

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

THE STATUS OF INDIAN HEALTH

April 13, 2005

STATEMENT OF THE INDIAN HEALTH SERVICE
HEARING ON THE
STATUS OF INDIAN HEALTH

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Mr. Chairman and Members of the Committees:

Good morning, I am Dr. Charles Grim, Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Robert G. McSwain, Deputy Director; Mr. Gary J. Hartz, Director, Office of Environmental Health and Engineering; and Dr. W. Craig Vanderwagen, Acting Chief Medical Officer. We are pleased to have this opportunity to testify on behalf of Secretary Leavitt on the status of Indian Health.

The IHS has the responsibility for the delivery of health services to an estimated 1.8 million Federally-recognized American Indians and Alaska Natives through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial decisions, and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L.94-437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the provision of programs, services and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also included authorities for the recruitment and retention of health professionals serving Indian communities, health services for people and the construction, replacement, and repair of health care facilities.

We are here today to discuss the status of the Indian health by focusing on health disparities and other related issues such as Urban Indian health, Indian health care facilities, Indian self determination, and portions of the Medicare Modernization Act.

Health Disparities

While the mortality rates of Indian people have improved dramatically over the past ten years, Indian people continue to experience health disparities and death rates (1999-2001) that are significantly higher than the rest of the U.S. general population (2000):

- Tuberculosis - 533% higher
- Alcoholism - 517% higher
- Diabetes - 208% higher
- Accidents - 150% higher
- Suicide - 60% higher
- Homicide - 87% higher.

While some view these statistics as insurmountable facts, they are influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices. For FY 2006, IHS is requesting a total budget of \$3.8 billion, including an increase of \$80 million for inflation and population growth which will allow for a renewed focus on health disparities.

It is the mission of the Indian Health Service to provide services and programs that promote healthy choices and assist in enabling Tribes to educate their members about prevention and treatment programs that address the unique needs of their individual communities.

I just returned from the Red Lake Band of Chippewa Indians in Minnesota and saw firsthand the results of the devastation brought about by the shootings at the Red Lake High School. I also saw the community coming together and drawing strength from the support of mental health professionals and tribal spiritual leaders. There is much to do, yet there is a sense of hope and a spirit of collaboration among the community and tribal leaders, the State and Federal programs. Within the Department of Health and Human Services alone, the Office of the Secretary's Office of Intergovernmental Affairs as well as the Department's operating divisions, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Children and Families (ACF) and its Administration for Native Americans, and the Office of Minority Health are joining the Bureau of Indian Affairs (BIA) within the Department of the Interior, the Department of Justice (DOJ), and the Department of Education to assist the tribe and community. My thanks to all those involved that are working together to improve the overall health of Indian people in Red Lake and throughout Indian Country.

How do we prevent such incidences from occurring? First, IHS focuses on screening and primary prevention in mental health especially for depression which manifests itself in suicide, domestic violence, and addictions. Secondly, we focus on the effective utilization of treatment modalities that are available; and, we are seeking to improve the documentation of mental health problems. IHS is currently utilizing effective tools for documentation through the behavioral health software package. And, we are working with communities who are focusing more on these mental health needs. In addition, our budget request includes \$59 million for IHS mental health services, an increase of 7.7 percent over FY 2005.

With 80% of the mental health budget and 97% of the alcohol and substance abuse budget in IHS going directly to tribally operated programs, the tribes and communities themselves are now taking responsibility for their own healing. They provide effective treatment and prevention services within their own communities.

A primary area of focus that I have identified based on these statistics is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in the ongoing battle to eliminate health disparities plaguing our people for far too long. Although IHS has long been an organization that emphasizes prevention, I am calling on the agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. Field, tribal, and urban participation in the initial stages of planning and implementation of this revitalization is critical to its success.

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care and public health efforts including massive vaccination and sanitation facilities construction programs. As the population lives longer and adopts more of a Western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population with the increasing rates of cardiovascular disease, Hepatitis C virus, and diabetes. Most chronic diseases are affected by lifestyle choices and behaviors.

The incidence and prevalence of diabetes has been increasing dramatically since 1972. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. The prevalence of type 2 diabetes is rising faster among American Indian and Alaska Native children and young adults than in any other ethnic population, increasing 106% in just one decade from 1990 to 2001. As diabetes develops at younger ages, so do related complications such as blindness, amputations, and end stage renal disease. We are hopeful, though, that we may be seeing a change in the pattern of diabetes mortality because the diabetes mortality rate for the entire American Indians and Alaska Natives population did not increase between 1996-98 and 1999-2001. In fact, the overall mortality rate for American Indians and Alaska Natives decreased approximately 1% between these same time periods. And there is good news that we have recently

measured a slight, but statistically significant, decline in kidney failure in the American Indians and Alaska Natives diabetic population as well.

What is most distressing however about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the chances of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventive approach to diabetes management is an important consideration, since the cost of caring of diabetes patients is staggering. According to a recent American Diabetes Association study, the managed care cost for treating diabetes annually per patient exceeds \$13,000.

In 1997, the Special Diabetes Program for Indians (SDPI) was enacted and provided \$150 million over a five year period to IHS for prevention and treatment services to address the growing problem of diabetes in American Indians and Alaska Natives. In 2001, Congress appropriated an additional \$70 million for fiscal years 2001 through 2002, and an additional \$100 million for fiscal year 2003. Then in 2002 Congress extended the SDPI through 2008, and increased the annual funding to \$150 million with the directive to address “primary prevention of type 2 diabetes.” These funds have substantially increased the availability of services - physical activity specialists, registered dietitians and nurses, wellness and physical activity centers, newer and better medications - which have led to a steady increase in the percentage of diabetics with ideal blood sugar control. We are proud to announce that our Division of Diabetes Treatment and Prevention launched a competitive grant demonstration project focused on primary prevention of type 2 diabetes in 35 American Indians and Alaska Natives communities in November 2004. This program is focusing on American Indians and Alaska Natives adults with pre-diabetes to determine if an intensive lifestyle intervention can be successfully implemented in American Indians and Alaska Natives communities. Our efforts are based on a model developed by the National Institutes of Health (NIH) that proved diabetes could be prevented. These programs will cover a four year period. The outcomes of the demonstration projects will enable us learn what may be applicable to other communities throughout Indian country.

Cardiovascular disease (CVD) is the leading cause of mortality among Indian people. The Strong Heart Study, a longitudinal study of cardiovascular disease in 13 American Indians and Alaska Natives communities, has clearly demonstrated that the vast majority of heart disease in American Indians and Alaska Natives occurs in people with diabetes. In 2002, we were also directed to address “the most compelling complications of diabetes,” which of course is heart disease with the increased SDPI funding. The IHS is working with other DHHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health’s National Heart, Lung, and Blood Institute, to develop a Native American Cardiovascular Disease Prevention Program.

Also contributing to the effort are the IHS Disease Prevention Task Force and the American Heart Association.

Our primary focus is on the development of more effective prevention programs for American Indians and Alaska Natives communities. The IHS has begun several programs to encourage employees and our tribal and health program partners to lose weight and exercise, such as “Walk the Talk” and “Take Charge Challenge” programs. Programs like these are cost effective in that prevention of both diabetes and heart disease, as well as a myriad of other chronic diseases, are all addressed through healthy eating and physical activity.

In summary, preventing disease and injury, promoting healthy behaviors and managing chronic diseases are a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. This is the path we must follow if we are to reduce and eliminate the disparities in health that so clearly affect American Indians and Alaska Natives people. We will spend \$330 million on specific health promotion and disease prevention activities in FY 2005.

Indian Health Manpower

IHS, Tribe and Urban Indian health programs could not function without adequate health care providers. The Indian Health Manpower program which is also authorized in the Indian Health Care Improvement Act (P.L. 94-437, as amended) consists of several components:

- The IHS Scholarship Program;
- The IHS Loan Repayment Program; and
- The IHS Health Professional Recruitment Program.

The IHS Scholarship Program plays a major role in the production of American Indians and Alaska Natives health care professionals. Since its inception in 1977, more than 7,000 American Indians and Alaska Natives students have participated in the program, with the result that the number of American Indians and Alaska Natives health professionals has been significantly increased. The program is unique in that it assists students who are interested in or preparing for entry into professional training. Most scholarships only provide assistance to those who have been accepted into a health professional training program. By providing this preparatory assistance, the program ensures that even those participants who do not complete their health professions training are better prepared to return to their communities and become productive members.

The IHS Scholarship Program (LRP) has been the starting point for the careers of a number of American Indians and Alaska Natives health professionals now working in

IHS, tribal, and health programs. Many are also involved in academia, continuing to help identify promising American Indians and Alaska Natives students and recruit them to the health professions, thereby helping to produce a self-sustaining program. We have had several instances of parents going through the program, followed later by their children, and in some cases, we have even seen children being followed by their parents. The average age of our students is 28 years, well above the norm for college students. It is not uncommon for students to have attended 5 or more colleges or universities during the course of their academic careers, not because they failed in the first four, but because they had to move in order to have the employment they needed to support their families.

The IHS Loan Repayment Program is very effective in both the recruitment and retention areas. The program provides an incentive both to bring health professionals into the IHS and to continue their employment with the agency. Keeping health professionals for longer periods of time provides a benefit to the overall Indian health program by increasing continuity of care.

The scholarship and loan repayment programs complement one another. Scholarships help individuals rise above their economic background to become contributing members of the community and participate in improving the well-being of the community. Loan repayment participants often graduate with large debt burdens which cause them to accept jobs with the highest salaries. The program is a way for them to provide service in return for assistance in repaying loans that could otherwise be overwhelming.

The recruitment program seeks to maximize the effectiveness of both programs, as well as to make the IHS more widely known within the health professional community and to assist interested professionals with job placement that best fits their professional and personal interests and needs. Our FY 2006 request includes \$32 million for Indian Health Professions, an increase of 3.6% over FY 2005.

Urban Indian Health

Another important aspect of our health care delivery system is the Urban Indian Health Program (UIHP) authorized by Congress in 1976 with the passage of the Indian Health Care Improvement Act. Title V of the IHCA was intended to make health services available to communities that were not otherwise met by an IHS administered health program. Urban American Indians and Alaska Natives are often times not included in the urban community health planning process because they represent a smaller percentage of the population in the urban areas in which they reside.

For many urban Indians, the UIHP may serve as a primary care provider or may provide critical assistance in helping urban Indians to access health care in the urban community. In this regard, UIHPs are remarkably successful. All UIHPs conduct extensive eligibility determinations, education about services, training in how to access services, assistance in applying for and qualifying for and state health benefits' programs, assessment of patient

needs and referral, and in some cases transportation to other health care sites. Many Urban Indians now get health care services from a variety of sources for which they are eligible as a result of the UIHP efforts. However, some may experience economic, cultural, and language barriers which can make it difficult for Urban Indians to access such programs. In addition, eligibility may vary over time in response to job conditions, personal circumstances and eligibility guidelines making continuity of care difficult to achieve.

In order to address the growing needs of Urban Indian populations, UIHP organizations partner with and received assistance and funding from many Federal health care agencies, including DHHS sister agencies, the Department of Veterans Affairs, and state and local governments. In fact, during 2003, Title V funding represented 48% of all funding received by the UIHPs, with the remaining 52% received as a result of collaborations. Through these collaborative efforts, the UIHPs work to obtain maximum health care services for Urban Indians.

In summary, the UIHP was established to provide basic services to eligible Indians who are not living on or near a reservation where the IHS or a Tribal program would otherwise provide for their healthcare. The UIHP is very successful in assisting eligible Urban Indians to utilize health care services when such services are available. When Urban Indians are not eligible for other programs, or lack access to basic health care, the UIHP provides basic services to Indian clients to the extent resources are available. Equal access and utilization of health care services by Urban Indians is achievable in combination with UIHP and other public and private sources. Our FY 2006 request includes \$33 million for Urban Health, an increase of 4.4% over FY 2005.

Access to Health Care: The Environmental Health and Engineering Program

The Environmental Health and Engineering program is a comprehensive public health program administered by IHS and Tribes. Two examples are the sanitation facilities construction program which provides safe water, wastewater disposal, and solid waste disposal system; and the injury prevention program which focuses on unintentional injuries. As a result of these two successful programs, 88 percent of American Indians and Alaska Natives homes now have safe water and unintentional injuries have been reduced by 53% between 1972 and 1996. Unfortunately, 12 percent of the homes still lack adequate sanitation facilities compared to 1% of the rest of the United States population; and the leading cause of death for American Indians and Alaska Natives between the ages of 1 and 44 years of age is unintentional injuries. Improving in these areas is integral to our mission. Our FY 2006 request will provide water and waste disposal services to 20,000 existing Indian homes.

The Environmental Health and Engineering program provides access to health care services through the health care facilities program which funds Federal and tribal construction, renovation, maintenance, and improvement of health care facilities where

health care services are provided. There are 49 hospitals, 231 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to American Indians and Alaska Natives people. The IHS is responsible for managing and maintaining the largest inventory of real property in the DHHS, with over 9.5 million square feet (880 000 gross square meters) of space and the Tribes own over 3.7 million square feet (353 000 gross square meters). This is in part the result of tribally funded construction of millions of dollars worth of space to provide health care services by the Indian Health Service funded programs.

Over the past decade, \$600 million in funding has been invested in the construction of health care facilities which include, 1 Medical Center, 5 Hospitals, 9 Health Centers, 3 Youth Regional Treatment Centers, 500 units of Staff Quarters, 27 Dental Units, and 21 Small Ambulatory Program construction projects. IHS has substantially improved its health care delivery capability in the newer health care facilities but we are still providing health care in a number of older and overcrowded facilities. At the same time, the resources to maintain and improve this space have remained steady over this past decade at \$38 million ten years ago to \$49 million in FY 2005.

In response to a Congressional request to revise the Health Care Facilities Construction Priority System, we have been working to better identify the health care delivery needs. This will enable us to prioritize the need for health care facilities infrastructure. We are using a master planning process to address the complex nature of health care delivery for American Indians and Alaska Natives communities. Both the Federal Government and Tribes will be able to use these plans to identify our greatest needs for services and health care facilities. In the time of fewer resources, we want to plan carefully on how to best utilize any possible resources. The IHS Health Care Facilities Construction program is fully prepared to address the needs identified through this process. The program recently received one of the highest Program Assessment Rating Tool scores in the Department of Health and Human Services.

Indian Self Determination/Self-Governance

The IHS has been contracting with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P. L. 93-638, as amended, since its enactment in 1975. IHS has implemented the Act in a manner that re-affirms and upholds the government-to-government relationship between Indian Tribes and the United States. The share of the IHS budget allocated to tribally operated programs has grown steadily over the years to the point where today over 50% of our budget is transferred through self-determination contracts/compacts. This percentage includes 30% of our budget transferred to 303 Tribes and Tribal organizations through self-governance compacts and funding agreements. Our budget request for Contract Support Costs includes an increase of \$5 million, sufficient to cover the contract support costs of the estimated number of new contract requests in FY 2006.

Consultation

As the principal author of major statutes affecting Indian health, this Committee is aware that a primary goal has always been to involve Indian and people in the activities of the IHS. I would like to acquaint the Committee with an initiative that I undertook last year to revise the policy that governs tribal consultation and participation in the activities of the IHS. Over the last 7 months, the IHS has worked closely with a representative group of tribal leaders and officials to revise our present Consultation policy with the intention of improving the process to ensure, to the maximum extent permitted by law, that leaders and officials are true partners with the IHS in policy development, budget allocation, and other activities. I anticipate that our “new” Consultation Policy and the improvements to the consultation process that it sets forth will be formally adopted by me next month, in May 2005. Our new policy will be our third revised Consultation Policy since 1997. The IHS is committed to improving consultation based on our experiences in this important area and our continuing discussions with Leaders concerning consultation activities in the IHS.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

American Indians and Alaska Natives will also benefit from several provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In 2004 and 2005, the transitional assistance credit of \$600 per year for low-income Medicare beneficiaries, including American Indians and Alaska Natives, might provide additional Medicare revenue for prescription drugs dispensed at IHS facilities in FY 2005. The Medicare Part D prescription drug benefit program, when implemented in January 2006, will make the new Part D prescription drug benefit available to American Indians and Alaska Natives Medicare beneficiaries. Other sections of the Act authorize a five-year expansion of benefits covered under Medicare Part B for American Indians and Alaska Natives beneficiaries.

In addition, the MMA introduced a number of provisions that expanded preventive benefits coverage in January 1, 2005. Beneficiaries whose Medicare Part B coverage begins on or after January 1, 2005, will be covered for an initial preventive physical examination within six months of enrollment. This exam includes counseling or referral with respect to screening and preventive services such as pneumococcal, influenza, and hepatitis B vaccinations; screening mammography; screening pap smear and pelvic exam; prostate cancer screening; colorectal cancer screening; diabetes outpatient self-management services; bone mass measurement; glaucoma screening; medical nutrition therapy services; cardiovascular screening blood test; and diabetes screening test which will be given to beneficiaries at risk for diabetes.

The cardiovascular screening blood test and diabetes screening test do not have a deductible or co-pays, so beneficiaries do not incur any cost. This is an additional incentive for those with limited resources who might not otherwise access these benefits.

The Centers for Medicare and Medicaid Services (CMS) is collaborating on education and outreach with the American Cancer Society, the American Diabetes Association, and the American Heart Association to help maximize attention to Medicare's new preventive benefits and help seniors to use them. CMS also plans to assist IHS in training IHS, tribal, and urban Indian health pharmacy staff on Medicare Part D, so staff and Indian Medicare beneficiaries will better understand the new Medicare prescription drug benefit.

In summary, Indian health has improved progressively since enactment of the Indian Health Care Improvement Act in 1976. The IHS has honored its commitment to improve the health status of all eligible American Indians and Alaska Natives as provided by IHCA and has worked with Tribes since the passage of the ISDEAA in 1975 to assist in the successful transition of the IHS administered health programs to Tribal control and administration. Prevention and health promotion programs continue to be a personal priority of mine and have received a \$33 million funding increase in the President's FY'06 proposed budget.

We recognize, however, that health disparities continue to exist between American Indians and Alaska Natives and all other groups in the U.S., and we seek to address this need through continued support of health education and disease prevention programs targeted at diseases with some of the highest mortality rates. In addition, our scholarship and loan program provides opportunities to recruit and retain young Indian professionals to serve their communities, while the sanitation facilities construction program continues to provide safe water, wastewater disposal, and solid waste disposal systems for the well being of many communities. And, through ongoing consultation, both Tribes and the Federal government benefit from communication that better identify priorities and how they might best be addressed. Finally, enactment of the MMA will provide much needed prescription drug coverage in a manner intended to enhance the well being of Tribal members.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the Indian health programs serving American Indians and Alaska Natives and their impact on the health status of American Indians and Alaska Natives. We will be happy to answer any questions that you may have.