National Indian Health Board

WRITTEN TESTIMONY OF AMBER TORRES,
INTERIM CHIEF OPERATING OFFICER, NATIONAL INDIAN HEALTH BOARD
BEFORE THE HOUSE NATURAL RESOURCES COMMITTEE
SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS
"LEGISLATIVE HEARING ON H.R. 8956, H.R. 8942, H.R. 8955"

July 25, 2024

Chairwoman Hageman, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally recognized American Indian and Alaska Native Tribal nations we serve, thank you for this opportunity to provide testimony on three pieces of legislation, H.R. 8956, the Uniform Credentials for IHS Providers Act of 2024, H.R. 8942, the Improving Tribal Cultural Training for Providers Act of 2024, and H.R. 8955, the IHS Provider Integrity Act. My name is Amber Torres. I am a member of the Walker River Paiute Tribe of Nevada and I serve as the Interim Chief Operations Officer for the National Indian Health Board (NIHB).

Healthcare workforce is the critical component of the Indian health system that directly meets the trust and treaty obligation to provide for the healthcare of our People. The legislation before the committee today seeks to address several important components of the staffing and provider hiring and onboarding process. The Uniform Credentials for IHS Providers Act of 2024 proposes to streamline the hiring process and the ability for providers to move around the Indian Health Service's network of hospitals and clinics. Uniform credentialing promises to improve the ability of IHS to quickly address staffing shortages across its system by more quickly deploying providers to areas which may have high vacancy rates. NIHB has shared feedback with the committee to ensure that the legislation includes definitions that would be appropriate to only IHS-operated facilities.

The Improving Tribal Cultural Training for Providers Act of 2024 would require IHS staff to receive cultural training. This bill would ensure that those working in our communities have a better understanding of our cultures and our ways to improve the experience that our Tribal citizens receive their care. This is critical to improving the patient experience and improving outcomes. When patients feel that they are understood and their concerns are received in a culturally informed manner, they are more likely to return for their follow up care and feel that their healthcare provider has their best interests at heart and the best interests of the community's overall health. Many tribal health providers already conduct this type of training, and we would encourage IHS to utilize these models as best practices as they implement the requirements of this bill.

Finally, H.R. 8955 would require in statute that providers under investigation be reported to their licensing boards. Further, the bill requires that as part of the hiring processes, IHS contact licensing boards to verify the good standing of provider's licensure, particularly seeking disciplinary actions or findings made by the licensing board. This legislation would address quality of providers to ensure that they can appropriately meet the needs of the IHS. NIHB has shared feedback with the Committee and the bill's

sponsors that would streamline the legislation so as not to make this onerous on the hiring process of the IHS. Often, state licensing boards can be under-staffed and it is possible this could create delays in the hiring process. It is also important to consider how long IHS and other providers keep personnel records. The 20 years outlined in the legislation may not be a feasible timeline to access records. Additionally, we would encourage the legislation to share only investigations that have reasonable findings, as investigations can often be started and there is found to be no wrongdoing by the provider.

As the Committee considers these bills, it is important to consider the current provider vacancy rates and the timeline for bringing on providers to fill vacancies. Additional requirements in the hiring and onboarding process creates the possibility to slow the current onboarding of critical providers. As of February 2024, IHS had a vacancy rate for physicians of 36 percent; for behavioral health providers, that rate is 44 percent. The dentist vacancy rate is 37 percent, and nurse practitioner vacancy is 35 percent. When we look at specific Areas, individual rates go as high as 58 percent vacancy rate for physician assistants in Billings Area, 63 percent vacancy rate for physicians in Great Plains and 78 percent for behavioral health providers in the Albuquerque Area.[1] These incredibly high vacancy rates correspond to low staffing levels on the ground.

Lower levels of staffing in IHS and Tribal facilities can impact access to care, reduce overall quality, and contribute to increased burnout for providers. Reduced staffing can make it difficult to get referrals for specialty care to treat chronic or comorbid conditions, which can have both individual and larger, enterprise-level impacts. Reliance on low levels of staffing also can impact quality of care. Providers working through burnout can miss important symptoms, but further, it creates reliance on particular providers that can leave huge gaps in service delivery if and when a provider moves on.
IHS and Tribal providers also work in an environment that requires cultural competence, sensitivity and awareness. Tribes have long requested that providers, employees, and Commissioned Officers go through cultural training to better serve and understand the communities in which they live and work. Cultural competence training for positions that work in Indian country is vital for the IHS, but there are positions across many federal departments and agencies which need this type of training to properly understand Tribal communities and the Indian health system.

The IHS has been working to improve its human resources, recruitment, hiring, and on-boarding experience through a centralized process known as One HR. Additional statutory requirements for systems changes to improve hiring and onboarding also need to come with appropriate resourcing to ensure the successful implementation of those changes. The House Appropriations Committee has moved to increase staffing funding to IHS in support of new facilities staff, recruitment tools, and staffing quarters to improve the current staffing crisis the Agency has been facing.

The pieces of legislation being considered address several concerns Tribes have raised. The language of the proposed bills would benefit from deeper dialogue with Tribes and IHS to ensure they fully meet the intent of Congress to improve the hiring and onboarding process for providers and the healthcare experience and outcomes for Tribal citizens. It is also important that the legislation is clear in its intent to improve the operations of the IHS, and that it does not infringe on the sovereignty of Tribes which operate their programs through agreements under the Indian Self-Determination and Education Assistance Act (25 U.S.C. ch. 14, subch. II § 5301 *et seq*).

There are also other legislative initiatives which are currently pending before Congress which would improve the tools already available to the IHS and Tribes to improve the recruitment and retention of a culturally competent and trained workforce. Although the Indian Health Program received a substantial increase in the House's Interior, Environment, and Related Agencies bill, the scholarship and loan repayment programs are not treated equally to other equivalent programs offered within HHS which enjoy tax-exemption, which allows all of the available funding to support recruitment. Additional funding for this program will be an important part of any multipart strategy to improve the workforce difficulties facing the Agency. NIHB supports language included in H.R. 8318, the Tribal Tax and Investment Reform Act of 2024, that would make IHS scholarship and loan repayment programs tax exempt. We encourage the House Natural Resources Committee members to voice their support for this legislation.

Expansion of midlevel provider types and grow-your-own education programs are another critical piece to the workforce development reform that is necessary to support the whole Indian health system. IHS has been working to expand the successful Community Health Aide Program, better known as CHAP, to help smaller communities have providers in their community even when it is difficult to hire a physician level provider. Tribal programs to encourage and educate youth and young professionals in healthcare careers need to be supported and resourced to ensure we are developing a larger pool of providers to meet current and future staffing needs.

Finally, we must work to ensure that the increases to the IHS budget go to support this work. Contract support costs and 105(*l*) lease payments have been determined by the U.S. Supreme Court to be required costs, regardless of the appropriation levels. Therefore, Congress must essentially pay these costs first before other areas of the IHS and Bureau of Indian Affairs budgets can be considered. In recent years, increases to CSC and 105(*l*) leases limited growth in direct services, facilities and other administrative support to the IHS budget that would have otherwise gone to support maintaining current staffing and service levels. Following the recent ruling in the *Becerra v. San Carlos Apache Tribe*, the costs are likely to increase, further straining the IHS and the Interior appropriations bill. As part of long-term support for addressing IHS workforce needs, it is critical that these costs, which are essentially already a mandatory cost provided as an "indefinite discretionary", be is addressed through common sense reform by appropriately classing them as mandatory appropriations. This will allow increases to the IHS budget to meet the important staffing needs to continue meeting the federal treaty and trust responsibility to Tribes. These funds are already required to be paid, and the Appropriations Committee does not have input in how much to allocate to these accounts. Without this change, the administrative funds that IHS would use to implement the changes outlined in these bills, will not be possible.

Conclusion:
In conclusion, we thank the Committee for their consideration of these bills that address important challenges to IHS staffing and cultural competency at IHS-operated facilities. As the process moves forward, we look forward to working with Committee staff and the bill's sponsors to ensure that the language would not inadvertently impact Tribally operated health systems, and would not have a deleterious impact on the efficiency of the IHS hiring process (a process that is already exceedingly slow and overburdened by bureaucracy). We also encourage the House Natural Resources Committee to support changes that would categorize CSC and 105(*l*) leases as mandatory funding. This will make it possible for they agency to allocate additional funds for activities to support staffing at IHS-operated facilities.