" theme and told me to leave him alone! he is fine! and denied all requests to go the hospital. Later that night, I called the ambulance he complaining of SOB and died in the ambulance. We were very close and I am in therapy praying for some type of closure. They didn't give me a new supervisor like I requested and forcing me to answer to her again without even an apology has made me angry. People in support of me said it would not do any good because it would not have any sincerity in it. I am very hurt and do not want to work here anymore under such inadequate supervision and taking it day by day hoping another job will appear soon that I would be able to apply for. Please make sure all supervisors are academically trained and up to par with their positions so a similar situation does not re-occur.

Sincerely,

CHARLENE M. JANIS,

From: Janis, Charlene (IHS/ABR/RCH)

To: Bruce, Pauline

Subject: RE: Stage 1 Griveance

Pauline,

Thanks, I am so grateful and yes this my first day back. not the same! The dates need are what you said but other than that very true and I will keep in touch Pauline. A quick mention I am wondering if other supervisors are up to par with sick leave requests and able to recognize serious health conditions. I have a husband and with a defibrillator need someone like Lynn who competent to address and any serious issues with should they arise.

I read that is Sioux Sans responsibility to ensure all supervisors are to be competent in everything and can be held liable for their misconduct one for making false statements via email or text or not recognizing serious medical condition a violation of the FMLA act.

Thanks,

CHARLENE M. JANIS

From: Bruce, Pauline

To: Janis, Charlene

Subject: FW: Stage 1 Griveance

Charlene: Providing you a copy of what I submitted (see below). I may not have dates correct but that's ok. I didn't want to make you go over the whole event again but I did state on or about so that leaves it open. I did not want to miss the timeframes so went ahead and filed. I will be away Monday and Tuesday next week but hope to touch base with you when I return.

Let's see where this goes. Again, I'm so very, very sorry for your loss.

Keeping you in prayer,

PAULINE BRUCE

From: Bruce, Pauline

To: Alberta Bad Wound, Lynn Pourier

Subject: Stage 1 Griveance

Importance: High

Grievant: Charlene Janis, Medical Records Tech

NATURE OF GRIEVANCE:

On or about December 6th, BUE, Charlene Janis, requested leave to address an emergent issue with her brother's health. BUE, Charlene Janis is the custodian of said brother and is responsible for his care. Ms. Janis shared with her supervisor the critical health issues concerning her brother. Ms. Janis requested leave and supervisor denied and stated that she would be AWOL. Following that event BUE, Charlene Janis went to meet with supervisor to take in documentation of brother's discharge from hospital papers to verify the seriousness of his illness, brother was to go back the following morning. Supervisor was no where to be found to get approval and employee ultimately had to seek approval from second line supervisor, Lynn Pourer who approved leave without pay. BUE, Charlene Janis, was emotional, distraught and severely stressed and wanted to ensure that she received approval prior to being out of the office. Supervisor, Alberta Bad Wound, showed no compassion, concern nor did she offer her availability to assist BUE during this critical, emotional time. Brother of BUE, Charlene Janis passed away on December 7th, the following day in which employee was attempting to secure leave approval. BUE,

Charlene Janis at this time is grieving the loss of her brother and the added emotional stress she was put through by her supervisor.

Supervisor Alberta Bad Wound has violated Article 1, Section 7 and Section 16.

SETTLEMENT DESIRED:

1. BUE, Charlene Janis be assisted with processing appropriate paperwork and approved for the Leave Share Program. Notification of approval of Leave Share be sent to all employees within IHS to seek leave donors to address the period of time in which BUE, Charlene Janis needs to be away from duty during this period of grief and time of healing.
2. BUE, Charlene Janis, be referred to Employee Assistance Counseling to allow her time and the opportunity to meet with a grief counselor. Time allowed to attend counseling will be in accordance with policy for EAP Counseling. Use of Official Time.
3. BUE, Charlene Janis be assigned under the direct supervision of Lynn Pourier, the second level supervisor who showed real compassion and concern for the BUE during this difficult time.

Respectfully Submitted,

PAULINE BRUCE

Senate Committee on Indian Affairs
 ATTN: Amanda Kelly
 838 Hart Senate Office Building
 Washington, DC 20510

Unprofessional workers, rude referrals. I made several trips to the ER, then it's too late. Ain't able to get an appointment, do not give pain medications. Lying about break of pain contract, don't diagnose the right treatment, get the run around.

Sincerely,



Akilitta
 P.O. Box 602
 Faith, S.D. 57626

Senate Committee on Indian Affairs
 ATTN: Amanda Kelly
 838 Hart Senate Office Building
 Washington, DC 20510

TO WHOM IT MAY CONCERN:

My name is Emery Long I am a member of the Cheyenne River Sioux Tribe which is in the State of South Dakota I am 51 years old. I am writing a statement about the care and treatment I was given at the IHS in Eagle Butte, South Dakota three years ago. I had my first heart attack I was not sent out to a larger hospital instead I was given pain pills and sent out the door. The following day I had another heart attack they checked me over and stated I did not have a heart attack. They did lab work but nothing came back proving I had a heart attack instead they gave me a bottle of nitroglycerin sublingual tablets and sent me back out the door again. On the third day since my first attack I had another heart attack this would be my third attack they kept me in the emergency room for a long time. My mother came to the hospital and was very upset about the way I was being treated at the hospital she told them to send me out. So after my third heart attack I was sent out to a bigger hospital. IHS hospital still did not detect any symptom of a heart attack they kept saying it was something else.

I was put into an ambulance and sent to Rapid City hospital on the way out the ambulance crew stopped in Newell at a gas station. The driver went in got himself pop and chips taking his good old time while I was in the back with a heart attack. I finally had to tell them we need to get going. So we left.

As we arrived in Rapid City they took me to the emergency room at Regional hospital right away they took blood from me and send it to the lab. The lab personnel return with their findings and found evidence that I was having a heart attack all that time. I was sent to operating room right away then they took care of my heart problem.

The referral process is a mess at Eagle Butte IHS if you know the person that is doing the referral or if you're a friend or relative you will get sent out. If you aren't you are not getting sent out.

The Contract Health personnel need to be removed. They are always given Tribal members a hard time about getting their medical bills paid but if you're half white it gets paid no problem. This has been going on for a long time.

Some elders have told me some of their complaints about IHS in Eagle Butte. This elder stated she came in for clinic she came from out in the districts about 70 miles away. She was in the clinic exam room waiting for the doctor to see her then the doctor never came so she just left.

Another elder came to the clinic to see a doctor. She was in the waiting room or exam room waiting for Doctor. When the doctor came in she said the doctor told her to go home and take a shower you stink. The doctor did not see her.

Another elder woman came in for clinic. She was waiting in the exam room when the doctor came in she had her file in her arms she was reading it. When the doctor finished she looked at the elder and told her she was too complicated to deal with and left the room. The elder woman had heart problems she left without being seen.

These are some of the things that have happened at the IHS in Eagle Butte, South Dakota. I feel there has to be some major changes in the way IHS is running things. There has to be some kind of help coming from the outside. This has to be done otherwise people are going to die when they don't have too.

This is my statement.

Emery Long
211 4th Street #46
Dupree, South Dakota 57623

Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Dear Senate Indian Affairs Committee Members;

Greetings, I am Pansey Boysen, a 79 year old Elder residing in Isabel, South Dakota on the Cheyenne River Reservation.

I have been in the hospital several times and called Indian Health Service to assist me financially in paying the (attached bill) that I'm sending to the Committee on Indian Affairs. New paragraph

I have presented this bill to the Indian health service and they have refused to pay this bill. I do not bother them anymore as I know what the answer is.

Please if you can assist me in any way and taking care of this bill for me I will be very grateful for any assistance that you can provide me.

Sincerely,

Pansey Boysen
Box 75
Isabel, SD 57647

Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

TO WHOM IT CONCERNS;

I am Michael F. Red Fox I was born on November 18, 1951 at the Old Cheyenne Agency, South Dakota. I have been here at the Cheyenne River Health Center in Eagle Butte three times since December 20, 2015. I have told the so-called providers about having Hepatitis C and that if necessary to refer me out to a clinic or hospital that will provide me with the proper medication to rid myself of this Hep C. There is not a damn thing has been done to take care of this from the IHS or the so-called providers here at IHS in Eagle Butte.

Ho Hecetuyelo,
Michael Red Fox
Isabel, South Dakota 57633

To whom this may concern:

I attended a meeting at the Isabel Manor in Isabel SD on 2/28/2016 where Bryce In The Woods explained that the CRST and the Senate Committee on Indian Affairs were seeking testimony from Individuals who had bad experiences with the Indian Health Service.

I will speak for 2 of my siblings who no longer have a voice. They have since passed on and I believe it is because I.H.S. didn't go far enough to help them.

First is my brother, Jim D. Anderson.

In 1988 to 1989 he had gone in for help with internal pain in his abdomen and was repeatedly given Maalox and sent home and at one appointment I had gone with him because I was very tired of this and had asked the Dr why no test were done.

He (the DR) became very angry and told my brother he could just go to the bar and buy a jug and he would be just fine!

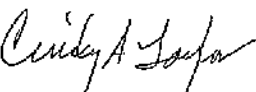
At this point I moved with my child and my brother to the Lemmon SD area, at which time my brother made an appointment with the clinic in Lemmon, which I might add I paid out of pocket for, and it was found that he had a Blood sugar of over 1200 and pancreatitis!!!!!! He was admitted to West River Hospital in Hettinger ND. My brother would have

lost his life if we had stayed on the rez and used I.H.S. It is bad enough we lost him 6 years later, but just think, A SIMPLE BLOOD SUGAR TEST!!!!!! Could have saved us more years with him. He passed away 10/15/1996, age 42.

Now my sister, Georgia L. (Taylor) Little Shield who was a great asset to this darn world! She was diagnosed with uterine and ovarian cancers in 2000, then Lupus after that. She had surgery and for years after, although the cancer never returned, she was always in pain. She was never treated for her lupus.

She was always left in the clinic room for HOURS! I had asked her to report it. She said no one would listen when she did. She was always in so much pain. At the time of her death she was on 37 (37!) different medications and I do remember her telling me she had 4 different blood thinners. WHY? She bled to death at home on 4/24/2012.(internally). This should not have happened. She was only 52 yrs old.

She could have been treated better if she would have access to better Doctors! But because we don't have health Insurance this is what we are stuck with. I.H.S. and there workers who didn't treat any of my family or people with the respect they deserved.

Cindy A. Taylor 

O.O. Box 183, Isabel SD 57633, 605-466-2216

Senate Committee on Indian Affairs
848 Senate Hart Building
Washington DC 20510

TO WHOM IT CONCERNS:

I became ill in 2001 I was diagnosed with chronic pain syndrome and fibromyalgia and chronic migraines I was sent to Mayo Clinic in several doctors throughout Rapid City, Bismarck, Pierre and Mayo. I was diagnosed I continued my treatment through IHS my main doctor has been Black Hills neurology Dr. Stephen Hata.

When I go to IHS they don't consider me a priority one and do not send me to my neurologist so I end up having to go either to the clinic or the ER. When I go to the clinic they cannot treat me because of my pain and they end up transferring me to the ER when I go to the ER they feel it's not an ER visit and they get frustrated with me Dr. Hata has written me a prescription of medications to be used in the ER that are not available to me that IHS will not provide. Although Dr. Hata has written the pain committee and requested these be on hand several different times. He has also written to the pain committee the type of medication that I should be taking in has put in request for each type of medication that I should be taking as per what they have requested and each prescription that he is put in for I've also been denied and they have refused to fill so when I do become ill with my illness they cannot treat me in the clinic and I cannot be treated properly in the ER and I have nowhere to go for medical treatment yet they will not send me out to see the neurologist as a priority one to get the proper treatment that I need Dr. Hata has suggested that I need pain blockers every three months which they will not give me he is also suggested that I need Botox to stop the chronic migraines which I have 3 to 4 times a week which they have denied and I'm constantly live in pain I'm allergic to incense and Tylenol products my only choice then is tramadol that Dr. Hata prescribes me which I have to call out to him to get a prescription that he calls into pharmacy and I get 15 a month or as needed which I called in 15 and the last five months as it causes me to itch and I have to call act with Benadryl and I do not like taking them I don't have much choice as far as pain medicine is concerned if I was getting treatment for my migraines I would not be blocking the ER. I just go back there cause I have no where else to go.

We need to be able to have medical facilities that we can go to that can provide care for us that we have a place to go to that we can get prescriptions that we need doctors that we can see that we can have medical care. Because of my condition I have been unable to work I worked as conservation District manager I worked solely for the Dupree news as a reporter as a photographer I work for the Dupree school district I was an active role in this community and because my condition I have also started having seizures I'm not unable to drive and because I cannot have treatment I can't work therefore I can't pay medical bills therefore IHS is my only way of getting medical treatment If I cannot afford medical care and if they can't help me who can and if they will not let me see doctors and get treatment how am I to get better to get a job I am capable of working of being an active role in my community if I am given the proper medical treatment so I am asking this community to take a look at how we are being treated in if given the proper care we can move forward as a people and make IHS work if given the proper funding and facilities. Thank You.

Sincerely,

Sherry Lou Higdon
P.O. Box 574
Dupree, SD 57623

Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

About 3 – 4 years ago, I got a Q-tip stuck in my ear. A male P.A. and Nurse mistreated me. The Nurse was really rude. A few months later, Peggy Hubbard got it out. They tried using forceps, and they treated me like a kid. "Don't you know your not supposed to stick Q-tips in your ears?"

During Diabetic Clinic, she said she left it in the ear. Somehow she got it out. She put solution on the right side, I went back again, it was very painful. She stuck me on an I.V., and she didn't take care of me. They referred me out to see a Dr. in Rapid City, and the Nurse was rude. All over pain pills. They said "oh, you don't need any pain pills." I lost my hearing on my ear, and the records will show that. Those people who treated me are no longer here.

Sincerely,



Carmelita Eagle Chasing

PREPARED STATEMENT OF KIROS A.B. AULD

My grandfather was an Urban Indian living and working in the Washington, D.C. area, hailing from a non-Federal Tribe. Despite his test scores, he was pulled out of school at the age of thirteen because "as a man" it was time for him to "pull his weight" for the family and he was the darkest of his siblings. Outside of his unit in World War 2, you wouldn't have heard of him from deed or song. An old man working odds and ends, he found a sore on his foot that would not heal. Left untreated, gangrene followed, resulting in the doctors taking his foot. That wasn't enough to save him, so the doctors took more of his leg. Soon, the illness took his life. I don't expect people to care about what happens to Indians from non-acknowledged tribes, so maybe a recent example will make you reconsider whether this is your problem.

A family friend who, unlike my grandfather, comes from a Tribe that is acknowledged by the Federal Government, traveled to the Nation's Capital to serve his community at an agency that fulfills trust responsibilities to Tribes and individuals. Back home, he is eligible for services at an Indian Health Services facility. Here in DC, he's an Urban Indian only eligible for services at Native American Lifelines, the closest health/dental provider accessible, but located in Baltimore, MD. He isn't a "Big DC Indian," but he reports to a few.

Now stop me if you've heard this one before. One day, he found a sore on his foot. Left untreated, he passed out on his way to a convenience store and awoke at the hospital. The infection was so severe that he lost his foot. His youth saved him from losing more than that.

In a sense, my grandfather was the lucky one, because in death, he escaped medical bills and the hard, expensive road to rehabilitation. Our friend is in store for all this without IHS support, which he would likely only have if he leaves his DC job and becomes another statistic back home. Despite coming here to serve his people, despite the history of Indians being drawn to our Capital to serve their Nations, and despite the Indians buried in the Congressional Cemetery, our "Little DC Indian" friend isn't going to get a dime from Indian Health Service because DC is somehow outside the coverage area.

IHS was established to provide health benefits pursuant to Treaty Obligations that were bought, bled, and bargained for. Pursuant to self-determination imperatives that strengthen Tribal Sovereignty, IHS employees are often selected from the Tribal Communities receiving those services. After what I've seen for decades, after what I've heard from being a spouse and friend to IHS employees, and after the recent Senate hearings, I have to wonder then whether IHS treatment priorities from the point of view of those at the top concerns not Indians at the bottom, rather the "bottoms" of those at the top.

Don't get me wrong, I appreciate when IHS provides quality care. Hell, if IHS was there for my mother as a little girl with an untreated ear infection, she would prob-

ably wouldn't have ended-up partially deaf. I wonder why, if even during an election year of all times, the bosses in D.C. won't just spare a staff member and a bit of metro fare to Rockville to put eyes and ears on what's going on at IHS Headquarters. I also wonder, as someone who isn't a Tribal Citizen of an Acknowledged Tribe, whether that lack of status makes me rate higher than the people IHS purportedly serves.

Responding to an article about Senator Jon Tester's 2014 inquiries, I published a complaint about management at IHS HQ in Rockville, MD. I wrote in as "Opechan," a default online handle I've used for over fifteen years. You might be familiar with it as "/u/Opechan," founder and moderator of/r/IndianCountry, the most active Native American community on Reddit.com, the ninth most popular website in the U.S.

This triggered a witch-hunt at IHS HQ and people were more concerned about "who complained" than the substance of the complaint. I expect people to again get defensive and focus on everything except whether care for Tribes and Urban Indians is a big enough priority around DC or in general, or whether those trusted with deciding how to provide that care are actually doing so or just nurturing public sector kingdoms.

I don't write this as a Tribal Citizen or employee, I write this as a U.S. citizen who wonders why tax dollars that should be going towards satisfying Treaty Obligations instead go towards settlement and promotions of bad high-level managers. I've wondered why, just outside of the Beltway, bad actors at IHS HQ fail upward and benefit from grade increases for performance without their HR settlements being taken into account. I understand the value of having an "outside dog" to scare away bad actors, but one does not bring it in for guests, especially if it's bitten members of the family and lacks house-training.

Even if I wasn't Indian at all (and I am), would that make anything I, you, and yours have seen and said about IHS less true? Shouldn't this be easier for law makers to figure out, seeing as how it's happening just outside the Beltway? It's such low-hanging fruit; an easy win for an election year.

I honestly don't know and I'm nobody really, but have you gotten the sore on your foot checked out?

You should.

And it probably shouldn't wait until you can afford airfare if you live off-rez, as most of us do.

Public Healthcare Meeting—Cheyenne River Motel, Eagle Butte, SD.

After 4½ years of a broken ribs, broken arm, and a result of weak bones, I fell and fractured my hip and a lot of pain and without offending or violation of pain management contract was not getting proper care. Some of the nine different PA so - called Indian Tribal Cultural Dr., I am left in the air without help. I live in a very high level of pain, and I am changing my Medicaid to someone who'll help me. I was told these medicines won't help me, so they hold out on medications, and tape gauze bandages from which we might be healed for pejuta wica, restored and protected. I know my life isn't going to be prolonged in good health, for the rest of my day wondering what the native people will do now that I am a diabetic. My culture, and descendant come in with other Indian Priority I and II list.

ETHYLENE BUCK ELK THUNDER

1) We want Doctors that are able to do their job independently, without having another Doctor oversee them. For example, I had an appointment with my Doctor, Dr. McLain, then a Nurse came in and said "Dr. McClain is needed in ER, and he has to admit a patient." Why is my Dr. getting pulled into this? The ER Doctors should be able to work independently, and they can't. they shouldn't be working in the ER anywhere.

2) We need Doctors that know how to investigate with doing a complete physical, labs, patient history, etc. so that prompt diagnosis will happen. For example, it took June, July, August, and IHS didn't know why I couldn't walk. They just kept giving me pain medication after pain medication. Dr. Francine Mousseau yelled at me and my Mom because she said "None of my providers want to see you! I don't want to see you, and Dr. Kahn don't want to see you." I said I have IHS eligibility. Then she went on to say "the regional office said my hospital don't have to see you or help you." So people are being yelled at with no diagnosis given, wrong diagnosis, wrong medication, and being turned away.

3) More Doctors for optometry, physical therapy, and diabetes. It's hard to get appointments, and then the Dr. or Therapist seems like they don't know what they are doing.

4) Wrongful firing of people that are qualified to work there. Seems like they are letting a lot of “brown or dark-skinned” employees go, and sexual harassment to employees.

To the Committee:

I have worked as a clinical psychologist at IHS for sixteen years and at “638” tribal clinics for over three years. The problems identified by current and past hearings are accurate and, as you know, they persist. I would like to speak to the daily frustrations of treatment providers trying to provide good care to patients.

Most of the IHS administrators at the top of the organization may be competent, as are most of the treatment providers who provide direct patient care. Unfortunately for tribal patients, that care is impeded by too many layers of managers who have priorities other than the mission of the agency. These mid-level managers seem to be invested in maintaining the status quo, not in challenging it in the interest of patients. And they will target for harassment employees who do speak up about deficiencies. The performance evaluation is their means for intimidating and silencing employees. That practice also serves to force out good treatment providers who don't want their personal and professional reputations damaged by negative performance ratings.

I was gratified to hear the statements of Chairman Barrasso about the rampant intimidation and harassment of employees, nepotism, and moving incompetent managers around within the organization. I have witnessed these things for years. That is the culture in which we labor and which is so demoralizing. I'm at a point where I do not believe anything will change for the better without a dramatic re-organization and elimination of several layers of bureaucracy. The dollars saved could be re-directed toward paying for needed services for patients.

Thank you for your continued efforts on behalf of Indian people.

Respectfully,

LOUISE CENATIEMPO, PH.D.
Licensed Clinical Psychologist

My name is Stanley Brokenleg from Parmelee SD last August my Mother was taken by ambulance to the Rosebud PHS we noticed she wasn't feeling well she was be incoherent the first ambulance trip the error staff send her home with pain medication the second time we called the ambulance 4 or 5 days afterward she was send home a Dr Hahn claimed she was too old to treat and sent home. We called the ambulance for a third time after an exam the er. Flew her out to Rapid City SD regional hospital because she was too sick to admit. To rosebud phs. From 10-20-15 she lay at the RC regional. She was diagnosed with mersa. She was treated with antibiotics until 11-09-15 twenty days the antibiotics did not work so a regional Dr. Started a larger dosage of an different antibiotics this worked after 15 days but by then my mom was weak she could not eat she went from about a 100 lb. To maybe 65 lbs.the Dr. At RC regional said we should put her on comfort care. Remember this was 35 plus days at R C regional they gave up on my mother the dr. Recommended taking her off all medical resources we could only pray after that her spirit was well. But to our amazed family mom started coming out of of the limited consciousness they had her in. She is alive but in a nursing home in Rapid City SD she is getting better and stronger every day . All together she spent 40 days at RC regional the Rosebud PHS was responsible for this great hardship on our family if they only took the time think of my mother as human. They should have made a decision to send her out instead of having to make my mother suffer. My mother is Grace Broken Leg born on 2-14-1926

My mother walked 5 miles a day up until august of 2015
 It has crossed my mind tho sue IHS for the hardship I and my family's experience caused by the great errors with Healthcare.
 Sincerely. Stanley Broken Leg

I participated in the 2010 hearing by cooperating with the investigator Senator Dorgan had to Indian Health Employees and Indian people who used the services. I was employed at the Winnebago Indian Health Service Unit until May 5, 2015 where to repeated emails to supervisor and up the chain on the poor care given, and nurses who failed to carry out the doctors orders, and that I had a license which prohibits me from taking & carrying out nursing care from unlicensed persons, such as a Dentist, Pharmacist.

I blew the whistle after numerous attempts for upper management to correct the unsafe practices, but was ignored, I contacted CMS after the dead of the male patient who died April 2014, I let all know I was going to report for the negligence in the poor care that resulted in the death of the 35 year old male.

I even let the Great Plains Area Director Ronald Cornelius know through emails. End result I was fired for making or scheduling clinic appointments so all and any patient can access care. I also responded to an email that was sent out by the Dentist that included all medical and nursing staff. I asked 2 questions, I did leave the email as it was sent out which all who were included in the email seen my questions.

Many at the facility did not know that Dr. Rodriguez was a Dentist who had no medical privileges and could not write orders or perform direct medical care on patients.

I also sent Robert McSwain and email, and the corp officer who came to the meeting held on or around June or July in Sioux City Iowa. It did not matter, because I took my oath of employment serious to uphold the oath and the laws I was fired, to be made an example as stated in my termination letter.

Why is it that the agency has fired federal employees for upholding the oath of office and supporting the constitution and state and federal laws have to waste government money to go to a EEO or MSPB hearing?

Tonie Greve RN had several exceptional PMAP, no problems other than sending email concerns about patient safety, and following the chain of command, only to be fired for bogus allegations of making clinic appointments for patients to access care, no federal or state or Winnebago regulation, policy violation? Why not give back my job as a clinical nurse who did great work performance?

Janet Uheling RN who had nearly 25 years of clinical nursing experience, great PMAP ratings. She did nothing wrong, she saved the gentleman in April 2014 who was severely ill, did patient advocate, got the permanent medical provider to come to the Emergency Room to see and treat the patient. The patient died 4 days later, but through no wrong doing of Janet Uheling RN. Karen Riser fired her for not documenting the results of a nebulizer treatment results, which had good results, as patient was admitted and alive, until the other nurses failed him on the inpatient unit for giving poor care, and not contacting the medical provider per parameters, and for failing to give standards of care, and notification of patient's health deteriorating.

Mr. Robert McSwain stated he did not want to discuss due to employee rights and privacy rights, but I am Tonie Greve and I am the named representative for Ms. Janet Uheling RN.

Karen Reiser was paid bonus and she failed to fulfill her job requirements, and performance. Trina Cleveland paid bonus she failed to fulfill her job requirements, Dr. Jose Rodriguez Dentist a commission corp officer who failed to fulfill his job duties and performance below standards. Mr. Ronald Cornelius knew of these problems yet ignored due to his personal friendships, instead of doing a complete unbiased investigation, instead he had the federal employees who upheld their oath of office fired instead of correcting the substandard care and poor job performers who continued to keep job after failing patients with standards or above standards of care.

I want my job back, and my name cleared, and just work as I took the oath to uphold. Janet Uheling wants her job back as she did not violate any policy, regulation, but saved a patient, The nurses who failed the male patient still have their jobs, and still giving poor care at the Winnebago Indian Health Service Unit.

This request is not abnormal, but seems fair request as I have had exception PMAPs, came to work daily, performed all duties required as a qualified nurse. I did leave and get a job in the private sector as a higher ranking and management position as Assistant Director of Nurses and helped that facility win awards for Standards of Care and participated in CIMRO standards, along with great plains but in the private sector. I left this job as I want to serve the Indian People as I am an enrolled AMERICAN Indian. I am willing to relocate if it is due to having family members in several of the Great Plains Tribes. I am asking for location in Pheonix area as I know no persons, have no family member in that area. I am willing to drop the MSPB hearing.

Mr. McSwain has the information, and e-mails that I have sent to him and to the members of the Indian Senate Committee members.

After reviewing the whole senate hearing that was conducted 2/3/2016, I have to write this letter.

1. Master, Bachelor, Medical Degree means nothing if you dont have the experience, this is the problem when hiring medical personnel.

2. When there are qualified staff hired with experience and want to implement positive change, training they are ignored, and told "No".

3. When a medical doctor, PA, NP tells a nurse to carry out an order, but they refuse, that medical staff should be able to write an complaint, and that nurse no matter who he/she is or related to should be disciplined immediately. Given training if they don't know and PIP for year to make sure the mistake does not happen again. In 2004 that was the policy when I started at the Agency, and believe me it took only 1 mistake, then I reviewed all the policies, regulations. I never repeated the mistake again.

4. If you don't train properly, or nurses refuse to attend trainings then they should be let go, as they are part of the problem. Same for Medical Staff. Medicine changes each year sometimes more rapidly.

5. ER/LR need to have medical background or the training so they will know if a staff is upholding the medical license they hold, rather than being called insubordinate. This will help determine if deliberate mistakes, or refusals to go outside scope of medical practice/license is prohibited.

6. Supervisors who have clicks and know that some staff refuse to fulfill the vision & mission but turn blind eye. Remove that supervisor don't promote or move to another facility. (Karen Reiser, Trina Cleveland, Miguel Fernandez, Jose Rodriques, Samir Joshi, Nancy Freemont, Deb Saunsoci) to name a few.

7. Nurse Educator is given more authority to issue letters to employees who fail to attend mandatory trainings, and give to supervisors to issue discipline, if that supervisor refuses the Nurse Educator is given the autonomy to go to the next in line to have that supervisor disciplined for failing to adhere to the vision & mission.

8. Transparency, meaning real transparency where one can report without reprisals. This was how it was back in 204 at Winnebago, but changed after 2012.

9. Allow all medical staff to be allowed medical training. (each year money was put aside but only a few were allowed) if all medical staff given opportunity to further education and return to give the training to others will retain that education and shared with others. THis was how it was handled back in 2004 at the Winnebago Facility. It stopped in 2009. This would show how well funds are being spent.

10. PMAP should be made each year that represents the Job Description of each individual, each department they are employed in. Right now the PMAP are generic and some if they have friends in supervisory positions get rated above the standards, which do not reflect the actual job performed.

11. Show employees who go above and beyond recognition, not the same employees over and over who get preference because of friendships.

12. Annual in person training from Great Plains ER/LR and Human Resources on expectations, regulations, policy. Doing computer training which can be falsely done is harming the education purposes.

I was preceptored by Gloria Thomas who is a great nurse at winnebago who was a supervisor who made sure all under her supervision was taught and educated upon hire and every quarter for the first year. I am only a product from a mentor who loves the medical profession, loved the supervisory position and fulfilled the vision & mission at the Winnebago Facility. I was one of the original nurses trained in this manner, and only expected others to follow.

13. when a nurse is the charge nurse (why have supervisor) who sits in an office and not come out to the floor to see what is going on, what needs attention for patient care, flow of clinic, what needs other areas need for nursing staff. Give that charge nurse the autonomy to fulfill her duties assigned to help with patient care, patient flow, patient safety.

I hope I did not submit too much information on how to correct the problems.

Sincerely,

TONIE GREVE, RN

In 2010–2011 I was experiencing fatigue and heart flutters as well as continuing to gain weight. Being tired constantly I thought maybe I could be anemic, making an appointment to have my iron level checked at the Eagle Butte Indian Health Service Out-Patient clinic. Kathy Zambo my provider listened to my symptoms then had blood drawn to see where my levels where.

Later that evening she called, informing me that my iron levels were within normal limits. She also stated that my thyroid was functioning at a 0.00. She informed me that she would be submitting a referral to have me visit with an Endocrinologist in Bismarck. I was then referred to Dr. Ahmed.

At my first appointment in Bismarck Dr. Ahmed performed various tests on my mobility as well as examining my thyroid. He concluded that I most likely suffered from Graves Disease and would be providing me with medication that would hopefully kick start my thyroid back into working order. Taking the medication (methamazole) for about 3 weeks I experienced an allergic reaction to the medication and was immediately taken off and prescribed another medication that is not for long term use as it begins to affect white blood cells and can affect your liver. I took the medication for approximately a year before being scheduled to undergo thyroid ablation with radioactive iodine.

After the radiation treatment I was scheduled to return to check my thyroid levels every 4–6 weeks in order to begin the replacement hormone for my thyroid. On the 3rd month of having my levels checked there had not been any change, Dr. Rauta stated that at the next test if it continued to not level out I would need to undergo another radiation treatment.

Finally, my thyroid began to respond after the third or fourth month and I was placed on a high dosage of the replacement hormone. Dr. Rauta wanted me to have my levels checked every 4–6 weeks again to ensure that I was being prescribed a proper dosage. In requesting the needed referrals I began to experience denials from Contract health stating that I could be seen within the IHS clinic by other providers

one being Dr. Siddiqui who eventually stated that he felt I should continue my follow up appointments with Dr. Rauta in Bismarck as he is the physician who ordered the radiation treatment and knew my case the best. My referrals were continued to be denied.

In the beginning of taking the replacement hormone I was prescribed a 150mg tablet but over time it was gradually reduced due to my thyroid reacting positively to the radiation treatment. I have not requested any further follow up in Bismarck as my symptoms have been steady at the level I am taking now which is an 88mg table 6 times a week.

JACKIE DUNN

Felix Johnson Indian Health Service Testimony:

Amputation through HIS:

4 to 5 years ago I was dealing with health issues relating to diabetes. Specifically, I was having an issue with an infection in my toes. I have always received care through the Indian Health Service and they were and are my primary care givers. This testimony relates to the Indian Health Care's lack of care, compassion, and funding. Diabetes is a disease that affects the Native American population at an increased rate. If you are not aware this disease is a type that needs to be closely monitored to prevent additional complications in the body.

Originally, went in to get my toes amputated based on my diagnosis. I was referred to a Fargo hospital through the Indian Health Service. I traveled to Fargo and the doctors amputated all my toes. At the point of discharge the Fargo hospital called the Indian Health Service for essential care items that I needed and the Indian Health Services informed the Fargo hospital that everything was going to get taken care of and a wheel chair would be there at discharge. At the time of discharge Indian Health Services did not have the wheel chair for me, and my son had to carry me from that point on. I continually requested a wheel chair and I ended up waiting for approximately 6 months for the Indian Health Services to issue me a wheel chair. That wheel chair was essential to my care and recovery. I was again referred to Fargo and they amputated more on my foot and Indian Health Service was to care for my discharge needs with a nurse. Indian Health Service did not have a nurse to care for me and told me their nurses were only educational nurses and so I was referred out to the local hospital for nurse care. The lack of care from the Indian health service continued throughout my amputations and due to lack of care, compassion, and funding I was not able to engage in rehabilitation services and now my muscles were in no shape to recover from the time spent without a wheel chair and needed nurse care. I continue to receive bills that are not being paid by the Indian Health Care Center and many have gone to collections. I am disappointed in the care I receive from the Indian Health Care Services and would like the issue looked into. Many of my elder relatives friends are also not being properly taken care of. The many doctors that come in and out are not consistent for proper care.



Felix Johnson

To whom it may concern:

My name is Willard Black Cat. I am an enrolled member of the Oglala Sioux Lakota and have resided on Pine Ridge Reservation my whole life. I am an elder, now presently in the hospital in Rapid City, South Dakota. A close friend, who is

my medical power of attorney and has been supporting me during recent surgeries, is writing this letter for me (Rev. Janet Weber).

I have many complaints over the years about my health care at IHS. I am diabetic and an amputee. It is a hardship for me to even get to the hospital, where I have to wait many long hours to be seen by a doctor. Sometimes I even have an appointment and when I get there I am told the doctor is not there, so I travelled for nothing. Sometimes I am there all day with no food, then it is very late and the CHR people have gone home and I have no ride home. I am an amputee and have no car.

Some of the doctors are nice, but almost every time I go to the hospital for a check up, I get a different doctor, sometimes they don't speak English too good. They don't know me or my history. All my friends and relatives have the same complaints about IHS. Every month my medications change completely. I got very sick on some of the medicines. Some affected my mind and I became suicidal and was hospitalized. My diabetes medicine Metformin got me sick too. The needle injections in my stomach made big bruises and hard lumps. Finally I got the easy 'pen' insulin, but then I was told to stop using this too. The medications change all the time and it is confusing. Also, the medical transport van to dialysis and the hospital sometimes does not show up. A few times also I fell in the van and broke ribs because the drivers do not always help me get in and out with my wheelchair.

The most recent problem I had was with my foot, which started over the summer of 2015. I went to the hospital a few times with pain. They gave me ointment and gauze and sent me home. Things got really bad and I went to the IHS Pine Ridge Hospital in an ambulance and a few other visits. They wrapped it and sent me home. The pain was so bad I could not sleep for weeks. Why did they not give me a referral to a doctor in Rapid City? This finally did happen. I went to a doctor specialist in Rapid City on Jan. 8, 2016. He told me I now had gangrene and I would need an amputation. (I lost my other leg last year 2015).

I am now in Rapid City Regional hospital since early January. I had stents put in my leg and they had to amputated all my toes and graft my heel. Why did Pine Ridge IHS wait so long—they never helped me and now I lost part of my foot. Here is a picture of my foot when I got to see the specialist in Rapid City on January 8th, 2016. Pine Ridge IHS saw this earlier and did nothing. This is malpractice if you ask me.

I have applied for residency in the new Oglala Sioux Lakota Nursing Home that is due to open in White Clay, Nebraska in April. I pray to God that this place will be giving us elders the good care that we need, and will be better than the IHS Hospital.

Thank you for trying to fix this broken situation—the Lakota people have suffered enough for too many generations.

Yours Truly,

WILLARD BLACK CAT

This is my son, Eric Dickson Keefe. (Pictures retained in the Committee files) The IHS RN Debbie Knispel, who was publicly seen barging into my private home, before the FBI or CI even had a chance to get their to conduct a homicide, spat out at me preniciously, "It was just a baby!!" Due to Debbie's visit I was forced to settle; rather than go to court. Without a warrant Mrs. Knispel conducted an illegal search, seized an item that was in a closed cabinet, tampered with it, demanded my bodily fluids (and certainly would have provided herself with the opportunity to tamper with that), falsified the medical records, and generally impeded a homicide investigation!

My son was sent to the mortician and procedures were preformed potentially loosing evidence before he was sent to autopsy. I still have some of Eric's blood that may be tested for any medications. I also have the dress I was wearing when Eric left this world. It has not been washed and is stained with his breast milk that kept coming during the hours he was dying. It may be tested for anything in my system. Dr. Lehman was upstairs and did not come down during the time he knew Eric was dying. Why did this so-called good man not come down? Instead, he sent a spy posing as a mourner to come prey upon me; not to pray with me.

Is it standard practice for an Indian Health Employee to come into our private homes (uninvited) during a time when evidence should have been secured by the proper authorities?! Dr. Douglas Dixon Lehman, the doctor who had performed Eric's circumcision and then immediately released us with no post period of observation, wrote to me encouraging me to continue to speak to Debbie.

For it not been for Mrs. Knispel's visit their would have been no reason for me not to go to trial. I did not go to Rosebud Indian Health Service in the mistaken

belief that I was engaging in "welfare". I went believing that according to the Ft. Laramie Treaty and Snyder Act that health care is what we got in lieu of the millions of acres of land and mineral rights given up.

I have been pursuing an attorney; to no avail, to pursue criminal charges against Mrs. Knispel. I was told by one, "I litigate for money; not the moral high ground." The fact of the matter is that I can prove some of Mrs. Knispel's lies, which is immensely disturbing and spiritually repugnant.

To make matters worse Josh Verges of the Sioux Falls Argus leader published the following article:

No where in any legal documents filed by my attorneys does indicate that "Once discharged, his mother gave him Motrin and Tylenol for the pain." I made a request to Mr. Verges and the editor of the Sioux Falls Argus Leader to retract this story...they never did. Mr. Verges let me know that since I did not speak to him he had to explain what happened. What he wrote NEVER occurred. This is a slanderous and libelous news story, which is detrimental to all boys being circumcised and all patients at IHS. I am working towards all beings having affordable, honest, quality, and accountable health care. Why did Mr. Verges fail to explain how Dr. Lehman breached the standard of care? IHS is using his news story to bolster their faulting me.

For almost everyday since June 19, 2008 I have either sat in the Evergreen Cemetery in Wood, SD or driven by it begging my God for some truth and justice. Eric's earthly suffering and death should not be in vain. Something good should come from it.

I beg of you to look further into what happened to my most precious to overcome this iniquity. Something has to be legally done about that RN and to provide for the integrity of the investigations of these deaths, so justice may prevail.

Sincerely,

MRS. MARY AURELIA KEEFE

Rosebud South Dakota couple files lawsuit over circumcision death

Category: Crime, Justice, Courts and Lawsuits, Pierre, South Dakota (AP) 10-09
A Wood couple has filed a lawsuit over the death of their 6-week-old son, who died after being circumcised at a hospital on the Rosebud Indian reservation.

The lawsuit filed during September in federal court says Eric Keefe was circumcised at Indian Health Service Hospital on June 13, 2008. Once discharged, his mother gave him Motrin and Tylenol for the pain. He died the next day of massive blood loss.

Forrest and Mary Keefe say in court documents the hospital failed to instruct them on what pain medications to give the boy.

The couple is seeking \$2 million from the Federal Government for personal injury and wrongful death.

Circumcision Death Case Settles for \$230,000

April 8th, 2011 by Dan Bollinger

Native American Boy Bleeds to Death

The lawsuit involving a South Dakota Native American infant, Eric Dickson Keefe, from the Rosebud Indian Reservation, who bled to death from a circumcision in 2008, was settled this week for \$230,000. The case involved an Indian Health Service doctor who circumcised the child at the end of the working day allowing for no period of post-surgical observation. Testimony showed the mother faced a long drive home on rural roads with other children in her care.

"This was sheer negligence and an ethical failure to consider the risk," says George C. Denniston, MD, MPH, President of Doctors Opposing Circumcision, a physicians' group based in Seattle, Washington, which assisted with the case. "Circumcision is unnecessary surgery, which the parents are never told holds a risk of death for their child."

Keefe bled to death during the night from his open circumcision wound in June, 2008. Medical professionals say that the loss of only two and one-half ounces of blood can cause the death of even a large eight-pound infant. "That amount of blood, just a few drops per hour, was easily hidden in the super-absorbent disposable diaper baby Keefe was diapered with," notes Denniston, "Parents are never told about that risk."

Doctors Opposing Circumcision has provided expert advice for numerous circumcision death cases. "Exsanguination, or bleeding to death, is hard to detect," says Denniston, "since the child slips away quietly, and no one wants to disturb what appears to be a sleeping child."

Death from circumcision is relatively rare, although a recent study estimates that around 117 children in the United States die each year from circumcision. "These

are entirely avoidable deaths,” says Denniston, “caused by a pointless surgery that the child would never choose for himself.”

Dear Senate Committee on Indian Affairs Panel,

As I am writing this, I am hearing a story on my local radio about the life expectancy of Native Americans in MT being 20 years shorter than those of white Montanans. I am thinking about an announcement at community gathering in Browning last year where it was announced that over 50 percent of mothers are using some kind of drug during their pregnancy. Over the past several months, my husband, a teacher at the alternative high school in Browning has been learning about ACE scores and that his students are disproportionately affected by traumatic events in their lives that have the potential to irreversibly alter their ability to cope with school, work, and leave them more vulnerable to acute and chronic disease. Our Native communities are hurting in disproportionate ways for which we can not expect an underfunded and under-resourced Indian Health Service to take the complete fall. I do believe that IHS is doing what it can with the resources it has. One of the few things that we are very proud of at Blackfeet Community Hospital, is our Baby-friendly designation status to assist mothers and families to get breastfeeding off to successful start. We are one of two hospitals in the state of MT to achieve this. IHS is capable of great things. It is capable of being a leader in Native communities to make lives healthier for Native people, but it needs significant resources and reform. I left the IHS for many reasons, but one of the main reasons being lack of good leadership and support at my local level. I dearly admired and respected our local leadership team, but many of them were terribly overworked and often not provided with the type of training and support necessary to successfully do their job.

I hope that tomorrow's hearing is ripe with ideas and support for improving this system. I truly believe that it has immense potential, but needs the support of the congress and the American people to demand that it is no longer ignored or passed over.

Senators Tester and Daines, thank you for being a part of this important committee and supporting Native lives and communities in Montana and across the country.

KIRSTEN KRANE

I am writing in hopes that there will be a thorough investigation into the staffing practices of the Phoenix Area Office. It seems as though the service unit I work at in Yuma, Arizona has plenty of funds to over staff and hire Commission Officers at almost 3 times the rate it would cost to hire civilians, who are just as qualified.

It's disturbing to know that the disregard for the patients who suffer the highest rates of amputations from diabetes yet they are being denied necessary health care because of lack of funds.

It doesn't take a Harvard trained accountant to do the math in this case. Every time I see a new Officer hired, I immediately think, "And we can't afford health care for the tribal peoples but we can afford to over staff and hire expensive Corp Officers." We have an over abundance of Nurses and Pharmacists who are also Commission Corp. The Acting Clinical Director is a Nurse Practitioner. We have been without a CEO: for almost a year now and a Clinical Director a year. This concerns me because the longer those positions are left vacant the longer it will take to fill them.

I need to mention that, a retired Corp Officer, Dr. Robert Harry, is kept on contract by the Phoenix Area Office to oversee troubled service units. Dr. Harry is often referred to as the "Cut Man." I was told he is used like a "Neighborhood Bully" to hone in on Native Americans, female staff members to create a "Hostile/Oppressive work place." I have to say he is good at it.

I have heard him say he is in his 80's and that made me realize that's why he repeats himself several times, forgets what he told you to do and makes management decisions based on gossip and hear say. I question the validity of his position as "Acting CEO" when he is on contract. He says he has authority to make decisions on staff matters. I know Dr. Harry is very partial to hiring Commission Corp officers but wont allow essential medications and referral services for the patients.

I am the Public Health Educator and I have not been allowed to spend any of the funds that were sent to Yuma from Portland Area Office. The funds are not part of the Yuma Service Unit budget yet I have not been allowed to order so much as a pen in almost a year. I believe, Dr. Harry makes certain that my job is difficult to perform without any supplies to do so. I further conclude Dr. Harry is trying to make my job miserable in hopes I will resign!

You can contact me in my office. I am an enrolled member of the Rockyboy Chipewewa Cree Tribe of Montana and I am an Indian Health Service Scholarship Awardee.

Thank you for any attention you can devote to the issues I have noted.

The "Good Ole Boys Syndrome" seems to be very active in the Phoenix Area.

Sincerely,

SARAH SCHMASOW BS, MS

The following narrative is, to the best of our recollection and records, representative of the problems our office has encountered in trying to receive payment for \$9,271.00 in medical services provided in September, 2015 to a single patient:

9/18/15: A patient was referred to Scott Eccarius, MD through the Rapid City Regional Hospital (RCRH) Emergency Department (ED). He received a call that Friday morning at 0650 to consult on the patient in the ED. He saw him and determined that he needed surgery to repair multiple lacerations involving the patient's left eye and left upper and eyelid from multiple stabbings earlier that morning. Patient also had 20+ non-life-threatening stab wounds elsewhere.

Dr. Eccarius spoke with the patient's father by phone that morning before surgery and received consent for treatment as the patient had significant injuries and ethanol intoxication precluding obtaining informed consent from the patient.

Patient was prepped for surgery and underwent 4-5 hours of surgery to repair an extensive scleral laceration, full-thickness left upper lid laceration and full-thickness left lower lid laceration.

Dr. Eccarius spoke to patient's mother right after surgery and explained what we had done and the profound nature of her son's injuries.

Patient stayed at RCRH overnight and was discharged by Dr. Eccarius the next day (Saturday).

9/21/15: The patient was, apparently, an enrolled member and eligible for IHS services. We called Sioux San IHS Hospital to determine if we could get a purchase order for the above services. Our office was told by Loydell at Sioux San that they would have to speak with the patient. Called the number we had for patient. We talked to a family member about the importance of getting patient to Sioux San to get the purchase order for care.

9/24/15: Patient returned to the clinic for a post-operative check up. Dr. Eccarius recommended that the patient be seen by a retinal specialist to care for the left eye, as to avoid developing vision loss in the right eye (sympathetic ophthalmia). The window of time to eliminate/reduce the chance of that developing is roughly 14 days from the time of injury. The 'clock was ticking' and we had no success in reaching the patient.

Patient was advised of the need for him to go to Sioux San to sign the necessary paperwork for the purchase order. He said he was going to try to get a ride.

9/28/15: Patient was a no-show to the appointment with the retinal specialist. Patient was called by our office as well as the retinal specialist's office to reschedule. He rescheduled for 10/05/15. Again, we stressed the importance of checking in with Sioux San so they could authorize a purchase order, as well as the importance of keeping his appointments.

10/5/15: Patient was again a no-show for the retinal specialist's consult.

10/7/15: Dr. Eccarius sent a certified letter to the patient's last known address detailing the missed appointments, the need for making these appointments, and the need for making contact with Sioux San.

10/20/15: Received the certified letter back marked "attempted not known". Eccarius Eye Clinic billing staff called the motel where the patient had been residing and where the letter was sent. We were told that he, his mother, and his girlfriend (all of our next-of-kin contacts) had been kicked out of that residence due to non-payment issues.

10/28/15: Patient's account was turned over to an outside collection agency.

10/30/15: Collection agency sent letter to patient.

11/11/15: Collection agency called patient.

11/13/15: Collection agency sent letter to patient.

Mid-December: Dr. Eccarius contacted Sen. Thune's office regarding the roadblocks encountered in dealing with the IHS system with respect to this case.

Mid-December: Dr. Eccarius received a call from and spoke with a top-ranking IHS official in Aberdeen, SD.

12/17/15: Dr. Eccarius called Sioux San hospital and talked to Rick Sorenson, CEO. He said that we were too late for claim filing deadlines, but that if we got a signature from the patient, we could appeal the denial for payment. Rick explained that if we had an address, they (Sioux San) would go as far as knocking

on his door to obtain a signature. Dr. Eccarius was also informed by Loydell at Sioux San that patient had non-paid IHS claims to providers dating back to 2014. She offered to 'deny them' and suggested that we could then send him to collections; she was informed that we already had. Dr. Eccarius left a voicemail message for the billing supervisor at Sioux San, Brenda, to call him back to discuss the case (she related that she never received the voicemail).

12/21/15: Left message for billing specialist at Sioux San, Brenda, to call us back if they had heard from the patient. We left her the updated address that a family member of the patient had given us. We did not hear back from her until her 12/31/15 call.

12/22/15: Collection agency called patient.

12/23/15: Called the collection agency and asked that they escalate this case. Gave them the updated phone number and address that the family member had given us. Collection agency attempted to call patient 3 times, and also sent a letter.

12/28/15: Collection agency called patient.

12/29/15: Collection agency called patient.

12/30/15: Left message for billing specialist at Sioux San, Brenda, to call us back if they had heard from the patient.

12/31/15: Brenda called back, and said they were still working to find a valid address for the patient.

Late December, 2015: Numerous attempts were made to make phone contact patient's girlfriend, mother, and father to locate the patient- all without success.

1/7/16: Collection agency called patient.

1/13/16: Collection agency called patient.

1/15/16: Jeannie Hovland from Sen. Thune's office called to update me on the situation.

1/15/16: Collection agency called patient.

1/18/16: Collection agency called patient.

1/18/16: Eccarius Eye Clinic found out that the patient was currently in the Pennington County Jail. We immediately called Sioux San and spoke to the secretary in Mr. Sorenson's office because they had previously said they would obtain patient's signature if they could determine where he was. We were told by Sioux San that they never "go and get a signature from the patient". We left a message to speak directly to Rick, since he had extended the offer.

1/19/16: Talked with Jeannie Hovland who facilitated a call-back from Sioux San.

1/19/16: Mr. Sorenson called back to let our office know that, "someone from his security team would go to the jail, and get the necessary paperwork for the purchase order to be signed".

1/20/16: Left message for Rick to call if he received necessary signature. Our office has not heard back from Rick or Brenda whether they were able to make contact with the patient or not.

1/22/16: Spoke with Jeannie Hovland with Sen. Thune's office. She had also spoken to Rick Sorenson and was advised that due to the delay in receiving the signature (not for a lack of effort on the part of the Eccarius Eye Clinic) an appeal would have to be made to the national IHS office.

1/26/16: Called collection agency. The agent said they have not talked to patient. They have called several times, and made contact with patient's girlfriend, but they have never been able to speak with the patient directly. They will attempt to call patient again today.

Our local IHS system is not set up to address the problems of a very challenging population, in our experience. It relies heavily on patient responsibility and, in turn, places undue financial and collection burdens on its providers. Furthermore, there appears to be few incentives/penalties built into the current system for either the patient or the IHS system to pay providers. In fact, it seems to be just the opposite: uncompensated providers, who have already rendered care, are artificially shoring up IHS budgets.

Dear Senate Committee on Indian Affairs:

I am a member of the Kickapoo Tribe of Oklahoma and have been a beneficiary of Indian Health Service (IHS) my entire life. My experience includes working in Indian Health for over three decades and I now serve my people as the Director of the Kickapoo Health Center. Thank you for the opportunity to submit comments on the topic of addressing critical concerns on Indian health.

While IHS has been, and continues to be, grossly underfunded, the care that I and my family have received as beneficiaries of IHS has been life-saving. I'm quite aware that services offered and the care provided could be improved—for any health system, not just IHS. The program's that IHS has implemented to care for our peo-

ple, such as the patient-centered home medical model, IPC and the Special Diabetes Program for Indians (SDPI) is very successful and has made great strides in the overall system. As a matter of fact, the United States Renal Data System 2015 Annual Data Report (<http://www.usrds.org/adr.aspx>) has published data related to the impact of IHS and the SDPI's efforts in Indian Country. Both end-stage renal disease (ESRD) incidence and prevalence in American Indians have continued to decline. Even more notable, is that these improvement are surpassing all other U.S. racial groups.

Seeing as my father had ESRD and his health suffered due to complications of diabetes, this news is quite refreshing. Please know that there are MANY positive outcomes in IHS. I know, first-hand, of the quality and passion that IHS has for our people. I am encouraged by the support Indian health and SDPI has from Representative Tom Cole. Hopefully others in Congress can follow his lead.

Thank you,

GLORIA ANICO,

Kickapoo Elder Health Director, Kickapoo Tribal Health Center

My name is Mr. Francis Archambeau, and I am the former Classification Officer for the Aberdeen & Bemidji Areas. I have been listening to the hearings regarding the great plains area.

I hope that I am not out of line as I am a former IHS employee, but I feel I must speak up regarding the problems in the Aberdeen Area.

I retired in February of 2007, but I was the Classification Officer from 1991 to September 2005. I retired about the same time as the former Area Director Don Lee. Other good managers have since retired.

Since Mr. Lee and myself retired, I have heard some alarming stories regarding the position classification program and staffing program which are situated in the Personnel (HR) office.

Classification: Management, including Charlene Red Thunder, former Area Director, Ms. Geri Fox (HR), Ms. Alice Lafontaine (HR) and other high level management began to abuse the position classification function. Super grades were ordered by Ms. Fox, and Ms. Lafontaine in collaboration with Ms. Red Thunder to reward friends and relatives.

These high grades are paid for by our tax dollars. Dollars that could be directed to patient care. The Area Office has too many deputies, full assistants and glorified secretary positions that were created to reward these friends and relatives.

Solutions: The Human Resources Division including staffing and classification should receive intense oversight by an outside entity to ensure integrity of these programs.

Staffing: It has been rumored that due to the same "rewarding of friends or relatives" that the IHS merit promotion plan is not being followed, and that some employees/persons may not even be eligible for positions, but were placed on selection certificates. My most recent memory of the staffing function in Aberdeen is that they create a merit promotion file when filling positions, but that file is shredded after one year. Should anyone wish to contest the filling of a position, there would be no record of that process.

Solutions: Again, an outside entity should oversee this process to ensure fairness as described in the merit promotion plan. Merit promotion files should be required to be maintained for up to six years.

Other abuses in the HR office and in conjunction with management direction are cash awards. Supervisors and managers are receiving awards, but not the worker who accomplishes the work. Ron Cornelius received a very large cash award recently, but nobody seems to know what it was for.

Customer service to IHS employees from the HR office is practically non-existent.

Final Statement: Each administrative program should be thoroughly reviewed and corrective action plans be implemented. Performance of all managers at the Division level and above should be reviewed, corrected or the managers should be re-assigned or retired. We used to review administrative programs annually, but I am not sure if this is done now.

Employees are afraid to speak up. Managers have ordered staff not to say anything if they are questioned by investigators.

The personnel office is only a part of the problem. There are other organizations in the Area Office that are a problem. However, I believe the problem begins at the top. As service unit personnel hear about what is going on in the Area Office, there is a negative effect.

Thanks

It is unfortunate that many of our tribal members have died due to lack of proper care and treatment. This is long overdue and has been a topic of controversy for many years—it just did not start five years ago. We all know that IHS provides sub-standard care to tribal members. The IHS facilities have rotating doors for their employees and do not promote continuity in quality health care.

There have been many occurrences that tribal members health care was not a high priority to IHS. The IHS Staff are the priority. It's obvious—look at our facilities—cheap not adequate to serve the population.

The federal government has a TRUST RESPONSIBILITY to provide health care to tribal members, however that has been the unaddressed issue for many years.

There was mention of SELF-DETERMINATION on the part of the Tribes in the Great Plains, unfortunately tribal leaders do not have the business savvy to operate this type of operation especially because of the consistent under-funded specifically for our health care in general. IHS should downsize and reorganize to decrease the administrative overhead throughout the organization.

BONITA MORIN, MSW

Community Research Liaison, Cankdeska Cikana Community College

My testimony of incidences of medical malpractice at IHS:

I was given an IUD and hormones at the same time causing unceasing bleeding had to go to the ER in Florida.

I broke my foot went to the ER no xray tech sent home no treatment. Went back to IHS it was already mending no referral to fix it. Had to rebreak it myself to get it set could not walk on it or get it into a shoe. No referral out. Emergency room has long waits and they forget about you a lot of the time. I also had a hysterectomy through IHS and am now having bladder issues. Referral denied because its not life or limb. I need a referral to a Urologist. Picked up meds for a diabetic no needles included. Got a prescription for a severe ear infection took 4 days to get the meds in then they mysteriously found them. All this is incompetence and mismanagement. Considering getting an attorney. It would be a great service to our people if these things no longer occurred. Thank you.

To you, my very best wishes.

Sincerely,

CONNIE CORWITT

I am forwarding this information as my testimony to how management conducts business at Fort Yuma Service Unit. The Acting CEO, Dr. Harry is a crony of Phoenix Area Office. He is a long time retired Commissioned Corp Officer and Dentist. I have been told he is in his 80's. I have seen him going through garbage cans in the clinic and staff break rooms. He asks the same questions, or re-tell stories he already mentioned. It has been my experience with the Indian Health Service that Corp Officers are hired without competition. They are rehired back after retirement without competition to work as a civilian (cronyism?) or Contractor. The Federal Policy for retirement is 70 years old unless there is some kind of special permission granted to work beyond the retirement age requirement.

It is a fact that Corp Officers are very expensive to employ when there are civilians available who cost about half the amount. This practice of unnecessary hiring Corp Officers consumes a huge amount of resources that could be better spent on direct patient care.

SARAH SCHMASOW
Yuma, AZ.

Dr. Russell,
Chief Medical Officer,
Phoenix Area Indian Health Service,
Phoenix, Arizona.

Dear Dr. Russell,

I would like to report the ongoing issues at Fort Yuma Service that I believe are a result of some preconceived notions and hear say about my job duties/performance. The action taken against me has created a "hostile work environment." I have had to endure the shadow cast over me that I believe was created by Ms. Amy Hamlet, Helen Safford, Shannon, Beyale, Commission Corp Officer, and Robert Harry Acting CEO, Fort Yuma.

The first incident is when I was at a Health Educators meeting at Phoenix Area Office in June 2015. Ms Shannon, Beyale was rude, disrespectful and appeared agi-

tated when I would participate in the discussions. She would not allow me to do my presentation of my activities at Fort Yuma. The other three Health Educators were allowed to take up almost the entire time for their presentations. I was left with maybe 5 minutes. When I started my presentation, Ms. Beyale cut me off abruptly saying Dr. Mac Intyre was scheduled to do a presentation on "Historical Trauma". Ms. Beyale said I would be allowed to finish my presentation later and that never happened. Ms. Beyale appeared hostile and disgusted when I talked about historical trauma and utilizing Native American approaches to healing.

I was purposely ignored during the entire meeting and the other 3 health educators participated fully in the discussions. I was excluded from the free time activities too with the group.

When I returned to Yuma, I was told that someone from Area Office called and said I wasn't prepared for my presentation and I had left early one day. I explained, to my Supervisor, Cynthia, Long that I had a unexpected medical issue and had to take my granddaughter to her medical appointment. I took sick leave for the 90 minutes I left the meeting.

I am not quite sure how Ms. Amerita Hamlet, Corp Officer became aware of the situation but after my supervisor told me Ms. Helen, Safford had shared this information with Ms. Hamlet. Ms. Hamlet told me that she was not sure how Ms. Safford got the information and that someone from Area Office was hating on me." The only person who I deduced might be responsible was Ms Beyale. I didn't report Ms. Beyale because I was concerned she might retaliate if I reported her disrespectful and hostile behavior towards me. I let this go but now I am experiencing the racist and discriminatory treatment by Ms. Beyale and Robert Harry.

I have always been respectful to Ms. Beyale. She is 20 plus years my junior. I am also aware the Commission Corp Officers are held to a very high standard of conduct which in my case Ms. Beyale doesn't apply when she interacts with me.

I am now faced with the recent encounter with Ms. Beyale during a site visit to Fort Yuma Service Unit. It was my understanding, Ms. Beyale's role is to act as a Consultant and Advisor to help me with the Health Education Program. That didn't happen because Ms. Beyale appeared to have a hidden agenda that I later realized after her outburst of shouting at me while we were alone. She told me in a very hostile loud voice of disgust, she was tired of hearing about the Beading Therapy and my mentions of Historical Trauma! My approach to Health Education is culture based which is reflected in the Mission Statement of the Indian Health Service to provide Culturally Sensitive Care.

Ms. Beyale's response was perplexing to me because when the AAAHC came to do the site visit this past September 2015, my Health Education Approach got the highest praise! My approach is from Native American Traditional thought and practice.

For some reason Ms. Beyale is downright hateful that I utilize Bead Work as a means and antidote to address stress and substance abuse issues. My Beading Therapy class was stopped by the Acting CEO, Mr. Harry for some mysterious reason without explanation.

Ms. Beyale email to Robert Harry, Acting CEO, stated I wasn't responding to her request for a date to do a site visit. I explained and apologized for the delay but it takes time to make all the arrangements to visit with all the programs I work with in the two tribal communities I work with.

I proposed that we could meet in February because I had a commitment to train the Cocopah ADAP Staff and the January date her and Mr. Harry agreed on wasn't going to work. I believe Ms. Beyale's motives for emailing Mr. Harry was intended to damage me by creating a hostile work environment and suspicion of my activities.

Ms. Beyale waited about 8 days before she would respond to the alternative date. When she did email me back she cc's my Supervisor and Mr. Harry. If Ms. Beyale would allow me to communicate with the chain of command on my own, would be a more respectful approach. When she cc's other in her emails to me can be misleading and can be concluded that I am being dishonest with my supervisor and Acting CEO. This results in creating a Hostile Work environment for me.

Ms. Beyale went into Mr. Harry's office and closed the door and came out after several minutes to join the meeting I was in. Before Ms. Beyale verbally attacked me, she was invited to sit in on the Sexual Assault Team meeting I had to attend before leaving on the planned tour.

After about 15 minutes into the meeting Ms. Beyale had a disinterested demeanor, pulls a bag of carrots out of her back pack and starts eating. We all know how loud it is to chew raw carrots. I chose to ignore her loud chewing and participated in the meeting. We are not allowed to eat in the workplace when it's not a lunch or rest break.

When I was ready to take Ms. Beyale on the tour of the programs I work with she indicated she didn't want to in spite of her email demanding a detailed agenda, prior to her arrival. I sent her a detailed agenda of the afternoon activities and cc it to Mr. Harry and Cynthia Long.

Again, I was not allowed the full benefit of a program presentation! She did not want to hear about the abrupt directive by Mr. Harry gave me to not conduct any Beading Therapy anywhere on Indian Health Service Property. When I tried to tell Ms. Beyale about the issues preventing me from doing a good job, i.e. not allowed ordering supplies for almost a year and unanswered questions and lack of supervision she was not interested.

All funds for health education was given to Yuma from Phoenix Area Office and now Portland Area. Ms. Beyale warned me, "you won't be able to spend these funds before they take them back because of the fiscal year ending and the approving officials were too backed up." I replied, then what good is it to send the money if I can't spend it down? I ultimately, wrote up a plan to have a series of professional speakers come to train the staff and community on Diabetes. This plan was never acted upon so at the least minute, I came up with a plan to spend down the funds rather than send it back. I requested that all staff be allowed to attend the Annual Diabetes Conference in San Diego. This effort was approved. I need to mention, Ms. Safford was the Acting CEO during this timeframe and she is also Ms. Beyale's direct supervisor.

Ms. Beyale, I believe, was aware or should have been, I had no budget for Health Education in 2015 or 2016. This lack of funds has negatively impacted Health Education. Mr. Joe Law from Portland Area did however send me \$10,000 for 2016 but I am not allowed to spend those funds either. Dr. Berkley made a statement long ago that I never forgot, "If you have no budget, you have no mission." Given that realization you can imagine how I have managed to do my job.

Further, my supervisor suggested since Mr. Harry would not allow me the preapproved comp time to conduct the staff stress management program. Ms. Long suggested I come in later.

However, when I followed Ms., Long's directive, Mr. Harry came to the room where we meet and pretended to be looking through a box of chocolates on the table. He asked me what I was doing. I replied that my Beading Class meets on Wednesdays 5-7 pm. He said, "Did your supervisor tell you I won't approve comp time?" "I responded, she said to just come in later and I did." The next day Ms. Long came to tell me Mr. Harry directed her to tell me that I had to request 2 hours of my annual leave to cover coming in 2 hours late. I did as directed until I could file a grievance or EEOC complaint.

While I met alone, behind closed doors, with Ms. Beyale, she was across the desk from me glaring at me. I asked her, "Why she looked so angry at me?" She was shaking, teeth clenched when she responded, "I am so tired of hearing about the beadwork and historical trauma!" She went on to say the other Health Educators didn't want to hear about it either from me. So, why is it ok for a Non-Indian (Dr. MacIntyre retired Corp Officer/friend of Ms. Beyale) to talk about it and not me? She responded, that's all you talk about." I replied, because this is at the root of most of the health issues Native Americans have.

The Beading Therapy has a successful track record in attracting participants!

Ms. Beyale's behavior toward me was hostile and I requested that it might be better to have someone else come to work with me since she can't keep her personal feelings against me out the work we needed to get done.

I asked, Ms. Beyale who her supervisor is but she would not tell me. I did find out that Ms. Safford is. I asked Ms. Beyale to wait until my supervisor joined us but with a look of disgust, grabbed her back pack, abruptly walked across the room to Mr. Harry's office and sat down smiling sarcastically at me.

I told Mr. Harry he needs to get someone else more impartial to oversee Health Education because Ms. Beyale can't be civil to me.

I was so upset afterwards, I had a Nurse check my blood pressure, seen a provider and went home on sick leave. I am at home now still feeling the effects of the horrible treatment. Ms. Beyale's behavior is outrageous, unprofessional, abusive, and uncalled for!

After realizing all the connections between Mr. Harry, Ms. Safford, Amy Hamlet and Ms. Beyale, I noticed how my position was being undermined and sabotaged! This conduct, I believe constitutes discrimination, retaliation and cronyism.

There are Federal Laws that protect the employees from this type of treatment. I believe, Ms. Hamlet is aware I wrote a formal complaint against her and I spoke personally with Dr. Russell regarding her conduct.

I have given Ms. Beyale every opportunity to be fair with me but apparently she can't. I suggest that Mr. Joe Law, Acting Health Education Director help me with the Health Education program.

Lastly, just as a mention, the Beading Therapy is in the process of being accepted as a best practice for Native Americans. When I mentioned to Ms. Beyale about this she was clearly disinterested and dismissive.

I have to also point out, that almost simultaneously, there was a hearing going on in DC with the Indian Health Service Officials and the Senate Committee on Indian Affairs. There was extensive testimony on Historical Trauma by Indian Health Service officials and Cronyism.

So, I really am at a loss, why Ms. Beyale is so hateful to me when I mention it. Her conduct and influence she has with Mr. Harry has created a substantial amount of duress, stress and Hostile work environment for me. I am home today on sick leave because I was so shocked and upset how Ms. Beyale treated me.

Furthermore, the series of events have the appearance of Discrimination against Native American Culture and retaliation.

I am requesting a full investigation into this matter and that I am offered immediate relief i.e. Administrative Leave from work until this matter is addressed.

Senate Committee on Indian Affairs—Thank you for taking time from your busy schedule to conduct hearings on the Indian Health Services. We are in Albuquerque, NM 87114. Attached are writings done on discrepancies existing within the Indian Health Service Areas. All us Indian people hear is, we cannot do this due to budgetary shortfall. This statement is not true as Congress and the Presidents budget always include increase in the budget. If we can help further, please call on us. Frank and Corie Moran Adakai. Thank you so much for reading the following.

January 31, 2016

Director,

Headquarters Office Indian Health Services.

This letter is to address a very serious existing situation and affecting patients in a very harmful manner. The continued practice of IHS physicians, without hesitation, of prescribing Narcotics based Prescription Drugs to ease the pain or ailment, has to come to a stop immediately. This practice is just a short term fix. It is a known fact that as soon as the prescription drug wears off, the pain still being there, the individual resorts to popping some more Narcotic based drugs to ease the pain. In the meantime, individuals on pain medication becomes addicted and absolutely cannot live without it. The Indian Health Services (IHS) physicians should establish other alternatives such as consulting with a Pain Management Specialist to pin point the real cause of the pain. Once this is done, proper treatment can be identified. Within the past week, the Congressional officials sent out communication to their constituents advising them to sign a petition. Some pharmaceutical companies are buying up existing drugs, often times cheap generic ones, and hiking up their prices by large amounts to increase profit margins. In one of the worst cases, a pharmaceutical CEO bought a drug that retailed for \$13.50 per tablet and raised it to \$750 almost overnight.

These increasing prices come with repercussions for New Mexico's most vulnerable. It was reported that 540 drugs covered by Medicare Part D increased at least 25 percent in cost-per-tablet in a year.

In our state, where 255,414 seniors are enrolled in Medicare Part D, you can imagine the financial toll these price hikes take. If this so, is IHS ready to pay the increased amount?

The issue at hand is the prescription of Narcotic based drugs being prescribed by the Indian Health physicians to patients. Every day you see individuals walking out of the IHS Pharmacy with two or three bags of prescription drugs. Most of the prescription is Narcotic based drugs. We all know this is a short term fix. The real cause of the pain or ailment is completely overlooked. In our immediate family we have actually experienced the tragic aftermath of Narcotic based drugs for pain prescribed for over thirty years, by the Indian Health Services physician. Our immediate family was very concerned over this long period of time, until in August of 2015, we did something about this. The IHS physicians in Belcourt, North Dakota were excellent in quickly acknowledging the problem, and doing something about it. During the treatment of our family member, they terminated the constant use of Narcotic based prescription drug. During the process, our family member went through the immediate after effect of withdrawal. It was not a very nice sight to see. The physicians started working with our family member towards further identi-

fying what was actually causing the pain. Presently, our family member is under the care of Pain Management Specialist.

Therefore, again, we are officially and respectfully asking Indian Health Services seriously consider reverting to working with Pain Management Specialist, and not continue to prescribe Narcotic Based Prescription Drugs.

November 1, 2015—Document Number: 161-QASU-126—Chart: 48470 AIH

Pursuant to 42 CFR 136.25, this appeal is being filed.

On October 20, 2015 we received a letter signed by CDR John Rael. The letter received outlined the following: Contract Health Services request for services on October 19, 2015. Request received October 8, 2015 and was for NM ORTHO ASSOC & NM SPINE.

Request had been received to authorize payment for Medical Services. Careful review of Contract Rules and Regulations was supposedly done and decision made that ALBUQUERQUE INDIAN HEALTH CTR will not authorize payment for the following reasons:

Lives outside Local CHS Area. Not eligible for Contract Health Services (CHS) because you do not live on the reservation and do not maintain close economic and social ties with the local tribe(s) for which the reservation was established. Close ties include marriage, employment or tribal certification (per 42 Code of Federal Regulations 36.23 (1986).

Reference was also made IHS records show that we have health care coverage/resources (such as private insurance, Medicare, Medicaid available to pay for this medical care. (see 42 Code of Federal Regulations 36.61c (1990).

The letter further stated: Any unpaid balances should be promptly submitted to the Indian Health Service Contract health Service Office for review.

It also states: If you have received a denial letter, but your alternate resources have not yet been billed or paid, you are not necessarily being denied authorization for PRC payment. The IHS is coordinating your benefits and waiting to receive notification of the remaining approved medical costs.

We do take exceptions to this denial letter for the following reasons:

1. Discrimination—We are solely being discriminated against by the very entity directed to provide health services to all Indian people. We feel strongly the Treaty signed between Indian people and United States clearly states that the Treaty will provide health services along with other services. No where in the Treaty does it state that certain class of individual Indian people will be denied payment for health services.

2. There are over five hundred Indian Tribes within the United States who receive benefits from the U.S. Federal Government through federal appropriation.

Just like any other programs and organizations, Indian Health Services uses the most recent census of population as justification to seek federal dollars. We, even though we reside within an Urban setting, are counted and our numbers are used as justification.

3. Many of us decided to leave the Reservation to seek better educational and employment opportunities. Many of us are retired from what employment we were involved with. Many of us have used what we learned from the white people.

They use to tell us, "SAVE FOR A RAINY DAY". Many of us used that principle statement and that is how we were able to save our money, invest, and bought homes and land in an urban setting. We just did not stand in line waiting for a free hand-out. Many of us thought about our family and procured Insurance and Health Benefits. But still yet we are ostracized.

4. The following statements contained in the letter are erroneous: do not maintain close economic and social ties with the local tribe(s) for which the reservation was established. Close ties include marriage, employment or tribal certification.

We have maintained and still are maintaining close economic and social ties with the local tribe(s). This is done for many years through the facilitation and consultant work we do and have done with the local tribes, Navajo to the west and the Pueblos up and down the Rio Grande. The patient, Corie Moran Adakai is married to a Navajo and has been and going on 53 years. Corie Moran Adakai is an enrolled member of the Ojibwa Tribe of Turtle Mountain Agency and does have an enrollment number. This should satisfy employment and tribal certification questions.

5. The letter contains references to the Code of Federal Regulation. The regulations cited are not law per se. It is only regulations and can always be changed as needed. Times are changing and there is constant progress.

If references are made to citations within the CFR, then a copy of the applicable CFR should accompany the letter. In this way, a review can be made by the person who the denial letter was sent to. Of course, not everyone understands terminologies used in the CFR.

6. The following statement also contains errors and is totally misconception: IHS records show that we have health care coverage/resources (such as private insurance, Medicare, Medicaid available to pay for this medical care.

We do have private health coverage and Medicare. We are not eligible for Medicaid, therefore, we do not have coverage under this provision. The medical records should be revised to reflect this.

7. The denial letter is very confusing and the writer is talking from both sides of the mouth. The letter stated: Any unpaid balances should be promptly submitted to the Indian Health Service Contract health Service Office for review.

If you have received a denial letter, but your alternate resources have not yet been billed or paid, you are not necessarily being denied authorization for PRC payment. The IHS is coordinating your benefits and waiting to receive notification of the remaining approved medical costs.

Our question is: Is the payment going to be made by IHS or not? I know this is a form letter and it should be reviewed and updated reflecting changes to our concerns and questions.

Sincerely,

CORIE MORAN ADAKAI

I'm 63 years old and an elder of the Cheyenne River Sioux Tribe in Eagle Butte, SD. Forty one years of public services work and still working. My concern is the competency of the Indian Health Services management people particularly a CEO at Eagle Butte. An individual with NO medical background nor employment in the health or medical fields. No college degree? I've known this CEO when he was a rookie in law enforcement back in the late 1980's and I think he's served a few positions of work in the criminal justice system including Chief of Police for the local Tribe and possible management positions in the BIA system. Up upon a couple of years ago or so I was informed that he was the current CEO of the local Indian Health hospital. I just about fell out of my chair when I heard this.

I was visiting with a professional friend of mine who's husband recently retired from the criminal justice field after forty years or so who had management experiences in that particular field. I asked her how she would feel if her husband went and applied for the CEO position in their local City's big hospital. She said it would be a joke and that he would never qualify for that position and would not be stupid enough to think he would be eligible for that position in a different professional field. I then told her what happened at Eagle Butte with the Indian Health Services in hiring this new CEO. She was shocked and appalled and felt for our Native people as she heard so much negativity about the Indian Health Services management issues.

For me and my personal medical issues getting services from this local hospital, I have absolutely NO confidence and comfort in the hospital's management here at all. I personally know at least three people who had EEO grievances or complaints against its local management. Also the nepotism here at the hospital plus the hiring of people with no college degrees, professional experiences, etc. I personally know of one person highly qualified who was passed over to hire one of the management's team members relative into that particular position. I AM ALL FOR REMOVING THE UPPER MANAGEMENT OFFICIALS HERE AND TO HIRE OUTSIDE HEALTH PROFESSIONALS TO MANAGE OUR HOSPITAL. SOME HOW AND SOME WAY THIS NEEDS TO BE DONE.

DARYL LEBEAU

Dear Senators,

I am a physician/psychiatrist currently working in the Indian Health Service, and have been here for 3½ years.

The Indian Health Service is inefficient, bureaucratic, outdated, suffers from poor leadership, and low moral.

Many of the problems with the Phoenix Veterans Administration (VA) Hospital are problems at the Phoenix Indian Medical Center/IHS hospital, and the IHS in general.

My recommendation is for eligible Native Americans to be offered a choice of private health insurance plans, such as the Affordable Care Act provides, by which Native Americans and their families could obtain a health insurance plan that suits them, is more efficient, and could provide quicker service of their health care needs.

The current system of the IHS providing clinics, hospitals would be slowly phased out. This would provide a cost savings to the government and taxpayers.

Sincerely,

DANIEL COULTER, M.D.

Dear Senate Committee

The IHS is disproportionately overburdened, serving such a high risk population in many remote and underprivileged areas, yet seriously underfunded. Sadly, the IHS does not receive due credit and consideration for the excellent work that they do.

Between 2012 and 2014, all 13 of the IHS' birthing facilities gained the WHO's prestigious Baby-Friendly designation. Baby-Friendly is an international designation earned by over 20,000 hospitals worldwide, yet fewer than 10 percent of U.S. facilities are designated, compared to 100 percent of IHS facilities. BFHI promotes optimal, evidence-based care for mothers and infants, and each hospital is designated by Baby-Friendly USA, an external organization performing an onsite assessment. IHS had the U.S.' first Baby-Friendly hospitals in Arizona, New Mexico, North Dakota, Oklahoma, and South Dakota. Early promotion and support for breastfeeding, a major component of Baby-Friendly status, is critical in AI/AN populations where obesity and diabetes are high. As highlighted by the Lancet's January 2016 Global Series on Breastfeeding, human milk offers strong protection against these conditions, and breastfeeding could save 800,000 infant lives per year worldwide, if practiced at the same level it is practiced in IHS facilities.

Please respect and honor this outstanding IHS achievement which took place under the medical leadership of Dr Susan Karol; an active, inspirational CMO for the Agency.

Sincerely

ANNE MEREWOOD PH.D MPH IBCLC,
*Consultant to the Indian Health Service Associate Professor of Pediatrics, Boston
 University School of Medicine Associate Professor of Community Health Sciences,
 BU School of Public Health*

I understand people are passed over for positions—but I also know Mr. Cornelius has been penalizing me professionally since he swept the embezzlement under the rug.

Also—a woman in our department harassed me outside of the office and brought that to the workplace. She had children with the Personnel Officer at the time, Mr. David Azure who was friends with the Executive Officer, Tony Peterson and also friends with the Finance officer at the time, Mr. Edmigio Violanta. Ms. Picotte would harass me outside of work and then come here and use her position with these men to try to get me fired.

Each time I applied for a position Mr. Cornelius brought this woman up and he put her on my resume every application thereafter.

Twenty years later that woman has six kids with five different men and is no better life situation today than she was in 1994.

My husband of 25 years and I bought a newly built home almost eleven years ago and have one gainfully employed son in graduate school and another on his third year of college.

When I applied for the next position in my career ladder after working 1900 hours of overtime to reduce cash I was passed over and asked in my interview how my past relationship with Ms. Picotte would affect my ability to do my job. Ms. Allery then denied asking the question—and destroyed evidence? She had two pieces of paper with questions written on them and she was taking notes as I was answering them.

Rather than go on and on—I will stop there—Never did Ms. Picotte and her harassment affect my ability to excel in my position. And if it did—why was I rated Exceptional for all those years? And given awards and QSIs for my performance.

Ms. Allery was the Budget Officer for several years and prefaced every meeting with me and the Accounts Payable Supervisor and the Accounts Receivable Supervisor with “I don't know what you do in your section but. . . .” Not to mention she was selecting for a position when she herself was retiring.

Ms. Mary Godfrey did the same 2 years later. . .

I fear Retaliation.

KATHLEEN BANKSTON

I am in full agreement with the delegation from I believe Rosebud in their testimonies regarding Robert McSwain's inability to address critical reports attesting the critical needs and conditions of Indian Health Service Units not only in the Great

Plains Region, but across Indian Country and after seeing his person, he need to retire. He looks overly tired and appears very uninterested. Senator Byron Dorgan's 68-page Report of 2010 addressing the critical conditions of all the Great Plain's Regional IHS was brought to the attention of McSwain in my letter addressing the Standing Rock Sioux Tribal Council's requesting its current CEO, Jana Gipp be placed replacing Winona Stabler without competition. I provide much documentation on my opposition to this practice, however, never received a response. All to the Great Plains Regional's Chairman's Health Board without a response. There is no monitoring or follow up by those contracting officers or employees whose responsibility is to provide technical assistance. And Yes, there is reprisal to employees who dare to speak out about deficiencies witnessed. McSwain lied. Since a majority of the Tribal Councils across Indian Country are corrupt and visionless, there is a dire need to get down to the grassroots people for identification of crucial health needs. The overload of programs on our reservation are only to provide salaries for those occupying these programs who are usually family members, relatives or friends of the tribal council so unqualified for the programs they are servicing. This has been a pattern of practice for decades and will not be eliminated overnight. Now that federal funding cuts are being manifested tribal councils will be forced to view its deficiencies and its resources to meet its memberships' medical needs and find out its resources are now limited. The health conditions of the poor are devastating and inhumane on our reservations, and this is a fact. The tribal councils are incompetent as well. Senator Thune needs to hear from the grassroots now either through hearings, phone, emails or regular postal mails. Some of our membership are threatened to sign up under the Affordable Health Care Act or its IRS refund will be withheld. This is ridiculous! The current employees of all IHS needs to be assessed with background checks for drugs and other unethical practices. *

LENA TOLEDO

Senate Committee on Indian Affairs

My name is Brandon Gypsy Wanna. I am employed by the Sisseton Wahpeton Oyate of the Lake Traverse Reservation. I work in our Community Health Education Program as the Wellness Coordinator. I know many people in the world go without health care because they can't afford it; I am thankful to have the Indian Health Service. However, this doesn't mean we should have inadequate care.

Below I have listed what I feel should be known about the Woodrow Wilson Keeble Memorial Health Care Center. (IHS, Sisseton Service Unit)

Patients are not informed about what laboratory tests are being ordered on them; especially the HIV screening tests. As part of my job, I organize screening events in the community. At these events several people have informed me they were already screened at IHS and they found out about it from Pharmacy when they were picking up medication refills. I wrote a formal complaint about this issue. I received a response stating that all people are told exactly what tests are being ordered for them. However, months later, I am still getting reports from people that they aren't told what lab tests are being ordered.

Many Native employees are being "forced" out because supervisors and administrative staff create and/or foster a hostile work environment and harass the native employees. Native employees are scrutinized on attendance, leave, breaks, etc. Often, the supervisors are getting advice from the area office.

Current native employees are afraid to speak up about wrongs they see. I know of at least 2 people that followed the process of filing a complaint on either their co-workers or supervisor. Both were fired. They filed wrongful termination and of course won their cases, however, the conditions at the facility still have NOT changed. They are still working in a hostile environment. The supervisors of these employees were never reprimanded and one got promoted to the area office.

Thank you for your time and allowing me to submit my letter.

BRANDON GYPSY WANNA

First I want to share with the committee that I am a dedicated employee of the Great Plains IHS, a veteran of the US Army, Commissioned Officer of the South Dakota Veteran's Commission, and a proud Lakota enrolled in the Cheyenne River Sioux Tribe.

Ever since I could remember, our people encouraged us to leave the reservation, get an education and come back to help our Tribe. With that said, I did just that. I joined the US Army and served my country. I attended college and received my

* Attachments have been retained in the Committee files.

Bachelor's in Business Administration with a focus in Marketing and then went on to earn my Master of Management/HR Management. I started working for the Bureau of Indian Affairs as the Administrative Officer and then I moved into Indian Health Service as a Contract specialist. I then moved into another area of Office of Tribal Programs as a Health System Specialist.

Before taking on the position in the Office of Tribal Programs, I was assured that if I enjoyed working with Tribes and helping them that this was the direction to take. I was told that this position was important as we would act as the liaison between the IHS and the Tribes. How awesome was that? I love working with our people, and I love the fact that I can make a difference. This of course has not been the case. Our office is supposed to support the Tribes in their efforts to 638. We receive proposals, resolutions, request for additional funding and in turn we are to provide assistance or respond with a declination. In my opinion, we have failed, miserably. I was given the task of responding to letters received that were over two years old! Some of those letters are still sitting with no signature. A family wrote a letter of complaint in regards to being declined for direct services. These letters are now going on three years old. The Area Director letter is yet to be mailed to the family. This is only one example. We have 90 days to respond to a proposal mailed in by the Tribe. Many times we miss the deadline and if the Tribe doesn't follow up, it slips through the cracks. If not, we have to send out funding that may not fit the criteria because we are tardy in our response time. This happens over and over. Who audits the Area office? I do not see an audit of whether or not we are following the law. I cannot submit the letter as evidence do to privacy, but the committee sure can come and ask during their investigation.

I have been in my current position for almost three years. My supervisor holds a high school diploma and my second line supervisor holds a GED. They have wrapped themselves up in a fictitious world of their own which includes their rules. Although they have years of "experience," their experience has not impressed me. They take their time in responding to the Tribes' needs, and they protect their jobs by not doing what they were hired to do. They were hired to support the Tribes and help the Tribes become self supporting. Instead of doing this, they stand in the way of progress. They avoid Tribal needs and give the Tribes the "run around." I have sat and observed their unprofessional behavior. I have been told to add "fluff" to letters. These 1-2 page responses to Tribes only add confusion. Many Tribes just give up because the hassle becomes time consuming.

Currently I have a sexual harassment, hostile work environment and retaliation claim against my supervisor Sandy Nelson and the former Area Director Ron Cornelius. I have attached my last pre-hearing report for EEOC No. 443-2015-00088X, Agency No. HHS-IHS-0290-2014 and the current retaliation documents that occurred in December 2015.*

For almost two years I have sat here putting up with continued retaliation and a hostile work environment. I have two written, unjustified reprimands that sit in my personnel folder that will sit for a total of two years. I provided rebuttals on the reprimands but not once did I receive a response from Mr. Nelson. In all of my career, I have never received a written reprimand, in a matter of six months following my EEO formal complaint, I received two. I have continued to decline in my personnel evaluations. My supervisor has increased percentages to over 90 percent just in order for me to pass at an acceptable level. If I wasn't passing with less than 90 percent, how am I to perform over 90 percent. It is called setting me up for failure. The attached documents will give you a very small insight to the broken EEO process. Every day I come to work and an unhealthy environment. Why do I stay? I have a family to support and as I sit here tortured daily, I job search for a better place, a place where the stress level has to be a lot lower. I have been "black listed." I have had interview after interview with no job offers. I had no problem with getting jobs in the past, after all, I do hold three college degrees, and I bring a wealth of experience any position. All I can assume is that my personnel file must contain something in regards to my recent EEO activity. For over two years, this haunts me and follows me. My supervising staff treat me like a receptionist. I write correspondence letters and forward emails mostly. I am happy that I am well versed in MS Outlook. Needless to say, I have been trying to find a way out of this position for a long time. I will continue to search daily for an opportunity and hope that one day a prospective employer will see the potential I hold. I am a hard worker and feel that I am dedicated. At one time, I was a loyal employee. I cannot say I am that now, not in Indian Health Service. Mr. Cornelius, former Area Director of the Great Plains, was an enabler and the HHS zero tolerance policy on retaliation and sexual harassment is just words. No meaning behind them as managers are not pe-

*The information referred to has been retained in the Committee files.

nalized for their actions. Heather McClane once worked at the Great Plains Area. I heard that she recommended the removal of Richard Huff for HIPAA violations. Ron Cornelius retaliated against her and took job duties away and gave them to Rachel Atkins. Randy Jordan and his girlfriend were resolutioned out by the Winnebago/Omaha Tribe but were given jobs at the Area office. Randy Jordan is a GS-15 who reports to a GS-14. Teresa Poignee, his girlfriend failed to make the panel for a IT position. Scott Anderson, former IHS employee in charge of the IT department, refused to hire Teresa in the position. Richard Huff took away Scott's hiring authority and took it upon himself to hire Teresa in a position she does not qualify for. Ron Cornelius retaliated against Mr. Anderson, instructed him to move from Sioux Falls to Aberdeen where he and his family resides. Mr. Anderson went on terminal leave and applied for retirement. His last day was his first day in the Aberdeen office. Only lower level staff are harassed, retaliated against or worse, fired for their actions. There are reasons why there are problems in the field. It begins with the behavior at the Area office and the unethical behavior of staff in administrative positions.

I watched the Senate Hearing and couldn't help but cry at the stories I have heard. My father passed recently but suffered years and years of being misdiagnosed at the Indian Health Service. I lived back on the reservation for a short time. I could have used the Indian Health Service instead of paying for insurance, but I did not. I paid for insurance as I was aware of the care that IHS provides. Going for an immunization or a common cold was the most I could trust the facility. My life and lives of my family are too important not put all my faith in IHS.

I see that my problems are small in comparison to others who have lost loved ones in the Indian Health Service because of misdiagnosis or improper medical care at a facility. I shared my personal experiences to prove the issues are deeper than the Senate Committee knows. To solve these issues, the Senate Committee has to make change at the highest level of administration. Those like my supervisor who come to work when he feels like it, makes sexual comments at females, carries on with unprofessional behavior and doesn't do his job. The Indian Health Service needs to be proactive in hiring educated individuals in positions of GS-9 or higher. IHS needs to stop hiring high school graduates in positions of power. The problems will not stop in the field because the decision made in the Area office are not on the same level of those in the private sector. A secretary in the Aberdeen IHS can be paid over \$90k a year, and I am almost certain they have no education to back that salary up. People in the private sector with degrees don't make that much money. I have seen time after time the jobs that have been created for area staff. Rhonda Webb, Special Assistant to the Area Director, holds such a position. She is a licensed cosmetologist yet she made the panel for a GS-14 making over \$97k a year. I know plenty of hairdressers who don't make a third of that. The job was created for her and many others who made the panel, who hold higher education degrees, were passed up. No interviews were conducted. Why? Because this job didn't have an education requirement. Like many other GS-14s and higher, you just have to know the right people to move up in the IHS. These uneducated individuals never had to take an English writing class, MS Excel class, MS Word class, the list goes on, but yet, they hold a dream job with benefits and high paying salaries. I personally have taught my co-worker, who has been in the government for over 30 years, how to set up a reoccurring meeting request in MS Outlook. This is high school 101 and she has no clue. Yet, she is in charge of working on audits with Tribes. She is a GS-12, step 10.

I work in a department where I am not allowed to even talk to members of the Tribes without be scolded or verbally reprimanded. How can I provide services to the Tribes if I am not allowed to talk to the Tribes? I know many people from the Tribes. I grew up on a reservation and experienced the many hardships that people face today. Indian Health Service was my medical provider my entire life. Luckily for me, I didn't have major health issues. Before we can fix problems at the local agencies, we need to clean up our Area office. Find out the real issues and find out how staff are treated. I have attached an example of a form of dictatorship in an email for the committee to review. Upon my arrival back into the office from leave, I received an email that was disturbing to me. I was also told that I am not allowed to "share" outside of the department. This email stated that we were not allowed to enter the Area Director's office without an appointment. This was the new "Office of the Area Director Protocol." It is apparent that the Area office lacks knowledge of the definition of transparency. The atmosphere in Indian Health service is scary and a part of me is scared to send this testimony, but I feel it is important. It is important that the committee understand the foundation that has been created. I have only worked in IHS going on four years and it has always been this way. Let's

find a way to clean up administration first and clean out the bad apples. If you don't get rid of the rotten apples, you will not see an improvement in any area of the Indian Health Service.

Thank you for allowing me to send in my documents. I am positive I missed something but am open to discussing or answering questions.

Pilamayaye!

KELLA WITH HORN

To Whom It May Concern:

In regards to the Re-examining the Substandard Quality of Indian Health Care in the Great Plains; I listened to all the sessions and felt compelled to remark on what had been discussed.

I am an Alaskan Native, I am an enrolled (descendant) member of Calista Incorporated and Cook Inlet Regional Incorporated (CIRI) descendant who received exemplary care at the Alaska Native Medical Center as run by the Alaska Native Tribal Health Consortium (ANHTC). As someone who worked for IHS in the past and someone who has friends who work for IHS or who receive care through the IHS facilities other than the Alaska Native Medical Center, I can honestly say that if I needed care through IHS in any area other than ANMC, I would willingly go into debt before being seen at any of the facilities that are in the Lower 48. I place a high value on my life and I feel that IHS does not place that same value on my life in regards to my healthcare.

Although I do know that the Great Plains Area needs quality physicians and nurses and needs to bring the hospitals out from under immediate jeopardy; did no one think to mention that some of the problems that have led to the issues at Great Plains Area starts with the lack of training that ALL staff do not receive?

It takes months to become hired through the Indian Health Service. One applies for a position through USAJobs.gov or through the IHS website, then one must wait anywhere from two weeks to six weeks until the closing date of the position before one is notified if one has been referred to the deciding official. Another two to six weeks before one is notified that one has been approved for an interview. Why? Because a panel must be put together that includes at least three or more individuals who have the same or slightly higher (or lower) qualifications for the position advertised and that all individuals must have proven that they are either American Indian/Alaskan Native through the B.I.A. Approved Form 4432.

Once one is interviewed, it takes another two to six weeks before one is contacted by a member of Human Resources that they have been chosen for the position. Once one accepts the position; an immediate barrage of paperwork is either emailed to them or faxed; or they must pick up and then fill out immediately and return immediately to the HR Department before one can report to their duty station. This paperwork is sent to the individual with little to no help from the HR Department. Once the paperwork is approved, one is told where to report and whom to report to.

One shows up on their first day, eager to make a difference in the healthcare quality of the service unit or at the area headquarters and they are given little to no TRAINING. The eager individual is expected to "hit the ground running, do not ask questions and don't make waves." They are not given time to learn the systems that they are expected to use such as the Electronic Health Records (EHR). If they do receive training, it is very limited and in a rushed fashion, such as 30 minutes on the "ins and outs" of the EHR from the Clinical Applications Coordinator (CAC), they are not shown how to access the Indian Health Manual, nor given any desk manuals or reference manuals that pertain to their position. If they ask for a copy of their position description, they are told they don't need a copy. They are expected to know everything they need to know about their position from the moment that they clock in.

This applies to ALL STAFF to include the nurses and physicians; how are they to know the IHS EHR if they are not trained on how to use it? How are they to know that they must provide clinical documentation on every patient and that they must finish and correct any notes if they are not trained on the system? When they ask for help or information; they are informed that they should know how to do their jobs and just "deal with it."

Staff are treated with contempt, lack of respect and they have no one that they can turn to for help; how can we expect to help care for all American Indians/Alaskan Natives if they are not given the training that they need or how to report issues without fear of retaliation? Fear of retaliation is very common and not just limited to one area. What happens when contract doctors leave because their contracts ended, they get their pay, which they are not supposed to receive until all their

notes are completed. It leaves patient care and patient safety severely lacking, it leads to medical charts being incomplete which puts patients at risk. That is not acceptable; for anyone whether they are native or non-native.

Please, before more money is spent on hiring doctors, physician assistants, nurses; and the accompanying support staff are hired; please ensure that the PROPER TRAINING has and is taking place. Lack of adequate training results in unprofessional standards of care. Training in customer care, proper documentation, policies and procedures should be standard when an individual is hired, no matter the position. Training is essential to ensure that all who receive care through Indian Health Services are given the best care in the nation.

Thank you,

Senate Committee on Indian Affairs
Attn: Amanda Kelly - Clerk
838 Hart Senate Office Building
Washington, DC 20510

12 Feb 16

Dear Sir/Madam,

We are Lakota women who are enrolled members of the Oglala Sioux Tribe and descendants of Chief Old Man Afraid of His Horses who also signed the Treaty with Sioux of 1868.

We are compelled to share our thoughts and answers about our Indian Health Service. We have been vigilant on this issue and the impact it has on our lives, the lives of our children, grandchildren and for the generations yet to come.

We know that we need qualified certified doctors who will provide continuity in the services we need. Our suggestion is to redirect the monies used for the flight for life and invest it back to Indian Health Service's needs. We have read about the many internal problems that are partially to blame on the local IHS levels. The news is dispiriting but it is also correctable.

Our health care cannot continue to be underfunded, our membership grows everyday. For any tribal official to entertain the idea of contracting our health care service need is obviously not educated about the treaties that the United States have made with many tribes across the nation.

We believe our tribal leaders have the role of protecting our treaty rights. In closing, our hope is that more tribal members are pro-active in expressing their concerns and offering solutions to ensure our treaty promises are kept. Individuals will be held accountable to prevent this from happening again.

Thank you for reading our letter.
Heceti SKto (this is how it is)

Sincerely,

Lillian Tobacco

Lillian Tobacco - grandmother/tribal elder
Box 977

Pine Ridge, SD 57770

Iva Good Voice Furt

Iva Good Voice Furt - mother/military veteran
Box 977

Pine Ridge, SD 57770

FACT: The GP Area Office has made it a common practice of recycling field operations staff from one ihs field site to another and sometimes these staff are discretely allowed to telework and or occupy unclassified duties at locations of their choice.

Question. Why are these employees allowed to float from location to location without being held accountable for their lack of performance or leadership at their pay grade?

FACT: The Billings, Bemidji and Great Plains areas combined their Human Resources departments and staff to improve the hiring process for all three locations. The GPA created a Administrative Security Division that was to expedite the background checking process to assist with improving the hiring process also. There are currently HR field staff that should be performing this work locally and all field supervisor's are required to complete approximately 80 percent of the HR process as instructed by GPA HR staff. When the capital HR system goes down which is fre-

quently, field staff are told the HR process is on hold until the system comes back on line.

Question. What improvements in HR and ASD have been made? How long does it take to get a position advertised? How long does it take to complete a background check or verify credentials? Does IHS have a backup plan or process when the HR Capital system goes down in order to keep the HR process moving? Do we need these departments at the area level and or would the anticipated services be better suited at the field sites?

FACT: The Great Plains Area has been informing field sites the GPA has a full time physician recruiter, whom is allowed to telework from their home. GPA staff have consistently pointed out that this recruiter has brought many new physicians on board within the GP Area.

Question. Who are these new physicians and where have they been hired and placed?

FACT: The Great Plains Administration is always informing on memo's, email announcements, etc., the fact that they are a TRANSPARENT organization.

Question. What is the GPA's definition of transparency? Does the support staff in the area office feel they are afforded organizational transparency? Does the field sites feel they are afforded organizational transparency? How many official EEO, Union and Administrative Grievances has the GPA been investigated for in the last ten years? How many have been settled in favor of the IHS in the last ten years? How many were settled in favor of the complainant in the last ten years? How much money has been paid out by the GPA in the last ten years as a result of the out comes?

MAIN Question. Mr. Cornelius, Do you feel the great plains area really needs a great plains area office if this is the type of leadership and guidance that you and your staff make available?

SCOTT SORENSEN

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JAMES LANKFORD TO
ANDY SLAVITT

Many small businesses that supply home medical equipment to their communities, a significant portion of which are seniors and thus Medicare beneficiaries, are struggling to continue doing business because of losing bids during Round 2 of the DMEPOS competitive bidding program. You may be aware that, of the bid winners, several of the "new" DME suppliers doing business in Oklahoma are from out-of-state. Oklahoma is now being threatened with an access problem to quality, local suppliers with which communities are familiar. During my travels across our state, I am hearing that many of the small, family-owned businesses that have been able to keep their doors open despite losing out in the Round 2 bidding process are now the subject of an audit by either a Recovery Audit Contractor (RAC) or a Zone Program Integrity Contractor (ZPIC). I am told that the combination of the losing bid followed by the daunting reality of audit compliance and reimbursement withholding is a knockout punch for those businesses who have managed to hold on post-bid loss.

Question. What resources, programs, or funding opportunities are available for small businesses—specifically those in the durable medical equipment space -who failed to secure a winning bid under DMEPOS competitive bidding program, and are now the target of a CMS audit, either through a RAC or a ZPIC audit?

Question. What can CMS do administratively to avoid putting DME businesses in this dangerous position?

Answer. Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program has been in effect since 2011 and is an essential tool to help Medicare set appropriate payment rates for DMEPOS items, save money for beneficiaries and taxpayers, and ensure access to quality items. Prior to the DMEPOS Competitive Bidding Program, Medicare paid for these DMEPOS items using a fee schedule that is generally based on historic supplier charges from the 1980s. Numerous studies from the Department of Health and Human Services' Office of Inspector General¹ and the Government Accountability

¹ See, for example, *Comparison of Prices for Negative Pressure Wound Therapy Pumps*, OEI-02-07-00660, March 2009; *Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services*, OEI-04-07-00400, August 2009; *Medicare Home Oxygen Equipment: Cost and Servicing*, OEI-09-04-00420, September 2006.

Office² have shown these fee schedule prices to be excessive, and taxpayers and Medicare beneficiaries bear the burden of these excessive payments.

Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas (CBAs). After the first two years of Round 2 and the national mail-order programs (July 1, 2013–June 30, 2015), Medicare has saved approximately \$3.6 billion while health monitoring data indicate that its implementation is going smoothly. There have been few inquiries or complaints and our real-time monitoring system has shown no negative impact on beneficiary health outcomes.

CMS is required by law to recompetitve contracts under the DMEPOS Competitive Bidding Program at least once every three years. The Round 2 and national mail-order program contract periods expire on June 30, 2016. Round 2 Recompetitve and the national mail-order recompetitve contracts are scheduled to become effective on July 1, 2016, and will expire on December 31, 2018.

During the implementation of this program, CMS adopted numerous strategies to ensure small suppliers have the opportunity to be considered for participation in the program. For example:

- CMS worked in close collaboration with the Small Business Administration to develop a new, more appropriate definition of “small supplier” for this program. Under this definition, a small supplier is a supplier that generates gross revenues of \$3.5 million or less in annual receipts including Medicare and non-Medicare revenue rather than the definition used by the Small Business Administration of 6.5 million. We believe that this \$3.5 million standard is representative of small suppliers that provide DMEPOS to Medicare beneficiaries.
- Further, recognizing that it may be difficult for small suppliers to furnish all the product categories under the program, suppliers are not required to submit bids for all product categories. The final regulation implementing the program allows small suppliers to join together in “networks” in order to meet the requirement to serve the entire competitive bidding area.
- The program attempts to have at least 30 percent of contract suppliers be small suppliers. During bid evaluation, qualified suppliers that meet all program eligibility requirements and whose composite bids are less than or equal to the pivotal bid will be offered a contract to participate in the Medicare DMEPOS Competitive Bidding Program. If there are not enough small suppliers at or below the pivotal bid to meet the small supplier target, additional contracts are offered to qualified small suppliers. Contracts are offered until the 30 percent target is reached or there are no more qualified small suppliers for that product category in that competitive bidding area.
- The financial standards and associated information collection that suppliers must adhere to as part of the bidding process were crafted in a way that considers small suppliers’ business practices and constraints. We have limited the number of financial documents that a supplier must submit so that the submission of this information will be less burdensome for all suppliers, including small suppliers. We believe we have balanced the needs of small suppliers and the needs of beneficiaries in requesting documents that will provide us with sufficient information to determine the financial soundness of a supplier.

CMS continues to identify program integrity as a top priority and strives to be a good steward of taxpayer dollars. We believe the statutorily required Medicare Fee-for-Service Recovery Audit Program is a valuable tool to reduce improper payments. Ongoing enhancements to the Recovery Audit Program allow CMS to use Recovery Auditors effectively by identifying and correcting improper payments according to a risk-based strategy. At the same time, these enhancements will increase transparency, improve provider fairness, and lead to improved communication between providers and Recovery Auditors. For example, Recovery Auditors must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. Providers can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment. Recovery Auditors also have 30 days to complete complex reviews and notify providers of their findings, which provides more immediate feedback to the provider on the outcome of their reviews. In addition, CMS instructed the Recovery Auditors to incrementally apply the additional documentation request limits to new providers under review to

²See, for example, *Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical*, GAO-08-767T, May 2008; *Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, HEHS-98-102, May 1998.

ensure that a new provider is able to respond to the request timely and with current staffing levels.³

The Recovery Audit Program uses techniques similar to commercial sector recovery auditing principles, such as using data analysis to identify improperly paid claims, requesting medical documentation to help identify possible improper payments, affording debtors a dispute or appeals process, and establishing recovery/collection processes. In addition, also similar to commercial sector recovery auditing, Recovery Auditors are paid on a contingency fee basis and must pay back contingency fees for review determinations that are overturned on appeal.

CMS is continuously working to improve collaboration between review contractors to promote accurate and efficient reviews of Medicare claims while reducing provider burden and ensuring beneficiary access to needed services. We encourage providers to work with the Recovery Auditors or Zone Program Integrity Contractors during the course of any reviews. Letters sent to providers when overpayments are identified include information on the potential for an Extended Repayment Schedule.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN THUNE TO
ROBERT G. MCSWAIN

Question 1. What percentage of appropriated funds is used for administrative costs throughout the entire Indian Health Service (IHS)?

Answer. The total Fiscal Year (FY) 2015 appropriation for IHS was \$4.6 billion, of which \$3 billion (65 percent) was allocated to Tribes for them to run their own health care operations and \$1.6 billion (35 percent) remained at IHS for federally operated health programs. Of the \$1.6 billion Federal allocation, \$191 million or approximately 12 percent was spent on administrative type costs such as: program services, information management/technical support, patient accounts/business office, financial management, personnel management, and systems development.

The \$191 million relates to the administration of Federal programs IHS-wide only and therefore, does not include administrative costs incurred by Tribes or Contract Support Costs. IHS remains committed to good stewardship of Federal funds and to directing resources to activities, including essential administrative type activities, necessary for the provision of quality health care to American Indians and Alaska Natives.

Question 1a. In the Great Plains Area?

Answer. In FY 2015, the Great Plains Area's appropriated budget authority was \$382 million, of which \$113 million (30 percent) was allocated to Tribes to run their own health care operations and the remaining \$268 million (70 percent) was used for federally operated health care programs. Of the \$268 million Federal Great Plains Area allocation, \$29 million (11 percent) was spent on administrative type costs. These figures relate to the administration of Federal programs Area-wide only and do not include administrative costs incurred by Tribes or Contract Support Costs. IHS remains committed to good stewardship of Federal funds and to directing resources to activities, including essential administrative type activities, necessary for the provision of quality health care to American Indians and Alaska Natives.

Question 2. In response to the 2011 Program Integrity Coordinating Council recommendations, which was formed to follow up on the 2010 Senate Committee on Indian Affairs report "In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area," the then Aberdeen Area IHS stated "Hospital CEOs are being held responsible for ensuring that Accreditation Specialist/QAPI Coordinators submit a Service Unit CMS Matrix to the Deputy Area Director-Field Operations by the 30th of each month outlining the level of compliance with CMS Conditions of Participation." Please provide the committee with copies of any and all of the above mentioned reports on file at either the Great Plains Area office or with IHS headquarters.

Answer. The agency would be happy to work with the staff separately on the document request.

Question 3. How many IHS Equal Employee Opportunity (EEO) complaints are filed in the Great Plains Area?

Answer. For FY 2015, there were 56 EEO complaints filed in connection with the Great Plains Area.

³See Recent Updates to the Recovery Audit Program: https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/recent_updates.html

Question 3a. How does this number compare with the other IHS Areas?

Answer. For FY 2015, there were a total of 79 EEO complaints filed in connection with the other IHS areas combined.

Question 4. Additional, the 2010 Committee report indicated that IHS repeatedly used transfers, reassignments, details, or lengthy administrative leave to deal with employees who had a record of misconduct or poor performance. Since 2010, how many transfers, reassignments, details, or lengthy administrative leave have been used in the Great Plains Area?

Answer. During FY 2010—FY 2015, the Great Plains Area processed 324 reassignments, 109 transfers, and 229 details. In addition, nine employees were placed on Administrative Leave.

Question 4a. Of that amount, how many employees have had a record of misconduct or poor performance?

Answer. Of the Great Plains Area employees identified above, seven have a record of misconduct or poor performance.

Question 5. Great Plains Area IHS facilities have, and continue to be, cited for leaving prescription medications unlocked and in patient access areas. What has IHS done to ensure that the correct process for prescription medication storage is being followed?

Answer. IHS is committed to ensuring proper controls over pharmaceuticals. IHS has developed new procedures related to controlled medications intended to improve control of pharmaceuticals. The new procedures include enhanced security during ordering, receipt, storage within the pharmacy, and storage outside of the pharmacy, as well as the requirement for security features such as automated dispensing machines, pharmacy locks, and video cameras. The processes also require IHS pharmacies to submit monthly reports on inventories of schedule II controlled substances, quarterly audits for schedule III–V controlled substances, and an annual physical audit on inventories of all schedule II–V controlled substances that must be conducted by a senior level pharmacist from outside the service unit. IHS reports to State Prescription Drug Monitoring Programs (PDMPs) in 26 States and is working in collaboration with other States where there are issues with either privacy requirements, licensure requirements, or health management systems that IHS does not have access to. IHS will continue to work to identify new strategies to further improve its policies and procedures in this area.

Question 5a. What changes can be made to ensure long-term compliance?

Answer. See above.

Question 6. In the Consolidated Appropriations Act, 2016 (P.L. 114–113), Congress appropriated \$2 million to assist with accreditation issues at IHS facilities. Have these funds been allocated? If so, on what date were they allocated?

Answer. Yes, funds were allotted to the Great Plains Area Office on March 8, 2016.

Question 6a. Additionally, please provide a spending plan for how these funds will be used.

Answer. The spending plan for the \$2 million included: \$426,886 to Omaha-Winnebagos; \$910,313 to Pine Ridge; and \$662,801 to Rosebud to purchase central monitoring systems for all three facilities and a laparoscopic tower at Rosebud. The laparoscopic/arthroscopic tower is installed and in use at Rosebud. The Rosebud central monitoring system has been purchased and will be installed in October 2016 with a “go live” date scheduled for November 2016. For both the Omaha-Winnebagos Hospital and the Pine Ridge Hospital the purchases are in the procurement process and it is expected that both will have purchase orders issued by the end of September 2016.

Question 7. In 2013, then Acting Director of the IHS Yvette Roubideaux had indicated that a feasibility study was conducted that justified the Great Plains Area decision to relocate its information technology department from Sioux Falls, South Dakota, to Aberdeen, South Dakota. Please provide the committee with a copy of that study.

Answer. A potential relocation of the information technology department from Sioux Falls, South Dakota to the Great Plains Area Office (GPA) in Aberdeen, South Dakota was contemplated by the GPA but, after conducting a reasonable search, we have not located any information regarding the existence of a formal plan/study to relocate the GPA Office of Information Technology (OIT) Department, including any evidence that such a study was conducted by OIT or submitted to Headquarters OIT for review.

Question 8. IHS facilities are now automatically designated as Health Professional Shortage Areas. What steps are HRSA and IHS taking to increase the number of eligible health professionals serving in IHS facilities?

Answer. Having Health Professional Shortage Area (HPSA) Site Scores and an up-to-date National Health Service Corps (NHSC) Jobs Center site profile is essential to attracting NHSC scholarship and loan repayment participants. The IHS Office of Human Resources (OHR) and HRSA's Bureau of Health Workforce (BHW) Shortage Designation Branch and Division of Regional Operations are working together to identify IHS federal facilities needing HPSA Site Score or NHSC Jobs Center site profile updates. HRSA's BHW prepared information and web presentations on the need for and how to update HPSA scores and NHSC Jobs Center site profiles. This information was widely distributed to IHS Federal facilities. IHS OHR also developed and distributed a fact sheet detailing how to update HPSA scores and NHSC Jobs Center site profiles.

HRSA BHW also conducts 1,100 to 1,200 site visits annually to NHSC sites, including IHS and Tribal facilities. On these visits, HRSA staff meet with CEOs, recruiters and Human Resources staff; conduct oversight and compliance activities; meet with NHSC scholars and loan repayment recipients; and provide technical assistance to sites (e.g., assisting in updating NHSC Jobs Center site profiles).

IHS and HRSA continue to promote IHS facilities as service sites for NHSC scholarship and loan repayment recipients. As of January 2016, there were 396 NHSC loan repayment and 22 NHSC scholarship participants at IHS and Tribal sites (including 20 in the Great Plains Area).

IHS is also working with the U.S. Public Health Service Commissioned Corps to increase the number of applicants to the Commissioned Corps who begin their Corps careers with an assignment in the IHS.

HRSA hosted a NHSC Facebook Chat titled "Finding Primary Care Jobs at High-Need Locations" on February 3, 2016. IHS recruiters, including one from the Great Plains Area, participated in this live chat session. Another Virtual Job Fair is being planned with IHS and other American Indian Health Facilities, highlighting current job vacancies.

Question 9. What strategies are the IHS and HRSA implementing to increase recruitment and retention of top quality health care providers?

Answer. The need to recruit and retain highly qualified health care professionals to serve Indian communities is of critical importance to IHS and our Tribal and Urban Indian program partners. Collaboration with HRSA programs is a key to our success. IHS and HRSA work collaboratively to promote virtual events for both agencies. IHS facilities will participate in four NHSC Virtual Job Fairs in calendar year 2016. HRSA and IHS are working to promote the HRSA Nurse Corps. In February 2016, there were 13 Nurse Corps loan repayment participants and five Nurse Corps scholarship recipients working at IHS and Tribal facilities. IHS is also developing materials to promote the State Loan Repayment Program.

The IHS has developed many materials to assist Clinical Directors, CEOs and others in recruitment and retention of health care providers. These materials are posted on the IHS Retention website at <http://www.ihs.gov/retention/>. HRSA also assists IHS with retention of NHSC and Nurse Corps providers. HRSA provides the contact information for providers and information on when the provider's scholarship or loan repayment service commitment will be completed. This allows IHS managers and Area Office staff to follow-up with providers to work on retaining the provider at the current facility or at another IHS site.

IHS is working to address these shortages using existing authorities for incentives to assist in the recruitment and retention of health professionals including:

- Title 5 and Title 38 Special Salary Rates
- Title 38 Physician and Dentist Pay (PDP)
- The 3Rs (recruitment, retention, and relocation incentives)
- Use of service credit to increase annual leave.

Title 38 Special Salary Rates have allowed IHS facilities to offer pay that is closer to what health care providers would receive in the private sector. Title 38 PDP allows IHS to hire specialists, such as orthopedic surgeons, that would otherwise not consider IHS employment.

Question 10. In addition to health care providers, there is also a need for top quality hospital administrators to properly manage and reduce bureaucracy at facilities in the Great Plains Area. What programs and resources are available to recruit the best hospital administrators to IHS facilities?

Answer. Attracting and retaining highly qualified and effective Chief Executive Officers and other senior administrative leaders at IHS and Tribal facilities is es-

sential to the success of Indian health care programs. Attracting these individuals to small hospitals and health centers in rural and remote locations is an ongoing challenge. IHS is able to offer incentives for these leadership positions including recruitment, relocation and retention incentives, service credit for annual leave, and setting pay above the minimum rate using the superior qualifications and special needs pay-setting authority.

IHS has previously worked to promote from within for hospital administrator positions. Currently under review is the potential of developing additional career ladder opportunities as well as cross-training and more robust administrator developmental programs. The Public Health Service Commissioned Corps provides an additional resource for hospital administrators, on a limited scale.

Question 10a. Do you need additional authorities to recruit hospital administrators or can existing authorities be used?

Answer. The IHS Loan Repayment Program (LRP) is a valuable tool for recruiting and retaining healthcare professionals. The LRP currently requires participants to serve their obligated full-time clinical practice of such individual's profession. Because health professionals appointed to purely administrative positions do not engage in full-time clinical practice, they cannot benefit from the current LRP. Additionally, the Internal Revenue Service has determined that IHS loan repayment/scholarship awards are taxable, reducing their value. The President's Budget contains two legislative proposals that address these problems. We look forward to working with this Committee and to answer any questions or provide any technical assistance you may need.

Question 11. What steps has IHS taken to include Tribal Governmental participation in the governing boards of the IHS facilities in the Great Plains Area?

Answer. IHS is committed to working in consultation with Tribes, including those in the Great Plains Area. It is the IHS policy that consultation with Indian tribes occurs to the extent practicable and permitted by law before any action is taken that will significantly affect such Indian tribes. This means that it is IHS' expectation and the governing board's obligation to engage affected tribes to ensure meaningful and timely input.

It is important to note the IHS Director does not have the ability to delegate its authority to run IHS facilities to individuals (elected tribal officials and other health care experts) who would not be accountable to IHS, the agency responsible for running the hospitals. Without clear authority, we cannot ensure IHS hospitals will meet the Centers for Medicare and Medicaid Services (CMS) accreditation. Moreover, governance board authority is extensive, and would include implementation of procedures for employee recruitment, hiring, supervision, and dismissal, and requiring hospital CEOs report to the board. Specifically, the inclusion of elected tribal officials and hospital administration experts outside the IHS system on governing boards raises legal concerns regarding inherently Federal functions, including the supervision of Federal employees by non-Federal employees, the sharing of confidential information, and conflicts of interest. In addition, at a time when several IHS hospitals need to be completely reorganized to maintain CMS accreditation, it is essential that authority over the operation of all hospitals remains clear and that IHS has the ability to affect change as needed.

Question 12. What steps is the IHS taking to ensure that patients in the Great Plains Area understand the difference between a medical referral for which no Purchased/Referred Care authorization for payment is made, and referrals where payment has been authorized?

Answer. To ensure that patients clearly understand the different types of referrals, IHS is developing outreach activities and training materials to ensure Purchased and Referred Care (PRC) patients and providers are aware of program requirements. Program materials will identify and explain the difference between medical referrals and PRC referrals authorized for payment. Staff will also incorporate this language into their daily use so patients and providers become accustomed to and recognize the difference in referrals.

The Great Plains Area Office also developed a "Basic PRC Requirements" sheet that was sent to all PRC staff at the service units with the intent of offering patients an outline of basic eligibility requirements and includes the PRC contact information at the service unit.

Question 13. GAO Report 14-57 recommended that the IHS separate reporting referrals from self-referrals and revise related to Government Performance Results Act reporting measures. What steps is IHS taking to implement that recommendation?

Answer. IHS is working to implement GAO's recommendation. As recommended by GAO-14-57 Report (Indian Health Service: Opportunities May Exist to Improve

the Contract Health Services Program), and with HHS concurrence in GAO-14-57 Appendix 1, the Office of Resource Access and Partnerships is developing the following two measures that will begin baseline reporting in calendar year 2016. PRC-2 will track IHS PRC referrals made by IHS providers and PRC-3 will track PRC self-referrals where patients present to emergency rooms or urgent care facilities outside of IHS.

The recommendation refers to timeliness for processing provider payments. The only self-referrals that will be tracked are those that are approved for PRC payment. No PRC payments are made for self-referrals that are denied. Self-referrals occur when patients visit a non-IHS facility for care without pre-authorization, so approved self-referrals will be tracked and denied self-referrals will not be tracked.

Question 14. What steps is IHS taking to negotiate contracts to provide transportation/ambulance/air ambulance services in the Great Plains Area?

Answer. IHS is committed to providing adequate access to these services in the Great Plains Area. The Great Plains Area Contracting Office has negotiated agreements at rates for 10 percent above the Medicaid rates for two contracts that are in place to service the Area.

- The Eagle Air Med Corporation contract provides air transportation to the Great Plains Area IHS, utilized for the purchase of emergency air transport for medical necessities throughout the GPA IHS service area.
- Period of performance for Air Methods Corporation/Black Hills Life Flight is May 15, 2015 through May 15, 2016 with four one-year options—May 15, 2016 through May 14, 2017, May 15, 2017 through May 14, 2018, May 15, 2018 through May 14, 2019, May 15, 2019 through May 14, 2020

Question 15. What strategies does IHS have in place to streamline the submission of third party claims and ensure that payment is received in a timely manner in the Great Plains Area?

Answer. IHS is committed to facilitating the submission and payment of third party claims. The Great Plains Area is implementing a number of strategies to improve billing and payment for services delivered to patients with third party resources. We are working wherever possible to implement electronic submission of claims and transfer of payments, either directly or through a commercial clearinghouse. In addition, the Great Plains Area is working to implement strategies intended to monitor the billing process so as to quickly identify and remedy potential backlogs. IHS is committed to continuing to review and strengthen its procedures in this area.