

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

CHARLES W. GRIM, D.D.S., M.H.S.A.,

ASSISTANT SURGEON GENERAL,

ACTING DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

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STATEMENT OF THE INDIAN HEALTH SERVICE
CONFIRMATION HEARING FOR CHARLES W. GRIM, D.D.S.
JULY 26, 2007

Mr. Chairman, Madam Vice-Chair, and other distinguished members of the Senate Committee on Indian Affairs:

It is a pleasure and an honor for me to have been nominated by the President, supported by tribal governments across the nation, endorsed by Secretary Leavitt, and for this Committee to consider renewing my term as director of the Indian Health Service.

I'd like to thank and acknowledge my family who could not be here today. They have all sacrificed to allow me to serve in this position, my wife Dr. Gloria Grim, our sons Steven, Jake, Chance and Nicholas. I'd also like to introduce here today my mother, Ms. Ruth Grim, sister Ms. Denise Grim and my daughter Ms. Kristen Grim.

I am proud to renew the pledge I made at my first confirmation hearing before this committee four years ago, to both the Federal and tribal governments, to do my best to uphold the federal government's commitment to raising the health status of

American Indians and Alaska Natives to the highest level. I remain committed to working with this Committee, the Administration, and Tribal Governments toward our shared goals and objectives.

The IHS delivers health services to approximately 1.9 million federally-recognized American Indians and Alaska Natives through a system of IHS, tribal, and urban operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, and social health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to ensure 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 commitment to promote healthy American Indian and Alaska Native people, communities, and cultures.

For those on the Committee and those attending this hearing, I would like to provide some background about myself. I am Charles W. Grim, a member of the Cherokee Nation of Oklahoma. I

come from the town of Cushing, Oklahoma. I am descended from those who walked the Trail of Tears. I would like to acknowledge my late father, Charles Grim and my mother Ruth Grim, whose confidence in me has always been a source of strength and pride. I draw my strong sense of heritage and culture from my family. From early in my life I envisioned working for the Indian Health Service as an important way to help Indian people. Upon my graduation from dental school, my aunt Ms. Dorothy Snake also encouraged me to work for the IHS as part of my National Health Service Corps educational scholarship pay back requirement.

My first assignment with the IHS was at the Indian health Center in Okmulgee, Oklahoma. Working there was like coming home and fulfilling the dream I had as a teenager to help Indian people. I knew then and I know now, just as strongly, that working for the Indian Health Service is a part of my life. I cannot imagine being as satisfied or having such a sense of reward working anywhere else. To be nominated for a second term to lead the Indian Health Service, and to be in a position to do so much for so many Indian people, is wonderful and humbling opportunity, as well as a great honor.

In addition to my personal connection and desire to lead the agency, I am a Doctor of Dental Surgery and I have a Masters degree in Health Services Administration with focus on the Management and Administration of health services, dental care, and hospital and ambulatory care. I have served with the U.S. Public Health Service for 24 years - through assignments to various offices and programs of the Indian Health Service, including five years as the Director of the Indian Health Service. I am ready to recommit to the job of Director of the Indian Health Service.

Rates of some health disparities are decreasing, but the 2001-2003 rates of most leading causes of death for Indian people remain more than double the rates for the rest of America - for injuries, the rate for Indian people is 154% of the rate for the general U.S. population; for alcoholism, 551%; for diabetes, 196%; for homicide, 108%; and for suicide, 57%.

The rate of diabetes-related kidney failure in American Indians and Alaska Natives is 3.5 times higher than the general US population, although the incidence of new cases has declined

18.5% in our population since 1999 (while it is still going up in whites and African Americans). Cardiovascular disease (CVD) is the number one killer of American Indian and Alaska Native adults. CVD is increasing in American Indian and Alaska Native population while it is decreasing in the general US population. Diabetes is the strongest risk factor in up to 70% of the CVD seen in our population. Amputations due to diabetes still occur at rates 3 to 4 times the rates for the rest of the nation.

And the tragedy of Sudden Infant Death Syndrome (SIDS) occurs at two times the rate of the U.S. general population. American Indian and Alaska Native (15-24 years) suicide mortality within Indian families occurs at three times the rate than for other families.

In the early history of the Indian Health Service, the greatest achievements in reducing health disparities were through increased medical care and public health efforts that included massive vaccination programs and bringing safe water and sanitation facilities to reservation homes and communities. I believe future reductions in disparities of any significance

will be made through health promotion and disease prevention efforts and programs rather than through treatment.

American Indians and Alaska Natives have the highest rate of type 2 diabetes for all age groups of any ethnic or racial group in the US. The prevalence of type 2 diabetes in American Indians and Alaska Natives is 2.2 times higher than for non-Hispanic whites and the death rate from diabetes is 3 times higher than the general US population - but it has been shown that with moderate changes in diet and exercise, such as reducing body weight by 7% and walking for 30-minutes a day 5-6 days per week - the onset of diabetes can be delayed and, in some cases, can be prevented.

Cardiovascular disease is now the leading cause of mortality among Indian people, with a increasing rate that is nearly 1 ½ times that of the U.S. general population; but by modifying or eliminating health risk factors such as obesity, sedentary lifestyles, smoking, high-fat diets, and hypertension, that trend may be reversed.

We need to invest in our communities so that despair does not fill the lives of our children. The IHS suicide morality rate among Indian youth is three times that of the general population. There are many programs, not just those of the Indian Health Service, which can be implemented to reduce or eliminate the number of our children who are killing themselves.

I believe the more we focus on promoting good health the less will be needed for treating the consequences of poor health. The Indian Health Service has a proud history of dramatically improving the health of Indian people. Since the passage of the Indian Self-Determination and Education Assistance Act in 1975, the greater involvement of Indian Tribes and Indian people in the decisions affecting their health has produced significant health improvements for Indian people: Indian life expectancy has increased by 8.7 years since 1973 and while significant disparities still exist, mortality rates have decreased for maternal deaths, tuberculosis, gastrointestinal disease, infant deaths, unintentional injuries and accidents, pneumonia and influenza, homicide, alcoholism, and suicide.

Tribes are IHS's partners as well as customers in providing approximately 60,000 inpatient admissions, 9.4 million outpatient visits, and 954,000 dental visits annual to approximately 1.8 million American Indians and Alaska Natives at more than 500 sites and 600,000 more American Indians and Alaska Natives at 34 urban sites. The Agency responded to the needs of more than 560 federally recognized sovereign Tribal nations in 35 states.

I will continue to support the decision of Tribes to contract, compact, or retain the Indian Health Service as their provider of choice. The Indian Self-Determination Act allows Tribes to manage their own health programs. In addition, this Administration and the Secretary have put their words into action and increased the involvement of tribal representatives in advising and participating in the decision-making processes of the Department.

We also invest wisely in our communities and in promoting good health. Health status is the result of interwoven factors such as socioeconomic status, educational status, community and spiritual wellness, cultural and family support systems, and

employment opportunities, to name a few. The connection between poverty and poor health cannot be broken just by access to health services or treatment alone.

Based on identified trends in Indian healthcare, I believe we must begin to lay the groundwork now for the health environment we want to have 5, 10 or 20, years in the future. I believe we must focus on emerging infectious and chronic disease patterns, and the related increasing cost of pharmaceuticals to treat and prevent disease. These issues can best be addressed through health promotion and disease prevention activities, so that our people will improve their health, which will decrease the demand for health services and pharmaceuticals.

Preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute and chronic care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering and prolonging life.

In the past four years, I focused the IHS on specific health

initiatives to address the goals, needs, and health status trends of American Indian and Alaska Native people. I believe the future of Tribal communities depends on how effectively the Indian health care system addresses chronic diseases, and therefore initiated a Chronic Care Initiative in 2003. Preventing and treating chronic disease requires an entirely different approach for care delivery.

I implemented strategies within the Indian health system that improve the health status of patients and populations affected by chronic conditions and reduce the prevalence and impact of those conditions by adapting and implementing a chronic care model. We are now committed to developing patient and family-centered care processes that apply across multiple chronic conditions (instead of care based on managing individual diseases). I am proud to inform the committee that, in 2007, fourteen sites within the Indian health system are piloting new approaches to managing chronic care as a result of my Chronic Care Initiative with assistance from a full partnership established with the renowned Institute for Healthcare Improvement.

My Behavioral Health Initiative has three programmatic parts - methamphetamine intervention, suicide prevention, and family safety and protection - and increases the emphasis on both clinical and community-based health promotion and disease prevention (HP/DP) efforts. We are focusing on using our collective ability to develop and implement programs designed to prevent disease rather than relying exclusively on treatment of disease. One half of IHS Areas will be integrating behavioral health into local Area Tribal Health Board plans. They share best and promising practices of how to integrate behavioral health with the other two initiatives.

We are forging collaborations with other organizations like the National Boys and Girls Clubs of America to increase clubs on reservations, NIKE Corporation to promote healthy lifestyles, CDC to fund IHS FTEs supporting epidemiology and disease prevention activities, Mayo Clinic to support efforts to reduce cancer and related health burdens, and Harvard University to improve American Indian and Alaska Native health and wellness.

Through these initiatives, we target health outcomes that will have a beneficial impact, and attempt to change basic practices

and procedures as well as unhealthy behaviors. Therefore, my third initiative is health promotion/disease prevention.

American Indian and Alaska Native patients will see increased focus on screening and primary prevention in mental health, actions aimed at HP/DP to promote healthy lifestyles, and increased primary prevention of chronic disease.

My business emphasis focuses on strengthening the infrastructure of the Indian health system. The infrastructure supports a very comprehensive public health and clinical services delivery program, including such diverse elements as water and sewage facilities, diabetes prevention and wellness programs, and emergency medical services. The IHS is the largest holder of real property in the Department with over 9 million square feet of space. There are 48 hospitals, 272 health centers, 11 school health centers, 320 health stations, satellite clinics, and Alaska village clinics, and 11 youth regional treatment centers that support the delivery of health care to our people.

Just as the health challenge has changed since 1955 when the IHS was transferred to the Department of Health, Education, and Welfare; so too has the infrastructure needed to meet those new

health demands. In 1955, our 2,500 employees and annual appropriation, of approximately \$18 million (\$124 million in today's dollars), provided health services for a population of 350,000 with a life expectancy 58 years for men and 62 years for women. In Fiscal Year 2006, we increased to a staff of approximately 15,000 and an appropriation of \$3.2 billion, supplemented by over half a billion dollars from our third-party collection efforts, which provides health services for 1.9 million American Indians and Alaska Natives with an average life expectancy of 72.3 years.

Our collections are critical to the solvency of our programs because these funds return to the service unit to pay for additional staff, equipment, or other infrastructure elements to address the health needs of that community. One of my top priorities has been to implement a market-based business plan that actively promotes innovation. The plan enhances the level of patient care through increased revenue, reduced costs, and improved business processes. In Fiscal Year 2006, IHS generated approximately \$700 million in third party revenue and saved \$352 million through the use of negotiated contracts with private providers to get the lowest costs possible when purchasing care.

For Fiscal Year 2007, the agency's overall program authority is over \$4 billion dollars.

In an environment of increased federal accountability, it was important for me to institute the restructuring of the IHS's approach to performance management at the national level. In 2005, I activated the IHS Performance Achievement Team to guide the Agency toward a more consistent, efficient, and effective performance management approach to achieve a results-oriented organizational culture. Accountability for performance measures is now part of the performance appraisal criteria at all organizational levels.

I attribute the improved Agency performance accomplishments to our strong focus on accountability. For example, the IHS was recognized in 2006 as a national leader in the use of health information technology to electronically provide clinical quality measures related to monitoring the Government Performance Results Act (GPRA) performance indicators. The Agency implemented reporting on GPRA annual targets in 2002 when 72 percent of the targets were met. In the agency's latest 2006 report, 82% of the clinical and non-clinical targets were

either met or exceeded. I am proud of the continuous improvement shown by the percentage that reached 82 percent in 2006, a documented increase of 10 percentage points since 2002.

Tribal stakeholders updated their health priorities in order to help support program assessment and as a result 65 percent of the Tribally-operated health programs voluntarily provided performance data and other information that demonstrated their achievement of program goals and management standards.

The IHS has made consistent progress in addressing management areas included in the President's Management Agenda, a government-wide management improvement initiative. The IHS met standards for success in carrying out action plans. The IHS continued to implement improvement plans for six programs assessed by the Program Assessment and Rating Tool, a program evaluation instrument. All six programs were rated Adequate or higher with IHS having one of the highest overall averages in the Federal Government by 2005.

We have continued to effectively implement results-oriented management by achieving a 10% relative increase in four areas of

program performance by 2007. In 2006, IHS made significant increases in rates for all four program measures over their 2005 levels: screening for alcohol use among female patients of childbearing ages increased 16%, domestic violence screening increased 15%, diabetic patients assessed for LDL cholesterol increased 9%, and pneumococcal vaccinations for elders increased 8%. The Agency has consistently demonstrated ability to impact targeted performance measures and successfully leverage performance management to advocate for improved health status for American Indian and Alaska Native people.

The IHS is the only federal program delivering hands-on care to Indian people based on a government-to-government relationship and today we are facing many challenges. Change and challenge is nothing new to the history of the nation or to Indian nations. Our history attests to our ability to respond to challenges, to overcome adversities that we sometimes face, and to maximize our opportunities.

I have great passion about this organization and our mission to raise the health of our people to the highest level possible. My actions will always reflect the honor of being entrusted to

provide health services to American Indian and Alaska Native people. I am ready to lead the Indian Health Service, with honor and respect for our ancestors, and to work with you and the Administration for the benefit of American Indian and Alaska Native people.

I am pleased to respond to any questions you may have concerning my nomination.

Thank you.