Healthcare Self-Determination Processes in South Dakota

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Healthcare Self-Determination in SD

Overview

• Phases of Federal Indian Policy
• Phases of Indian Health Service
• Current Trends in Indian Health
• Self-Determination opportunities in SD
Provision of health services to AI/ANs grew out of the special *government to government* relationship between the federal government and Indian tribes.
TREATY WITH THE POTAWATOMI NATION, 1846.

Whereas the various bands of the Potawatowomi Indians, known as the Chipewas, Ottawas, and Potowatowomies, the Pottowatomies of the Prairie, the Pottowatomies of the Waubash, and the Pottowatomies of Indiana, have, subsequent to the year 1838, entered into separate and distinct treaties with the United States, by which they have been separated and located in different countries, and difficulties have arisen as to the proper distribution of the stipulations under various treaties, and being the same people by kindred, by feeling, and by language, and having, in former periods, lived on and owned their lands in common; and being desirous to unite in one common country, and again become one people, and receive their annuities and other benefits in common, and to abolish all minor distinctions of bands by which they have heretofore been divided, and are anxious to be known only as the Pottowatomie Nation, thereby reinstating the national character; and

Whereas the United States are also anxious to restore and concentrate said tribes to a state so desirable and necessary for the happiness of their people, as well as to enable the Government to arrange and manage its intercourse with them:

Now, therefore, the United States and the said Indians do hereby agree that said people shall hereafter be known as a nation, to be called the Pottowatowomi Nation; and to the following:

Articles of a treaty made and concluded at the Agency on the Missouri River, near Council Bluffs, on the fifth day of June, and at Pottawatomie Creek, near the Osage River, south and west of the State of Missouri, on the tenth day of the same month, in the year of our Lord one thousand eight hundred and forty-six, between T. P. Andrews, Thomas H. Harvey, and Gideon O. Mallock, commissioners on the part of the United States, on the one part, and the various bands of the Pottowatomie, Chippewa, and Ottowa Indians on the other part:

ARTICLE 1. It is solemnly agreed that the peace and friendship which so happily exist between the people of the United States and the Pottowatomie Indians shall continue forever; the said tribes of Indians giving assurance, hereby, of fidelity and friendship to the Government and people of the United States; and the United States giving, at the same time, promise of all proper care and parental protection.
AI/AN Healthcare

• Commerce Clause (Article I, Section 8) of the US Constitution stipulates that Indian Affairs are handled by Congress.

• Federal – Tribal relationship has changed in form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders, including PPACA.
The Indian Health Service

- The Indian Health Service (IHS) is the principal federal health care provider and health advocate for Indian people.
- Its goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.
Indian Health Service

- The *mission* of the IHS, in partnership with AI/AN people, is to raise their physical, mental, social and spiritual health to the highest level.

- The *goal* is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.

- The *foundation* is to uphold the federal government’s obligation to promote healthy AI/AN people, communities and cultures and to honor and protect the inherent sovereign rights of Tribes.
To traditional American Indians the Eagle is the guardian of health. Traditional healers draw strength, wisdom and knowledge from the Eagle as they care for their people. The Indian Health Service (IHS) offers physicians the unique opportunity to go beyond contemporary medicine and enter the world of the Eagle.

The IHS offers community-oriented practices in such diverse settings as the enchanting high deserts of the southwest, the majestic Rockies, the historic Black Hills of the Dakotas, and the far reaches of Alaska.
Federal Policies and Laws

- 1800-1840—Removal
- 1849-1920—Reservation and Assimilation
- 1930-1950—Indian Reorganization
- 1950-1970—Termination
- 1975-current—Self-Determination
Period of Removal 1800-1840

- Pressure for land motivated government policy to remove Indians westward with public policy justifications as this being the only way to “save the Indian”
Period of Removal 1800-1840

- Federal health services were primarily oriented toward military containment managed within the War Department
Federal Policies and Laws

- In 1849, the military control of Indian Affairs ended and the BIA was transferred to the Department of the Interior.
- In 1911, Congress made the first Federal appropriation specifically for health services for AIs but made no provisions for recurring appropriations for that purpose.
Reservation and Assimilation Policy 1849-1920

- This period has been characterized by the saying “kill the Indian, but save the person”
- Initially, federal policy was to keep native peoples racially segregated until “civilized”
- The policy was accomplished via destruction of Indian economies, confinement to reservations and removal of Indian children from their families and communities and placement in boarding schools
Reservation and Assimilation Policy 1849-1920

- Motto of Carlisle Indian School: “Kill the Indian, but save the man”
Indian Reorganization 1930-1950

- In 1926, the Secretary of the Interior authorized the Institute for Government Research to conduct a study of the BIA.

- In 1928, the Meriam Report marked a shift in federal policy. The report recommended more funds for health and education.

- In 1934, the Indian Reorganization Act was passed, which implemented the recommendations of the report.
Federal Policies and Laws

- The 1954 Transfer Act, Public Law 83-568, transferred the responsibility for Indian health services from the BIA (Department of Interior) to the Public Health Service in the Department of Health, Education and Welfare. Its mission was twofold:
  - Terminate reservation status
  - Improve health services for Indians
Termination 1950-1970

- Solution of the “Indian Problem” was to end the relationship between Indians and the federal government.

- In 1953, House Concurrent Resolution 108 was adopted, which called for termination of the federal relationship with tribes “as soon as possible.”

- Policies were a product of the backlash of the 1930 reforms which led to congressional studies of 1943 that again found serious problems in the administration of Indian Affairs.
Termination 1950-1970

- Urban migration, which began in World War II, was accelerated by federal programs to relocate reservation Indians to cities.
Federal Policies, Laws and Decisions

- Federal Policy changed with the 1970 President Nixon executive proclamation, ending the policy of termination and the beginning of the policy of Indian self-determination.

Self-Determination 1975-current

- 1976 PL 94-437: Indian Health Care Improvement Act
  - Urban Indian Health Centers (Title V)
  - IHS Scholarships
  - Loan Repayment Program

- 1988 PL 100-713: Indian Health Care Amendments—M & M Billing

- 2010 Patient Protection and Affordable Care Act—Included Reauthorization of IHCIA
Phases of Indian Health Service

- Phase I: Establishing Basic Clinical Services (1955-1962)
- Phase II: Expanding Management, Training and Research (1963-1969)
- Phase III: Transition to Indian Community Control (1970-present)
IHS

- Agency in the US Dept. of Health and Human Services and is responsible for providing health services to *federally recognized tribes* of American Indians and Alaska Natives.

- IHS currently provides health services to approximately 1.6 million AI/ANs who belong to more than 560 federally recognized tribes in 35 states.
IHS

- Headquarters in Rockville, Maryland.
- Composed of 12 Areas.
- 127 service units.
- Operates 37 hospitals.
- 60 health centers.
- 47 health stations.
- 34 urban health projects.
- 3 school health centers.
Aberdeen Area
2009 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita

Per Capita spending in the year for which data are published most recently – see base of each bar.

See page 2 notes on reverse for data sources and extrapolation assumptions.
Percent At or Below FPL

- US All Races
- IHS Total
- Aberdeen
# AI Health Disparities

## Life Expectancy in Years:

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>73.2</td>
<td>79.6</td>
<td>76.5</td>
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<tr>
<td>AI/AN</td>
<td>66.1</td>
<td>74.4</td>
<td>70.6</td>
</tr>
<tr>
<td><strong>Disparity:</strong></td>
<td><strong>7.1</strong></td>
<td><strong>5.2</strong></td>
<td><strong>5.9</strong></td>
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</table>

## Median age at death in SD (2009):

- **General Population**: 81
- **AI Population**: 58
AI Health Disparities

Death rates from preventable diseases among AIs are significantly higher than among non-Indians:

- Diabetes 208% greater
- Alcoholism 526% greater
- Accidents 150% greater
- Suicide 60% greater
- Infant Mortality in SD

Indian Health Service. *Regional Differences in Indian Health 2002-2003*
Public Law 93-638

The Indian Self-Determination and Education Assistance Act of 1975
Origin of Self-Determination

“The time has come to break decisively with the past and to create the conditions for a new era in which the Indian future is determined by Indian acts and Indian Decisions”

Richard Nixon – 1970
Origin of Self-Determination

“We have turned from the question of whether the Federal government has a responsibility to Indians to the question of how that responsibility can best be furthered.”

“We have concluded that the Indians will get better programs and that public monies will be more effectively expended if the people who are most affected by these programs are responsible for operating them”

Richard Nixon – 1970
Public Law 93-638

- Title I—Indian Self-Determination
- Title II—Educational Assistance
- Title III—Tribal Self-Governance Demonstration Project
- Title V—Self-Governance Compacting
Declaration of Policy

- Sec. 3(a) The Congress recognizes obligation of US to respond to the strong expression of Indian people for Self-Determination by assuring maximum Indian participation in the direction of educational services so as to render such services more responsive to the needs and desires of those communities.
Carryover of Funds

- Sec. 8 ...any funds...for any fiscal year which are not obligated or expended...shall remain available for obligation or expenditure during such succeeding fiscal year...for which they were originally appropriated, contracted or granted,...no additional justification...need be provided by the tribal organization..
Title I Indian Self-Determination Act

- Sec. 102 (a)(1) …upon the request of any Indian tribe by tribal resolution, to enter into a self-determination contract…to plan, conduct, and administer programs…

- (2) ..an Indian tribe…may submit a proposal..to amend or renew a self-determination contract for review
Effect on Existing Rights

- Section 111 (Page 53) Nothing in this Act shall be construed as- (1) affecting, modifying, diminishing, or otherwise impairing the sovereign immunity from suit enjoyed by an Indian tribe; or (2) authorizing or requiring the termination of any existing trust responsibility of the US with respect to the Indian people.
PL 93-638 Utilization for Health Programs

- Hospitals: 13/49 (27%)
- Health Centers: 158/221 (71%)
- Residential Treatment Centers: 28/33 (85%)
- 42% of Indian Health Service budget for 2003
- 51% of IHS budget for 2005
- Nearly 60% of 2013 budget
IHS Funds Managed by Tribes

- 1995: 733 million
- 1998: 943 million
- 2001: 1,407 million
- 2004: 1,618 million

$ in Millions
Financial Advantages

- Carry-Over Funding
- Third-Party Revenue
- Eligibility for Grants (e.g. HRSA 330—FQHC)
- Contract Support Costs
- FTCA
- Medicaid Administrative Match
- Ability to Lobby
- Others
PL 93-638 Programs in Phoenix Area IHS

PIMC

Hu Hu Kam Memorial Hospital
Gila River Health Care Corporation
Process Improvements under PL 93-638

• Hu Hu Kam Hospital funded at 65% estimated need in 1989
• GRIC conducted PL 93-638 feasibility study in 1994
• GRHCC formed in October 1995
• Increased and improved services (ER, specialty, PC)
• Improvements in MIS and third party revenue
PL 93-638 Programs in Alaska Area IHS

ANMC
PL 93-638 Programs in Alaska Area IHS

SCAT

LBST
Alaska Native Tribal Health Consortium [501(c)3]

ANMC (Anchorage) Inpatient/ Specialty Clinics
Alaska Native Tribal Health Consortium [501(c)3]
## Lakota Nation 638 Considerations

<table>
<thead>
<tr>
<th>Function</th>
<th>Alaska</th>
<th>Lakota Nation HC</th>
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<tbody>
<tr>
<td>Number of Tribes, Villages, Communities</td>
<td>&gt;200</td>
<td>3</td>
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<tr>
<td>Referral Medical Center</td>
<td>Alaska Native Medical Center</td>
<td>Lakota Nation Medical Center</td>
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<tr>
<td>Medical Center Management</td>
<td>Southcentral Foundation</td>
<td>Lakota Nation Healthcare Corporation</td>
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</table>
South Dakota Indian Health Facilities

- **Rapid City**—Sioux San Hospital
- **Pine Ridge**—Pine Ridge Hospital, Kyle, Wanblee
- **Rosebud**—Rosebud Hospital
- **Cheyenne River**—Eagle Butte Hospital
- **Standing Rock**—McLaughlin
- **Lower Brule**—Lower Brule
- **Crow Creek**—Ft. Thompson
- **Yankton**—Wagner
- **Sisseton**—Woodrow Wilson Keeble
- **Flandreau**—Flandreau
South Dakota Indian Health Facilities Managed by Tribes

- **Rapid City**—Sioux San Hospital
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South Dakota Indian Health PFSAs Managed by Tribes

<table>
<thead>
<tr>
<th>Program, Function, Service, Activity</th>
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<tbody>
<tr>
<td>Hospitals &amp; Clinics</td>
</tr>
<tr>
<td>Mental Health</td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>Community Health Representative</td>
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<tr>
<td>Emergency Medical Service</td>
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<tr>
<td>Contract Health Services</td>
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<tr>
<td>Maintenance &amp; Improvement</td>
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<tr>
<td>Equipment</td>
</tr>
<tr>
<td>Contract Support Costs (direct)</td>
</tr>
</tbody>
</table>
Challenges

• Poverty
• Staffing
• Housing
• Health Status
• Rural
• Partnerships?
Considerations for the Future

Health Policy Research / HSR

• 638 Feasibility Studies
• Governance Structures / Tribal Partnerships
• Tribal-State Relations
• Public-Private Partnerships
• Role of PPACA in AI Health
• Workforce Development
• Best Practices in AI Health Policy
• Academic Partnerships
• Traditional Medicine