Phoenix Area Tribal/Urban Budget Recommendations

Fiscal Year 2019

Submitted on behalf of the Tribal Governments and the Urban Indian Health Programs served by the Phoenix Area Indian Health Service

PHOENIX AREA RECOMMENDATIONS

Fiscal Year 2019 Indian Health Service (IHS) Budget Request
Narrative of Budget Priorities

The Annual Phoenix Area Indian Health Service Budget Formulation Meeting was held in Mesa, Arizona on November 29, 2016. Tribal Leaders, Tribal health directors and urban Indian health program directors in the Phoenix Area met to develop the recommended budget for the fiscal year (FY) 2019 Indian Health Service (IHS) budget request. The one-day meeting accomplished several tasks, including a training on the IHS budget formulation process, review of the FY 2018 Tribal recommendations, an overview of the 2016 Area Budget and the 2017 President's Budget Request and a discussion on hot or emerging issues. The principle activity was dedicated to developing the National and Area level FY2019 budget recommendations.

SUMMARY OF RECOMMENDATIONS

The overall amounts supported for the IHS national budget by the Tribes and urban Indian Health Programs in the Phoenix Area are summarized below. The detailed spreadsheets are attached to this report.

SUMMARY OF PHOENIX AREA TRIBAL RECOMMENDATIONS FOR THE FY 2019 IHS BUDGET
(Dollars in Thousands)

Sub Sub Activity	FY 2016 IHS Enacted Level	FY 2017 IHS President's Budget Request	FY 2019 Current Services & Binding Obligations (Estimate)	FY 2019 Phoenix Area Specific Recommendations (+33% - Program Increase)	FY 2019 Phoenix Area National Budget Recommendation (Total)
Clinical Services	3,237,055	3,473,587	214,220	702,430	4,153,705
Preventive Health	155,734	166,075	8,590	30,000	194,324
Other Services	173,598	175,447	4,398	95,000	272,996
Contract Support Costs	717,970	800,000	100,000	0	817,970
Facilities	523,232	569,906	116,866	315,000	955,098
TOTAL	**4,807,589**	**5,815,015**	**444,074**	**1,142,430**	**6,394,093**

Recommendation 1- Fiscal Year 2019 IHS Budget

Tribal and urban Indian health program leadership recommend a total Indian Health Service budget of **$6,394,093,000** for Fiscal Year 2019. This represents a **33 percent** increase above the FY 2016 IHS Enacted Budget of $4.8 billion which served as the planning base for the FY 2019 budget formulation process. The top 10 budget priorities are as follows:

1. **Purchased Referred Care (+$125 million)**
2. **Hospitals & Clinics (+$437.4 million)**
3. **Mental Health (Behavioral Health) (+$55 million)**
4. **Dental Services (+$30 million)**
5. **Alcohol & Substance Abuse (+$55 million)**
6. **Sanitation Facilities Construction (Water) ($55 million)**
7. **Health Education (+$7.5 million)**
8. **Facilities Construction (+$175 million)**
9. **Urban Health (+$20 million)**
10. **Community Health Representatives (+$7.5 million)**

The following is a submission from one of the Tribal officials present at the meeting. It summarizes the needs for this considerable program increase.

"Although the IHS budget has increased by a historic 29% since 2008, this equates to an average of 7.25% per year, barely enough to cover medical and non-medical inflation and the cost of contract health care for our growing population. Additionally, when automatic budget rescissions and sequestration are taken into account, IHS has lost $240 million since FY 2011. Both serious budgetary increases and changes to resources supporting this health care system are necessary if we are going to effectively address the growing gap in health disparities, which has resulted in early death, and preventable, expensive chronic care costs for AI/ANs of all ages."

Several of the priorities are connected to provisions of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. Chapter 18) identified as priorities. The description of the priorities in this report includes this information.

Current Services/Binding Obligations - The proposed +33 percent increase for the national and the Phoenix Area budgets include amounts to maintain Current Services and to support the Binding Obligations of the Indian Health Service totaling **$444 million**. Current Services include amounts needed to maintain the current level of health care services. The national estimates for FY 2019 are as follows:

Current Services:

- $68.7 million for Population Growth
- $70 million for Medical Inflation
- $10.3 million for Non-medical Inflation
- $11.9 million for Tribal Pay Costs (current staff)

- $7.9 million in Federal Pay Costs (current staff)

Binding Obligations:
- $100 million for pending Health Care Facilities Construction (HCFC) projects
- $75 million for Staffing for New Facilities

Binding Obligations are amounts that IHS commits to fund per statutory requirements. The obligations of the agency include pending construction projects. $100 million is the placeholder amount identified. The amount of $75 million is the placeholder amount for staffing the new facilities. This would provide for approximately 80 percent of the staffing at facilities planned to be opened in fiscal year 2019.

Recommendation 2 – FY 2019 Phoenix Area IHS Budget

The IHS budget formulation instructions stated that each IHS Area submit an Area budget recommendation that provides a **33 percent** increase above the FY 2016 IHS Budget Request. This would add **$124.3 million** to the recurring base of $376.8 million for a total budget request of **$501.2 million**. The estimated Current Services & Binding Obligations allocations that would be afforded to the Phoenix Area are not included in this amount, as these figures were not available at the time of the meeting. The requested program increases align with the national budget priorities listed above and specific regional priorities were identified that include;

Hospitals & Clinics:
+$2 million to hire new PRC staff
+$5 million for Information Technology
Preventive Health:
+$1 million for Public Health Nursing
+$2 million for Health Education
+$2 million for Community Health Representatives
Mental Health:
+$10 million for the Indian Youth Program
Direct Operations:
+$500,000 for Tribal Consultation
Facilities:
+$4 million for Maintenance & Improvement
+$1.5 million for Equipment

Recommendation 3 – FY 2019 Hot Topics

The agenda included a discussion on hot topics that the participants identified. During the discussion the Tribes were asked to identify new hot topics, emerging issues or IHCIA priorities that continue to be of concern. They were asked if specific health care policies and funding levels must be highlighted and the issues have long been problems that have not been adequately addressed. The FY 2019 Hot Topics identified by the Tribes and the urban Indian program representatives are identified below.

- Advanced Appropriations for the IHS

- Special Diabetes Program for Indians (Permanent reauthorization & increase funding)
- National Community Health Aide Program (CHAP) (Extend to the lower 48 states and amend state laws to allow Dental Health Aide Therapy)
- Tribal Correctional Health Care Services (Increase resources through HHS appropriations)
- Treatment of Co-occurring Substance Abuse & Mental Health Disorders (Increase crises response for suicidal and violent behavior with a focus on youth; eliminate barriers to psychological evaluation services; address prescription drug opioid addiction)
- Rehabilitation Services for injuries and illnesses (Increase resources through HHS/IHS appropriations & CMS reimbursement)
- Continuation of the Tribal Health Steering Committee for the Phoenix Area IHS (Provide long term sustainability to this Tribal Leader advisory committee)

<u>Budget Narrative Justification - Top 10 Phoenix Area National IHS Budget Priorities</u>
As noted, the Tribes and urban Indian program representatives at the Phoenix Area meeting developed a 33 percent national budget request reflective of their agreed upon priorities. The issues and concerns surrounding the top five priorities are described below.

1. Purchased Referred Care (PRC) (+$125 million)

The Tribes in the Phoenix Area recommend an increase of **$125 million** at the 33% level for a program increase to the PRC line item. Because the Indian Health Service does not receive sufficient appropriations to provide some levels of tertiary care, the need to purchase specialty care from private providers continues to exceed the funding available. The increase is especially critical for Tribes and IHS Service Units in Nevada, Utah and rural areas of Arizona that are significantly more reliant on PRC funding.

Tribes in the Phoenix Area reiterate a past recommendation that a portion of new resources made available to the IHS support implementation of the Indian Health Care Improvement Act (IHCIA) provisions pertaining to PRC. These include;

Section 129. Patient Travel Costs (25 U.S.C. §1621l). Tribes noted that much of their PRC allocations are utilized to cover these costs. Safe, coordinated and cost effective transportation must be provided.

Section 135. Liability for Payment-No Recourse (25 U.S.C. §1621u). Tribes expressed the need to clarify to PRC providers they have no further recourse against a patient who is not liable for the payment of any costs or charges where the provider has received notice that the patient is authorized by IHS to receive PRC and if the claim has been deemed accepted.

Section 192. Arizona, North Dakota and South Dakota as Contract Health Service Delivery Area (CHSDA); Eligibility of California Indians (25 U.S.C. § 1678, §1678a, §1679). IHS should determine the level of funding required for the permanent designation of these states as PRC delivery areas. Implementation is required, but a concern is that existing appropriations is not sufficient to expand eligibility to the eligible AI/AN's in the new CHSDA's. The funding needed for implementation and a

feasible timeline should be identified. IHS should be required to consult with the Tribes in these respective states regarding this statute

2. Hospitals & Clinics (+$437.4 million)

Tribes in the Phoenix Area recommend an increase of **$437.4 million** at the 33% level increase for the Hospitals & Clinics (H&C) line item. Of this amount **$75 million** is sought to implement the Long Term/Hospice Care provisions of the IHCIA and **$25 million** for Information Technology. H&C provides the greatest flexibility for the IHS and Tribes to provide medical care and the request addresses needed improvements to increase access to health care to address chronic diseases such as heart disease, cancer, and diabetes and communicable diseases such as influenza, pneumonia, respiratory diseases and other risk factors, such as unintentional injury, chronic liver disease and cirrhosis which cause the highest levels of mortality among American Indians in the Phoenix Area.

In addition to services, staffing and technology in IHS/Tribal hospitals and clinics needed to meet the projected workload, IHS must be prepared for the possibility that the Patient Protection and Affordable Care Act is in serious jeopardy of repeal and that the replacement may not include resources that states have relied on to expand Medicaid or subsidies for individuals up to 400% FPL who obtain Health Insurance Marketplace coverage. The request put forth by the Tribes takes this into consideration as this major policy change will have a detrimental financial impact on the Indian health care system. Other recommendations were identified. They include:

- Reduce long waits for medical appointments to prevent having to go to an Emergency Room or seek a PRC referral if the health issue is beyond care levels that IHS and Tribes are able to routinely provide.

- Keep pace with needed pharmaceutical services, including the types of medications that are required for patients seen through PRC referrals who fill their prescriptions at IHS or Tribal pharmacies.

- Address professional and mid-level provider vacancies by increasing recruitment and retention measures. Collaborate with the educational system to promote pathways into health careers so AI/AN's acquire their education with the goal of working in Tribal communities.

- Provide the resources to upgrade Information Technology (IT) pertaining to the Electronic Health Record (EHR), the Registration Patient Management System (RPMS) or compatible software, and maximize billing and collection.

While there are numerous provisions in the Indian Health Care Improvement Act (IHCIA) that pertain to health care delivery, Tribes in the Phoenix Area seek these new resources to implement at least three provisions pertaining to H&C. These include;

Section 112. Health Professional Chronic Shortage Demonstration Programs (25 U.S.C. §1616p). Expands placement of medical students and training of alternative providers, including Community Health Representatives (CHRs) and Community Health Aides (CHAs) in clinical settings.

Section 124. Assisted Living, Home and Community Based Services, Hospice, Long Term Care and Convenient Care Services (25 U.S.C. §1621d). The provision establishes new Indian health authorities.

Section 166. Health Information Technology (25 U.S.C. 1660h). Allows IHS to make grants and contracts with urban Indian organizations to develop information technology systems and provide technical assistance for the same.

3. Mental Health (Behavioral Health) (+$55 million)

Tribes in the Phoenix Area seek an overall increase of **$55 million** dollars for the Mental Health line item. The Tribes discussed several concerns:

The need for qualified mental health providers; in particular, Tribes have difficulty recruiting and retaining fulltime professionals to work in rural areas and adapt to Tribal settings which may be resolved over time as we grow our own Indian health professionals. It was noted that a significant number of youth and adults in Tribal communities experience severe depression, suicidal thoughts, anxiety and other forms of mental illness, although prevention and treatment efforts have been elevated that promote life and wellness among yield positive results. It was noted that Tribal court orders for inpatient involuntary treatment in state facilities that provide care to Medicaid eligible clients or private facilities that may or may not work with private health insurance plans are difficult to process. A factor related to this is the difficulty obtaining necessary psychological evaluations and ongoing compliance with State along with Tribal requirements which are doable, but require comprehensive case management of each patient's case.

There are numerous provisions in the Indian Health Care Improvement Act (IHCIA) that pertain to behavioral health. Tribes in the Phoenix Area seek these new resources to enhance current services and to fund implementation of at least two provisions pertaining to mental health care and co-occurring disorders. These are;

Section 704. Behavioral Health Prevention and Treatment Services (25 U.S.C. §1665, 25 U.S.C. §1665b, 25 U.S.C. §1665c). Establishes the authorities for comprehensive services and emphasizes collaboration among alcohol and substance abuse, social service and mental health programs.

Section 705. Mental Health Technician Program (25 U.S.C. § 1665d). Comprehensive training of community mental health paraprofessionals to provide community based mental health care that includes identification, prevention, education and referral for treatment services and the use and promotion of traditional health care practices.

4. Dental Services (+$30 million)

An increase of **$30 million** to the Dental Services line item is requested. The need to improve oral health care delivery, workforce and prevention efforts cannot be understated. The need for access to dental care in AI/AN communities reported by IHS is significant, as tooth decay is five times higher among American Indian children ages 2-4 years than the U.S. average and 72 percent of AI/AN children 6-8 years have untreated caries, more than twice the rate of the general population. In 2015, IHS reported that since 1999, the oral health of AI/adult dental patients has improved, but still suffer disproportionately from untreated dental caries, with twice the prevalence of untreated caries as the general U.S. population and more than any other racial/ethnic group.

While the IHS system needs dentists and all such available positons are required to be filled by dentists, dental therapy is a viable addition to the Indian health care dental workforce. The IHCIA requires in 25 U.S.C. §10221(d)(3)(A) that the use of Dental Therapy services or any mid-level dental health provider in the lower 48 states must be authorized under state law. In December 2016, Tribes in Arizona supported the effort of Dental Care Arizona to establish Dental Health Aide Therapy through the state's Sunrise Application process. Unfortunately the majority of the committee members that considered the proposal rejected the application. Some legislators stated they were not convinced that access to dental care was as critical an issue that would require establishing this new type of mid-level provider, among other factors, although information was provided that most of the reservations and rural areas of the state are located in Dental Health Professional Shortage Areas and therefore a significant portion of the general population without dental insurance would benefit from this expansion.

The following IHCIA provision is a priority of the Tribes in the Phoenix Area.

Section 111. Community Health Aide Program (25 U.S.C. § 1616l(d)). Nationalization of the Community Health Aide Program would bring to the lower 48 states a successful program that currently operates in Alaska comprised of highly trained paraprofessional workforce of Community Health Aides (CHAs), Behavioral Health Aides (BHAs) and Dental Health Aide Therapists (DHATs). Although the Dental Health Aide Therapy (DHAT) is excluded in the lower 48 states unless state authorized, it is envisioned that over time barriers to DHAT, especially operating in the Indian health care system, will be seen as beneficial.

5. Alcohol & Substance Abuse (+$55 million)

Alcohol and substance abuse health risks in Tribal communities continue to be a major concern and correlates to two of the leading causes of death in the Phoenix Area, which are, unintentional injuries and chronic liver disease and cirrhosis. A **$55 million** increase is needed to fund staffing and treatment costs, prevention efforts as well as coordination of care with behavioral health staff with regard to co-occurring mental health disorders. The updated behavioral health title of the Indian Health Care has been largely underfunded. Progress has been made on a priority IHCIA provision identified by the Tribes but should remain at the forefront of planning and implementation:

Section 704. Comprehensive Behavioral Health Prevention and Treatment Program (25 U.S.C. §1665c). Expands the scope of American Indian/Alaska Native behavioral health care programs and services.

Section 708. Indian Youth Program (25 U.S.C. §1665g). Expands the scope of treatment in Youth Regional Treatment Centers and would provide funds to construct and renovate existing health facilities to provide intermediate behavioral health services, hire professionals and staff intermediate adolescent services such as group homes, sober housing, youth shelters and psychiatric units.

(NOTE: Budget priority areas, 6-10, are of considerable importance to the Tribes in the Phoenix Area. A description of these issues will be provided to the National IHS Budget Formulation Workgroup in preparation for the submittal to the IHS Director and the Secretary of Health).

PHOENIX AREA REPRESENTATIVES

Tribal leaders were nominated to serve on the National IHS Tribal Budget Formulation Workgroup and represent the Phoenix Area. Tribes in the Phoenix Area also requested the accompaniment of an urban program representative to the National IHS Budget Formulation Meeting to provide advisement and information as needed during the workgroup process.

The following individuals will represent the Phoenix Area;

Primary:
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Alternate:
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Second Alternate (if required):
Amber Torres, Chairperson
Walker River Paiute Tribe
P.O. Box 220

Schurz, Nevada 89427
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Urban Representative (Requested):
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Technical support will be provided by the Phoenix Area Office and the Inter Tribal Council of Arizona, Inc. (ITCA) staff.

Phoenix Area Health Status

Information was provided from a prior Phoenix Area Health Status presentation on the significant growth of the population in the Phoenix Area from 2001 (135,604 Active Users) – 2015 (174,260), a 28.5% increase. Information was noted on the top five causes of death in the Phoenix Area, the top 10 causes of ambulatory visits, inpatient IHS visits and inpatient Purchased Referred Care (PRC) visits in the Phoenix Area and within in each state (Arizona, Nevada, Utah). This background gave the participants helpful information to determine the distribution of funds among the line items to address primary, secondary and tertiary prevention and treatment needs.

In the Phoenix Area, it was noted that the top five causes of death in 2013 were:

- Diseases of the Heart
- Malignant Neoplasms
- Unintentional Injuries
- Diabetes Mellitus
- Chronic Liver Disease/Cirrhosis

The top ten causes of ambulatory visits in the Phoenix Area in FY 2015 were:

- Diabetes Mellitus
- Hypertension
- Hyperlipidemia
- Acute Upper Respiratory Infection
- Allergic Rhinitis
- Asthma
- Lumbago
- Obesity
- Esophageal Reflux
- Hypothyroidism

The top ten causes of IHS inpatient visits in the Phoenix Area in FY 2015 were:

- Single Live Born
- Hypertension
- Diabetes Mellitus
- Hypopotassemia
- Hyperlipidemia
- Obesity
- Anemia
- Urinary Tract Infection
- Pneumonia
- Hyposmolality/Hyponatremia

The top ten causes of PRC inpatient visits in the Phoenix Area in FY 2015 were:

- Hypertension
- Kidney Failure/End Stage Renal Disease
- Hyposmolality/Hyponatremia
- Pneumonia
- Urinary Tract Infection
- Acute Upper Respiratory Infection
- Unspecified Septicemia
- Acidosis
- Cellulitis and Abscess of Leg
- Acute Posthemorrhagic Anemia

The age-adjusted mortality rates for American Indians/Alaska Natives vary by state. 2013 information was noted on this and other data from the Inter Tribal Council of Arizona, Inc. Tribal Epidemiology Center's Regional Community Health Profile (2009-2014), which reported chronic disease, mental health, communicable disease, maternal and child health and injury data for the Phoenix and Tucson Area IHS Service Areas. (See http://itcaonline.com/wp-content/uploads/2013/05/Regional.pdf).

American Indian/Alaska Native Mortality Rates by State, 2013

Arizona	Nevada	Utah
Heart Disease (123)	Heart Disease (142)	Cancer (122)
Cancer (101)	Cancer (100)	Heart Disease (103)
Unintentional Injury (95)	Unintentional Injury (40)	Respiratory Disease (85)
Diabetes (80)	Chronic Liver Disease & Cirrhosis (33)	Influenza/Pneumonia (32)
Chronic Liver Disease & Cirrhosis (59)	Influenza/Pneumonia (22)	Alcohol-Induced (30)

Rate per 100,000 populations

ADDENDUM I – PHOENIX AREA IHS FY 2018 BUDGET FORMULATION MEETING ANNOUNCEMENT/AGENDA/MAP OF THE PHOENIX AREA

ADDENDUM II - WORKSHEETS ON BUDGET RECOMMENDATIONS

- National Budget +33% Level Increase
- Phoenix Area Budget +33% Level Increase

ADDENDUM III – DESCRIPTIONS OF THE FY 2019 PHOENIX AREA HOT TOPICS

ISSUE: IHS Advanced Appropriations

BACKGROUND: Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget was enacted by the beginning of the fiscal year. It is simply too difficult for the Indian Health Service, Tribally operated and urban Indian health programs to plan, budget for, and sustain their health care services to Indian patients when the U.S. Congress is not able to complete the appropriations process at least in close proximity to the required timelines. It is difficult to recruit and retain qualified medical staff, plan programs and services and purchase equipment and supplies when budget levels are distributed piecemeal throughout the year. For the same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts. Two-year advance appropriations should likewise be enacted for the Indian Health Service to provide stable and predictable funding for the Indian Health Care system.

RECOMMENDATIONS: Tribes and urban Indian health programs in the Phoenix Area support two year advance appropriations for the Indian Health Service.

ISSUE: Special Diabetes Program for Indians

BACKGROUND: In response to the growing diabetes epidemic among American Indian and Alaska Native (AI/AN) people, Congress established the Special Diabetes Program for Indians (SDPI) through the Balanced Budget Act of 1997. The SDPI is a $150 million per year program that provides grants for diabetes treatment and prevention services to 404 Indian Health Service (IHS), tribal, and urban (I/T/U) Indian health programs across the United States. Diabetes is a debilitating chronic disease that requires tremendous long-term efforts to prevent and treat and American Indian people have been disproportionality effected by it. SDPI has afforded Tribal communities the opportunity to slow the increase in the diabetes prevalence rate.

RECOMMENDATIONS: SDPI expires on September 30, 2017. Tribes and urban Indian health programs seek the permanent reauthorization of the program and a long overdue increase of funding at $200 million per year in Fiscal Year 2017.

ISSUE: Nationalization of the Community Health Aide Program (CHAP)

BACKGROUND: The Community Health Aide Program now operating in Alaska includes Community Health Aides (CHAs), Behavioral Health Aides (BHAs) and Dental Health Aide Therapists (DHATs). Since the 1980's Community Health Representatives (CHR's) in the lower 48 states have worked to educate and assist Tribal members and it continues to be a very popular program supported by Tribal leaders. It is welcoming that IHS is proposing to expand CHAP to the lower 48 states that will enhance the prevention health care focus in our communities. The infusion of the mid-level provider workforce in the IHS health care system makes a lot of sense in rural and frontier Tribal communities. They can be well trained and medical and dental providers will provide supervision. Training requirements can be met either online or in local educational institutions, depending on the subject matter. Overall the CHAP program is seen as cost effective and provides an opportunity for Tribal members that live on the reservation to become well trained and have meaningful employment.

RECOMMENDATIONS: Tribes in the Phoenix Area seek an increase of $7.5 million in the CHR line item in FY 2019 to implement CHAP as well as to provide resources for Tribes to raise the salaries of the currently employed CHR's.

ISSUE: Correctional Health Care in Tribal & Bureau of Indian Affairs (BIA) Operated Institutions

BACKGROUND: In October 2015, the Tuba City Regional Health Care Corporation began to reach out to Tribes and Tribal organizations in Arizona where Tribes operate 5 of 7 correctional facilities formally operated by the BIA to address poor inmate health. As a result, the Arizona Tribal Correctional Health Care Coalition was born and began to visit these locations and address possible solutions**.** Their concern was that Tribes and IHS bear the costs of health care for their inmates for which there are no delegated resources. Inmates and their families suffer when they are discharged in poor health. At the present time there is no federal funding for Tribal or BIA correctional health care, which is provided to inmates at other federal institutions by the Federal Bureau of Prisons. Medical services are extremely limited, i.e., dispensing medications to inmates and at some locations behavioral health counseling may be provided on an intermittent basis. Inmates that seek outpatient health care at the IHS or Tribal clinic must be transported and accompanied by corrections officers to the appointment.

RECOMMENDATION: Tribes in the Phoenix Area request that the Indian Health Service provide technical support to Tribes and the BIA seeking a Memorandum of Agreement with the U.S. Public Health Service to get Commissioned Corps Officers assigned to Tribal and BIA operated jails. Another remedy Tribes seek is that the BIA budget includes a correctional health care line item so that inmate healthcare may be arranged under the auspices of the local Tribe or the Indian Health Service in order for services to be provided more regularly at the correctional facility to the extent that space and security can be arranged.

ISSUE: Treatment of Co-occurring Substance Abuse & Mental Health Disorders

BACKGROUND: Tribes have long identified the need to address co-occurring mental health and substance abuse disorders among the afflicted American Indian population. In term of Fiscal Year 2019, this issue is addressed among our top five priorities. Tribes see the connection between the two issues and therefore seek comprehensive efforts to strengthen the Tribes' ability to aide individuals with a mental illness, to prevent alcohol and substance abuse, including prescription drug opioid abuse and to respond to suicidal and violent behavior that effect some of our youth and young adults. At the present time, behavioral health funding is limited to the level of resources that Tribes contract for through the IHS. Few Tribes have additional tribal dollars to contribute to these services. If a client is Medicaid eligible or has private health insurance some of the costs of inpatient, intensive outpatient or residential treatment may be defrayed, but in most cases inpatient hospitalization and psychiatric care is very expensive and located outside of Tribal communities.

RECOMMENDATION: The IHS, SAMHSA and Tribes assisted the U.S. Department of Health and Human Services develop a national Tribal Behavioral Health Agenda that was released in its final form on December 6, 2016. (See http://store.samhsa.gov/product/PEP16-NTBH-AGENDA). Instituting the recommendations that will result in strengthening behavioral health systems, related services and supports should be the highest priority of all partners going forward.

ISSUE: Rehabilitation Services for Injuries and Illnesses

BACKGROUND: Services provided by physical therapists, including audiology, occupational, respiratory therapy and speech-language pathology y services were enhanced beginning in the 1980's at IHS facilities. Their role continues to address the needed services to American Indians that experience physical, mental and emotional trauma as a result of injury and debilitating illness. At the present time the resources for physical rehabilitation services are included in the Hospital & Clinics line item and are limited to what's available at an IHS or Tribal facility. If the patient in PRC eligible and the injury or illness is deemed as a medical priority, the patient may get referred to the private sector.

RECOMMENDATION: Physical rehabilitation services restore one's ability to recuperate satisfactorily from injury and illness and promote the restoration of optimal health. An assessment of the services needed by the population and funding that can be addressed in the H&C and the PRC line items is needed. Some of the Tribes in the Phoenix Area expressed that appointment setting can be delayed due to the overwhelming workload of the Physical Therapy departments. In some instances the services are limited and should be expanded.

ISSUE: Continuation of the Tribal Health Steering Committee for the Phoenix Area IHS

BACKGROUND: Dr. Ty Reidhead, Director of the Phoenix Area IHS agreed to obtain views on whether or not the Steering Committee should exist or some other form of it and what level of staffing support is needed at a special meeting held on November 30, 2017. This came about as a result of information that the Area office does not have sufficient funds to continue supporting the Steering Committee. The Steering Committee was established by a joint resolution adopted by the Inter Tribal Council of Nevada, Inter Tribal Council of Arizona and Utah Tribal Leaders on March 20, 1981. The concept was further defined and ratified by Tribal Leaders at a Joint ITCA/ITCN/Utah Tribes Meeting on January 20, 1983 which led to a Memorandum of Understanding signed on November 28, 1984, by Tribal Leaders representing the three organizations and Dr. George Blue Spruce, D.D.S. Phoenix Area IHS Director and Dr. Everett Rhoades, M.D., IHS Director. The purpose of the Steering Committee is to provide an open and objective forum to address and analyze American Indian health care concerns, policy issues and IHS appropriations. Its role was enhanced by Presidential Executive Memorandums on Tribal Consultation and it serves as the Tribal Health Board for the Phoenix Area IHS and assists in the identification of issues and coordination of Area office consultation. A representative serves on the National Indian Health Board to represent the Phoenix Area. It is comprised of 12 Tribal Leaders and there is one urban Indian health representative.

RECOMMENDATION: Tribes in the Phoenix Area value the role of the Tribal Health Steering Committee and the staff support it's provided by the Inter Tribal Council of Arizona. Because funding is limited, the Committee is comprised of 5 Tribal Leaders from Nevada, 5 from Arizona and 2 from Utah. It is doubtful that new members to represent the three-state region will be added any time in the near future, although a strategy to broaden its role and the efforts of the Phoenix Area IHS to engage Tribes in meaningful consultation and confer with Urban Indian organizations must be the principal policy of any IHS administration.