Senate Committee on Indian Affairs

Legislative Hearing

S. 3937, Special Diabetes Programs for Indians Reauthorization Act of 2020

S. 3126, Native Behavioral Health Access Improvement Act of 2019

S. 4556, a bill to authorize HHS to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California

Statement by
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Good afternoon Chairman Hoeven, Ranking Member Udall, and members of the Committee on Indian Affairs. Thank you for the opportunity to testify on S. 3937, Special Diabetes Reauthorization Act of 2020; S. 3126, Native Behavioral Health Access Improvement Act of 2019; and legislation to authorize the Department of Health and Human Services (HHS) to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California.

As an agency within HHS, the Indian Health Service (IHS) mission is to raise the physical, mental, social, and spiritual health of American Indian and Alaska Native people to the highest level. This mission is carried out in partnership with American Indian and Alaska Native Tribal communities through a network of over 605 Federal and tribal health facilities and 41 Urban Indian

Organizations (UIOs) that are located across 37 states and provide health care services to approximately 2.6 million American Indian and Alaska Native people annually.

S. 3937

S. 3937, Special Diabetes Programs for Indians (SDPI) Reauthorization Act of 2020, would amend section 330C of the Public Health Service Act to reauthorize the SDPI for five (5) years at an increased annual funding level of $200 million, which would significantly bolster SDPI's diabetes prevention and treatment efforts. In addition, while S. 3937 provides for the SDPI to continue as a grant program overall, for the first time, this bill includes language stating that the grant may be awarded pursuant to an Indian tribe or tribal organization's Indian Self-Determination and Education Assistance Act (ISDEAA) contract or compact.

Congress established the SDPI in the Balanced Budget Act of 1997 (P.L. 105-33) to address the burgeoning diabetes epidemic in American Indian/Alaska Native (AI/AN) people. The initial annual funding amount of $30 million was increased to $100 million in Fiscal Year (FY) 2001 and again in FY 2004 to its current level of $150 million. There are currently 301 SDPI program sites in 35 states operated by Tribes, Tribal Organizations, UIOs, and the IHS.

FY 2020 is the twenty-third (23rd) year of the SDPI and recent data show that, since the beginning of the SDPI, tremendous improvements have been made in many important diabetes outcomes in AI/AN people. New cases of diabetes-related kidney failure decreased by 54 percent between 1996

and 2013[1] and a just published study[2] shows that those decreases have been sustained. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) has estimated that this decrease in kidney failure will save Medicare as much as half a billion dollars over 10 years[3].

Diabetic eye disease incidence has also decreased by more than half[4] and hospitalizations for uncontrolled diabetes have decreased by 84 percent.[5] We are also happy to report that, after years of increasing, the prevalence of diabetes in AI/AN people decreased each year from 2013 to 2017[6], while it has plateaued in U.S. adults overall as well as for other racial/ethnic groups.[7] As Congress envisioned, tremendous improvements are occurring in diabetes outcomes for AI/AN people – and the SDPI plays a key role in making them happen.

Regarding the issue of how these grant funds would be transferred to tribes or tribal organizations, currently, under Title V of the ISDEAA, a statutorily mandated grant such as SDPI may be added to a Title V funding agreement after award. This ISDEAA authority is not applicable to Title I Contracts. A statutorily mandated grant program added to a funding agreement is subject to the

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[1] Bullock A, Burrows NR, Narva AS, Sheff K, et al. Vital Signs: Decrease in incidence of diabetes-related end-stage renal disease among American Indians/Alaska Natives—United States, 1996-2013. MMWR 2017;66(1):26-32

[2] Burrows NR, Zhang Y, Hora I, Pavkov ME, et al. Sustained lower incidence of diabetes-related end-stage kidney disease among American Indians and Alaska Natives, Blacks, and Hispanics in the U.S., 2000-2016. Diabetes Care 2020;43:2090-2097

[3] Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Special Diabetes Program for Indians: estimates of Medicare savings. ASPE Issue Brief. Department of Health and Human Services, May 10, 2019. https://aspe.hhs.gov/pdf-report/special-diabetes-program-indians-estimates-medicare-savings

[4] Bursell SE, Fonda SJ, Lewis DG, Horton MB. Prevalence of diabetic retinopathy and diabetic macular edema in a primary care-based teleophthalmology program for American Indians and Alaska Natives. PLoS ONE 2018;13(6):e0198551

[5] Agency for Healthcare Research and Quality. Data Spotlight: Hospital admissions for uncontrolled diabetes improving among American Indians and Alaska Natives. AHRQ Publication No. 18(19)-0033-7-EF. December 2018. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/dataspotlight-aian-diabetes.pdf

[6] Bullock A, Sheff K, Hora I, Burrows NR, et al. Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006–2017. BMJ Open Diab Res Care 2020;8:e001218. doi:10.1136/bmjdrc-2020-001218

[7] Benoit SR, Hora I, Albright AL, et al. New directions in incidence and prevalence of diagnosed diabetes in the USA. BMJ Open Diab Res Care 2019;7:e000657.

terms and conditions of the grant award (e.g., reporting requirements of the grant award program remain in place).

S. 3126

S. 3126, the Native Behavioral Health Access Improvement Act of 2019, would authorize the creation of a Special Behavioral Health Program for Indians by awarding grants to prevent and treat mental health and substance use disorders. This bill requires the IHS to coordinate with the Office of the Assistant Secretary for Mental Health and Substance Use to support the behavioral health needs of AI/AN communities, establish a technical assistance center and develop specific metrics, in consultation with Tribes, to monitor and evaluate outcomes and impact of the Special Behavioral Health Program for Indians.

I appreciate the opportunity to share our efforts within IHS that address the behavioral health disparities impacting the AI/AN population. The Division of Behavioral Health manages and administers national behavioral health initiatives and policy development for mental health, alcohol and substance abuse, and family violence prevention programs for AI/AN people. IHS works in partnership with our IHS Facilities, Tribes, Tribal organizations, and Urban Indian health organizations (I/T/Us) to implement evidence-based, practice-based and culturally-based activities, to share knowledge and build capacity in Indian Country.

IHS has managed behavioral health grant programs that support community-based, culturally appropriate prevention and treatment services and supports to tribal and urban communities. These programs include the Substance Abuse and Suicide Prevention Program, the Domestic Violence Prevention Program, and the Youth Regional Treatment Center Aftercare Pilot Projects. IHS also supports initiatives focused on improving behavioral health services within clinical settings, including the Zero Suicide Initiative and the Behavioral Health Integration Initiative. We

anticipate publication of the funding announcement for a new grant program designed to combat the opioid crisis, the Community Opioid Intervention Pilot Projects, will occur before the end of September.

The behavioral health disparities experienced among the AI/AN population prior to, and during, the pandemic continue to impact the overall health and wellbeing of individuals, families and communities.[8] In response to the pandemic and to support tribal communities experiencing new demands and stay-at-home orders, IHS provided administrative flexibilities to our grantees to the greatest extent possible. For example, for current grants and initiatives scheduled to end in FY 2020, we authorized a one-year extension on the project period to provide additional time to implement services and complete objectives of the grant.

IHS acknowledges the mental and behavioral health impact of the pandemic and that the associated consequences will likely be felt for a long time to come. These priorities will shape our approach to behavioral health in ways that we could not have imagined a few years ago. The backdrop of COVID-19, and its impact will play a role in the future of mental health and how those services are delivered across the I/T/U system. Like other agencies, IHS is adapting to meet the needs of the "new normal" for providing healthcare, and mental health care in particular. We are beginning to see an influx of new patients seeking care for grief, anxiety, and depression due to the effects of the pandemic and we anticipate this need to continue as long as the pandemic is impacting daily life. Our staff is equally impacted as front-line providers working hard and stretching their limits to follow the mission of the IHS.

[8] MMWR - Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1166–1169. DOI: http://dx.doi.org/10.15585/mmwr.mm6934e1

S. 3126, the Native Behavioral Health Access Improvement Act of 2019, would expand tools to address mental health, alcohol and substance abuse disparities, and increase access to treatment across the I/T/U system. The IHS currently provides access to outpatient clinical and preventive mental health services through a system of IHS, tribally operated and urban Indian health programs. While IHS is a direct service provider for behavioral health, the majority of behavioral health services are provided by tribes under Indian Self-Determination Act contracts and compacts. The AI/AN population continues to experience persistently higher rates of serious behavioral health issues than the general population, and the impact on the overall health and wellbeing of individuals, families and communities demands a comprehensive approach.

The suicide rate in AI/AN communities has previously been discussed before this Committee, and remains a priority IHS continues to address in partnership with the tribes. According to the CDC, the suicide rate for AI/AN adolescents and young adults ages 15-34 was 1.3 times higher than the national average for that age group in the general population. Suicide is the eighth leading cause of death among all AI/AN across all ages.[9] According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health, AI/AN adolescents had a prevalence rate of 16.3 percent for major depressive episode with or without severe impairment, which was the highest rate compared to other ethnicities. In addition, the AI/AN adult prevalence rate of 8.0 percent for a major depressive episode with or without severe impairment was the highest when compared to other ethnicities, and their prevalence rate of 18.9 percent was the third highest for serious mental illness compared to other ethnicities.[10]

[9] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from

[10] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from https://nsduhweb.rti.org/respweb/homepage.cfm

Under S. 3126, the creation of a Special Behavioral Health Program for Indians grant program would provide additional tools to address mental health disorders across the I/T/U system. The grant would increase the number of behavioral health providers and expand access to services such as: acute inpatient crisis stabilization to focus on first episode psychosis and suicidal ideation, mobile crisis teams, first episode psychosis peer support, behavioral health services within primary care and emergency rooms, assessment and treatment of early childhood mental health disorders and developmental disabilities, and assessment and treatment of post-traumatic stress disorder. With the expansion of services at local systems of care through these new grants, individuals would receive interventions aimed at preventing the development of severe and possibly life threatening symptoms.

The Committee, as evidenced by past oversight and legislative hearings on the opioid crisis in Indian Country, is well aware of the significant impact the opioid crisis has had on the AI/AN population. The rate of drug overdose deaths among AI/ANs is above the national average. From 2015-2017, the overall rate of overdose deaths for AI/ANs increased by 13 percent. The IHS Alcohol and Substance Abuse Program's mission is to reduce the incidence and prevalence of alcohol and substance abuse among AI/ANs to a level at or below the general U.S. population. The Alcohol and Substance Abuse Program provides funding, policy, training, and technical assistance to local IHS, tribal, and urban Indian programs to ensure a variety of treatment options exist. IHS actively solicits feedback and works with tribes to develop and implement models of care that are effective and sustainable. Our primary focus is to support treatments that are evidence-based and culturally effective and that will have a significant impact on the prevention, treatment and recovery efforts to combating alcohol and substance abuse.

Under S. 3126, a Special Behavioral Health Program for Indians would expand existing IHS efforts by increasing availability, access, and quality of evidence-based treatment and recovery services for alcohol and substance use disorders, particularly in rural, urban, and other underserved tribal communities. In addition, the program would support tribes as they develop priority activities aligned with the Administration's *National Treatment Plan* addressing unmet need by expanding access to medication for opioid use disorder in specialty addiction treatment programs, expanded clinical settings such as emergency departments and medical mobile units and efforts to create a robust peer recovery training program. The expansion of the IHS Community Health Aide Program (CHAP) could play a significant role in the training and development of a cadre of peer recovery specialists whose services are grounded in traditional and cultural-based practices and could be sustainable through reimbursement of treatment services. The ability to collect data and evaluate these interventions of this new program could help facilitate IHS taking a more unified approach in working with tribal communities to evaluate the overall impact of these interventions and build on lessons learned.

Despite our best efforts, access to behavioral health care services has been a longstanding issue in many Native communities. Though true for all behavioral health needs, this is especially true for pediatric and other specialty care. One effective and efficient means of increasing access to care is telebehavioral health. To date, the IHS Telebehavioral Health Center of Excellence provides clinical services and technical assistance to 26 facilities with an established waitlist for an additional 31 sites. To better determine need, in December of 2019, IHS polled the waitlisted sites. We found a significant and growing demand for services include a request for 268 hours of behavioral health services (roughly 450 to 500 patients) per week. When asked about the types of services needed, 93 percent wanted services for youth and 74 percent requested behavioral health prescribing services.

While many of our IHS and tribal behavioral health clinics adapted swiftly to offer limited continuity of care through telebehavioral health services following the outbreak of the COVID-19 pandemic, we expect an influx of new patients seeking care for grief, anxiety and depression due to the effects of the pandemic. To address these concerns, and to provide timely support to Tribal communities, IHS has prioritized the expansion of telebehavioral health. Given the efficacy and efficiencies of telebehavioral health and the clearly documented need, the expansion of telebehavioral health would have a significant and positive impact on access to behavioral health services. S. 3126 would greatly expand the IHS efforts to provide effective telebehavioral health services across the entire I/T/U system, especially those communities that are the most rural and remote.

Finally, I would like to discuss the establishment of the Technical Assistance Center described in S. 3126. Both the Indian Health Service and SAMHSA currently provide technical assistance to grantees funded by the different behavioral health grant programs within a limited scope based on the grant objectives. We are also aware SAMHSA has other tribal technical assistance centers focused on AI/AN communities funded through contracts and cooperative agreements. A technical assistance center for the Special Behavioral Health Program for Indians could help support tribes as they implement behavioral health programming within their communities, and could help improve behavioral health services. For instance, our grantees have shared challenges that range from administrative challenges such as insufficient staffing or staff turnover to crisis response resources and coordination In addition, a technical assistance center could assist in the coordination of data collection between IHS and all facilities that serve the AI/AN population to improve evaluation efforts demonstrating lessons learned, progress, and outcomes.

S. 4556

S. 4556, legislation introduced by Senator Feinstein would authorize HHS to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California. This legislation authorizes the IHS Director, through the HHS Secretary, to acquire land that contains a dirt road known as "Best Road" and other land or interests in lands in order to facilitate access to the IHS Desert Sage Youth Wellness Note to Center (Desert Sage), in Hemet, California. Once the land is acquired, the Feinstein legislation provides for the IHS Director to construct and maintain a paved road on that land.

The IHS Desert Sage is a co-ed residential treatment facility for youth (ages 12-17) with substance abuse and co-occurring disorders. Approximately 8,000 American Indian and Alaska Native youth per year in California require substance abuse treatment based on Census 2000 data. The facility concurrently provides care for maximum of 32 youth. Services offered include mental health, chemical dependency counseling, individual and group counseling, family therapy, traditional healing services, traditional arts and crafts, cultural activities, field/recreation trips, educational opportunities, academic and life-skills education, fitness program, and access to medical specialties and dental care. Desert Sage began operations in 2017 and received The Joint Commission accreditation on February 11, 2019. Desert Sage's activities are authorized under Section 704 of amended P.L. 94-437, Indian Health Care Improvement Act.

The Desert Sage facility is located on the "Taylor Ranch" property in Riverside County (County) near Hemet, California. The property was purchased in October 2012 for the facility. At that time, IHS had an agreement with the landowners to use the unpaved easement, Best Road, to cross two properties (Genus and Moon Valley Nurseries) to access the facility.

Best Road is an unimproved road, privately owned, and approximately 0.5 mile long located in the County that runs from Sage Road to the driveway entrance of the Desert Sage facility. The road conditions on Best Road deteriorate during storm events and become nearly impassible due to flooding in low-lying areas, poor surface drainage, and the lack of all-weather driving surface. Since October 2017, the IHS California Area Office continues to perform regularly scheduled maintenance every other month including grading and backfilling low areas with gravel. Emergency work is also done on an as-needed basis after major storm events. Currently, IHS does not have the authority to acquire and/or improve Best Road. The Feinstein legislation would authorize the Director of IHS to acquire and improve Best Road to provide safe access to the Desert Sage facility for staff and emergency vehicles.

We appreciate all of your efforts in helping us provide the best possible care to the people we serve. Thank you again for the opportunity to meet with you today.