Department of Health and Human Services

Statement of the
Indian Health Service by
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Before the
Senate Committee on Indian Affairs
June 11, 2003

Mr. Chairman, Mr. Vice-Chairman, 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 George W. Bush, supported by tribal governments across the nation, endorsed by Secretary Tommy G. Thompson, and for this Committee to consider me as the seventh director of the Indian Health Service.

For those on the Committee and those attending this hearing, I would like to introduce myself. I am Charles W. Grim. I am 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 am the father of two children, Kristen and Steven, who are here with me today. My sister, Denise Grim, is also here to celebrate this honor. My mother, Ruth Kannady Grim, who has also traveled to be with me today, understands how important an occasion this is for me. I would also like to mention my father, Charles Grim, who has passed away but whose confidence in me gave me the strength to face moments in life such as this.

As a child, both my parents, and also my aunt and uncle, Larry and Dorothy Snake, instilled in me a sense of my heritage and culture. With their encouragement and guidance, I grew up knowing my Indian heritage while living in a non-Indian world.

As an adolescent, I wanted to work for the Indian Health Service as a way to help Indian people. And after I decided on dentistry as my career field and graduated from dental school, my aunt 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 to lead the Indian Health Service, and to be in a position to do so much for so many Indian people, is an unexpected and humbling opportunity, as well as a great honor.

The text is a composite of the written and oral statement of Dr. Charles W. Grim at his Confirmation Health before the Senate Indian Affairs Committee on Wednesday, June 11, 2003, in Washington, D.C. It should be used with the understanding that some material may have been added or omitted during presentation.

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 20 years – through assignments to various offices and programs of the Indian Health Service. I am ready to take on the job of Director of the Indian Health Service.

The opportunity to sit before you today is the culmination of events put into motion in 1784 with the signing of the first treaty between the Federal Government and an Indian Nation. My ancestors and yours helped build this great nation and have brought us to this moment and this opportunity. I pledge to both the Federal and tribal governments that I will do my best to take full advantage of this opportunity and to work with this Committee, the Administration, Secretary Thompson, and Tribal Governments toward our shared goals and objectives.

I am pleased to serve as the Director of the Indian Health Service during this time in our nation's history and also to be a part of the Department's management team under the leadership of Secretary Thompson as the Department undergoes change to respond to the health needs of all Americans. Through Secretary Thompson's leadership as a key policy maker I am confident that Tribal Government's and the position of Director of the IHS will enjoy new opportunities to be involved in the evolution of their health programs. I will also benefit from the Secretary's policy guidance as I lead the Indian Health Service to a position of greater influence within the Department envisioned by the Secretary.

For the benefit of guests of this Committee and future researchers of the Congressional Record, this is the description of the Indian Health Service today: The IHS has the responsibility for the delivery of health services to approximately 1.6 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, 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 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 obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

I believe the overriding question is: how will I meet the challenge of eliminating the disparity between the health status of American Indians and Alaska Natives and the rest of the nation? I intend to focus on health promotion and disease prevention. The rates of some health disparities are decreasing, but the rates of most leading causes of death for Indian people remain more than double the rates for the rest of America – for accidents, the rate for Indian people is 280% of the rate for the general U.S. population; for alcoholism, 770%; for diabetes, 420%; for homicide, 210%; and for suicide, 190%. The number of American Indians and Alaska Natives enduring end stage renal disease is 2.8 times the rate for whites. The rate of diabetic end stage renal disease for American Indians and Alaska Natives is 6 times the rate for the rest of the nation. Amputations due to circulatory consequences of diabetes have decreased significantly, but 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) and adolescent suicide occurs within Indian families at more than twice the rate 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. To continue on a treatment track alone would bankrupt the nation's health system, including the IHS. For the Indian health system as well as all the United States health programs, there is no practical way the health resources of this great nation can begin to meet the health demands of an aging population whose chronic health conditions are largely the result of a western diet and sedentary lifestyle.

For example, while the mortality rate for Indian people due to diabetes is 420% of that for the rest of the nation, the occurrence of Type 2 diabetes is 2.6 times the national average, and it is rising faster among American Indians and Alaska Native children and young adults than in any other population group – but with minimal changes in diet and exercise, such as reducing body weight by 10 pounds and walking 30-minutes a day – 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 rising rate that is

already almost double 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 can be reversed.

Another example, infant mortality in Indian country can be reduced by 25 percent – 25 percent – as more parents understand that placing their infants on their back to go to sleep removes one of the major risks for SIDS.

And we need to invest in our communities so that despair does not fill the lives of our children. The rate of suicide among Indian youth is twice that for 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 invest in 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: Indian life expectancy has increased by 7.1 years since 1973 (although still 6 years below the general U.S. population) 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.

And the greater involvement, since the passage of the Indian Self-Determination and Education Assistance Act in 1975, of Indian Tribes and Indian people in the decisions affecting their health has also produced significant health improvements for Indian people. I will continue to support the decision of Tribes to contract, compact, or retain the Indian Health Service as their provider of choice.

In a study of indigenous people and their health, cited in the British Medical Journal (March 2003), it was noted that lack of self-governance, if allowed to continue, can have a devastating impact on health indicators. The Indian Self-Determination Act gives Tribe the right to manage their health programs. The continual increase in the number of Tribes electing to contract and compact for Indian Health Service programs and the increased political influence of Indian Tribes and organizations at the state and national level, also are having a positive impact on health indicators. In addition, this Administration and the Secretary have put their words into action and increased the involvement of tribal and urban Indian representation in advising and participating in the decision-making processes of the Department.

Increased tribal involvement also results in the development of an American Indian and Alaska Native workforce, the significance of this is twofold – a demonstration of self-determination and also improving the health status of Indian people because it is well known that there is a positive correlation between employment and health status – for example, 69 percent of the 15,000 employee Indian Health Service workforce is American Indian and Alaska Native and, excluding the medical professional employees where there is not a large Indian applicant pool, 88 percent of the IHS workforce is American Indian or Alaska Native. The tribal and urban Indian operated programs have similar to, or higher, Indian workforce participation rates than the IHS. Because of the location of many of the IHS and tribal facilities, many are the major employer in the area. So, in addition to salaries, most of the operating funds are spent or invested back into the local and surrounding economies, in many cases through tribal and Indian community businesses and operations.

We should invest wisely in our communities and in promoting good health. We cannot increase our health promotion and disease prevention programs at the expense of our treatment programs. And without improvements in other areas that affect health, improvement in health status cannot be sustained. Health status is the result of an interwoven tapestry of 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 down the road. I believe we must focus on identifying emerging infectious and chronic disease patterns, and the related dramatically increasing cost of pharmaceuticals to treat illness and 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.

I have mentioned my health emphasis will be on health promotion and disease prevention. My business

emphasis will be to focus on strengthening the infrastructure of the Indian health system – the Indian Health Service program and the tribal and urban Indian programs. 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, emergency medical services, and organ transplants. The IHS is the largest holder of real property in the Department with over 9 million square feet of space. There are 49 hospitals, 231 health centers, 5 school health centers, and 309 health stations, satellite clinics, and Alaska village clinics 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 (or $124 million in today's dollars), provided health services for a population of 350,000 with a life expectancy 58 years. We have since increased to a staff of approximately 15,000 and an appropriation of $3 billion, supplemented by almost half a billion dollars from our third-party collection efforts, which provides limited comprehensive health services for 1.6 million American Indians and Alaska Natives with an average life expectancy of 71 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. It is among my priorities to implement a market-based business plan that actively promotes innovation. The plan is expected to enhance the level of patient care through increased revenue, reduced costs, and improved business processes. I have been involved with this plan, developed through a joint IHS-Tribal-urban Indian workgroup, since I served as the IHS co-chair of the workgroup when I was the Oklahoma Area Director. The plan will be implemented as part of the reorganization of the Headquarters functions that I have also initiated, and will mention later in my statement, in order to also strengthen our support for infrastructure development.

Our workforce is another infrastructure element that is in crisis. Our annual average vacancy rate for critical health professions such as doctors, dentists, nurses, pharmacists, sanitarians, and engineers is approximately 12%, ranging from 5% for sanitarians to a high of 23% for dentists. I have initiated a review of the various recruitment and retention tools available to the agency in order to establish a more rigorous recruitment and retention effort. Scholarships, recruitment and retention grants, and health career specific collegiate programs are some of the funded tools that will create a greater pool of potential IHS and tribal employees. However, nationwide the demand for healthcare professionals and support staff outpaces the supply. To augment our health workforce, particularly for remote and isolated locations that are difficult to staff or do not have sufficient workload to justify an on-site or local facility, the agency will need to continue its efforts to maximize the use of telemedicine and export the use of an electronic health record from the few test sites today to across the IHS network as early as next year.

Another infrastructure issue is the age of the IHS buildings. Excluding housing, the IHS has 701 buildings comparable to private sector health facilities. The average age of our health facility buildings is 36 years, ranging from newly opened facilities this past year to the 103 year old Pawnee Health Center. In the private sector, according to The Almanac of Hospital Financial and Operating Indicators, the average age of a health facility is 9 years. Only 20 percent of the IHS facilities fall within this range. To strengthen our efforts to modernize or replace facilities, I have emphasized additional consideration of collaborative projects between the IHS and Tribes whenever feasible, and I intend to implement a proactive approach to assist Tribes in developing project proposals and expedite the review and approval process.

The Indian Health Service and the Tribes and urban Indian health programs are not alone in trying to meet the health needs of Indian people – the Department of Health and Human Service is a vast resource as well. As the Secretary has stated numerous times at meetings with the Tribes, during visits to Indian country, and to all of the Operating Divisions of the Department – the programs of the Department must do more to make them work better for American Indians and Alaska Natives and increase consultation with Tribes in order to improve the HHS policies and services to Indian communities. To enact that philosophy, the Secretary revitalized the Intradepartmental Council on Native American Affairs, a Council on which the Director of the Indian Health Service serves as the Vice-Chair, by relocating it into the Office of the Secretary from an organizational location two levels down within another HHS component agency. The Secretary has also incorporated consideration of Indian programs into his "One Department" initiative as benefits are derived from that initiative throughout the Department.

For example, I have had the privilege of participating in the Intradepartmental Council and the "One Department" initiative since my appointment last

August by the President as the Interim Director of the Indian Health Service. Some of the benefits to Indian country have been the establishment, as one of the four top research priorities of the Department, the identification of the research needs in Indian health and the conducting of such research; a proposed increase in the IHS sanitation facilities construction program of $21 million and the contract health services program of $18 million for Fiscal Year 2004; expanding the responsibility of the Office of Intergovernmental Affairs to increase access of Tribes to the Secretary and his regional staff; and a review of HHS programs to determine which programs Tribes are accessing and what can be done to help Tribes access more programs.

The Secretary's "One Department" initiative also includes consolidating similar functions within agencies to increase mission effectiveness and economies of scale. I have been asked by this Committee in previous hearings whether "One Department" initiatives would be good for the Indian Health Service and Indian people. I fully support the "One Department" concept and assure you that IHS and Indian people will benefit. As we gain efficiencies in administrative management areas through consolidations and better use of technology, we will be able to redirect resources to our health care programs. I can assure you that the Department is working closely with the IHS to assess the impact of consolidation on the programs of the agency and the affect it will have on employees, services, and the economic consequences to our communities. Those discussions have been positive.

For example, since my last appearance before this Committee, the Department has finalized their decision that all IHS human resource employees can remain at their current work sites and continue providing personnel services to our staff – even though the human resource position converts to HHS positions on October 1, 2003. Our staff can remain in place unless they choose to apply for an HHS position elsewhere. In addition, there was a shared concern by the Department, the IHS, and the Tribes that these positions retain their Indian Preference designation. By working together we have developed a process that will retain the Indian Preference hiring authority for these positions as they become vacant in the future. I anticipate that other functional consolidations will also benefit from the close working relationship between the Department and the IHS and from the Department's considerations of any special needs of our particular programs.

I have heard and share the concerns that Indian programs stand a great risk of being lost or forgotten if they are absorbed into larger organizations and programs. To avoid that we must be vigilant and provide to others the information they need in order to make wise decisions rather than make decisions based on assumptions. Our financial, personnel, and construction needs and requirements are nothing like any other "inside the beltway" agency. The laws governing self-determination, child protection, Buy-Indian, and Indian preference in hiring, for example, are unique to the Indian Health Service and expertise with those laws and our programs will be exported through efforts of Departmental consolidation – and I believe that the more Indian people and employees with IHS expertise who are dispersed throughout the Department at all levels, the more likely the "One Department" goal of raising the health status of American Indians and Alaska Natives and eliminating health disparities for all Americans can be achieved.

The IHS is the only federal program delivering hands-on care to Indian people based on government-to-government treaties. I have found this Administration and particularly this Secretary and his staff to be receptive to receiving factual information as well as an Indian perspective on the interpretation of laws and regulations. I agree with this Committee and the Tribes of the nation that influence within the Department is necessary. And I believe this Secretary has strengthened the position of Director of the Indian Health Service to increase the degree of influence over the decisions of the Department that impact Indian country.

I believe that now there is an across-the-board understanding by all the Operating Divisions that the Department is responsible for the health of all the people of the nation; that the health of American Indians and Alaska Natives is not the exclusive responsibility of the Indian Health Service, and that the Department's resources and funds need to also be directed to this population group.

"One Department" is not the only restructuring effort being undertaken within the Department that affects the Indian Health Service. The IHS and Tribes are also working together to restructure the agency. Even before there was the "One Department" initiative, the Indian Health Service entered into an IHS Restructuring Initiative with the Tribes and urban Indian representatives. Their recommendations focused on the functions and operations of the agency at the Area Office and field level based on projected health challenges the agency may face in the future. I remain committed to that consultation process and will review the recommendations of the joint workgroup.

In addition to the IHS Restructuring Initiative and the "One Department" initiative, upon my interim appointment I established some short-term management priorities to improve the responsiveness of the agency to the Tribes and to the Department. I mentioned some

earlier, and also among them was a reorganization of the IHS Headquarters functions. This process, including Tribal consultation, is ongoing and is designed to reflect the restructuring recommendations of the Tribes, the "One Department" initiative of the Department, the President's management agenda, and the day-to-day management and operational demands of the $3.5 billion Indian health program.

And, it is not just the Department, the Tribes, or the agency calling for change. It is also this Committee and the Congress. I agree with the Secretary when he says, about the Department: "Any organization that does business the same way it did 35 years ago is obsolete." That applies to the Indian Health Service – the reauthorization of the Indian Health Care Improvement Act is currently under consideration by this Committee. It was passed 28 years ago – but we do not need to wait until 35 years have passed to realize that the health needs of American Indians and Alaska Natives, much less the world, have dramatically changed over time. The proposed language of the Act outlines a restructuring of the authorities of the Indian Health Service to reflect the reality that changes in the health care environment have changed the ability of Tribes, urban Indian health programs, the Indian Health Service, and the Department to deliver high quality and much needed services. The Department supports the purposes of the reauthorization of the Act, but has concerns that are valid and deserve further consideration. Just as the concerns of the Tribes and this Committee toward consolidation and internal reorganization of the agency are valid and need to be addressed.

Today we are facing many challenges. Change and challenge is nothing new to the history of the nation or to Indian nations. Our history as a people 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 and Secretary Thompson 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.

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