

HEARING: SENATE COMMITTEE ON INDIAN AFFAIRS,
August 15, 2007, CROW AGENCY, MONTANA.

Testimony Provided by Ada M. White, Member of the Crow Tribe, Director of the Crow Tribal Health Department:

To the august Members of the United States Senate, serving on the Senate Select Committee of Indian Affairs, welcome to Crow Country. On behalf of the Crow Tribal Members, I thank you for this opportunity to provide Crow Tribal Health concerns to this esteemed Body.

My name is Ada White, I am a member of the Crow Tribe, and currently employed by the Crow Tribe as the Director of the Crow tribal Health Department. Previously, some seventeen (17) years ago, I worked in Tribal Health, as the Director of the Community Health representatives Program for nineteen years. I briefly worked for Indian Health Service for eighteen (18) months, and returned to Crow Tribal Employment in the Administrative Department (Finance, Social Services and Administrative Officer) for ten (10) years. I then became employed by the Little Big Horn College as the Grants and Contracts Officer for three (3) years, and have been back with the Crow Tribe, at the Health Department for an additional four (4) years. I share my employment history for the sole purpose in validating the commitment and involvement I've had in the various aspects of Tribal Health development. Throughout these years, the maintenance and protection of the Federal Trust Responsibility; the strengthening of Tribal Sovereignty, and the enhancement of Tribal self-determination have been dominant in my endeavors.

Senator Dorgan, Senator Tester and other members of the Senate Committee on Indian Affairs, I commend your vigilance, in assuring the Indian Tribes of this Country that Indian Health Care is a Federal Trust Responsibility

However, as Tribal Groups continue to work with the Federal Government, this Trust Responsibility must be promulgated and enforced. According to my Colleague (James Melborne) from the Ft. Peck Reservation, "the issue of entitlement versus discretionary funding must be addressed by Congress".

2.

On July 3, 2007, an article in the Great Falls Tribune stated, “access to and the availability of health care for the First Americans of this Nation was a trust contract in the Constitution in 1787”. Certainly, Members of the Crow Tribe firmly believe health care is assured in the Ft. Laramie Treaty of 1855.

We are also cognizant of this Great Nation’s growing pains in affording basic human rights to its citizenry: the need for the Civil Rights Act; the need for the Voting Rights Act (there is a pending case here in Big Horn County, filed by the Citizens Equal Rights Alliance a right winged group alleging “denying non-tribal members an opportunity to participate effectively in the political process on an equal basis with other members of the electorate..”); the list can go on and on. To those associated with the current Administration in Washington, D.C. alleging “race based” considerations, I strongly urge their perusal of printed materials and studies which document racism in the delivery of health care; race based discrepancies in health care and funding restrictions prohibiting resource parity.

I quote from an article, **CARDIOVASCULAR RISK FACTORS IN MONTANA AMERICAN INDIANS WITH AND WITHOUT DIABETES**, “Yet the rationing of health care for American Indians described in the recent Institute Of Medicine Report on Racial and Ethnic Disparities emphasizes the lack of resources for preventive care in this population”. A dichotomy is self- evident wherein a major study indicates a lack of funding for preventive care, and Indian Health is emphasizing Health Promotion and Disease Prevention. Or, most likely it’s the “catch up” syndrome.

Honorable Senators Dorgan and Tester, we know you are monitoring this race based phenomena very closely, and you have voiced your displeasure, and for this we are most grateful.

I will now proceed in localizing my observations to the Crow Tribal Health Care concerns. Let me emphasize, that my observations and comments are not to be interrupted as “Indian Health Service Bashings”. I know we have many Health Professionals highly committed, deeply compassionate and under recognized for their services.

3.

HEALTH CARE MEANS ACCESSING HEALTH RESOURCES.
HEALTH CARE MEANS THE PROVISION OF HEALTH SERVICES.
BEING HEALTHY MEANS A CONDITION OF WELLNESS, OR
FEELING WELL.

At a meeting in Billings, Montana, August 2, 2006, Dr. Charles Grimm, the Director of Indian Health Service was asked about the prospect for improved health services, and his response was, “Indian Health Service people are the services”. So this leads one to focus attention on “the people”.

THE CURRENT STATE, RELATIVE TO HEALTH CARE, OF THE CROW INDIAN HEALTH SERVICE HOSPITAL AND CLINICS HAS EXCEEDED THE CRISIS MODE. What is being provided by Indian Health Service is woefully inadequate and can be classified as scandalous, unconscionable.

Approximately three (3) years ago, the Acting CEO of the Crow Service Unit stated that “67%” of the local budget was applied to personnel salaries.

June 2006, Indian Health Service indicated the Crow Service Unit fiscal deficit was approximately 4.3 million.

August 2, 2006 at a meeting in Billings, Montana, Mr. Pete Conway, the Director of the Billings Area Indian Health Service stated: “As the dollar gets tighter, there is a need to find ways to cut in other areas’. What implications does this comment bear locally, Consider:

1. According to Indian Health Service, there has been a 46% increase in denials from Indian Health Service for services through the Contract Health Service Program from 2001 to 2006. It’s an effort to budget the funds available, \$520.5 million in fiscal year 2006 efficiently” (Great Falls Tribune Article, July 3, 2007).
2. The deferred Contract Health Service surgical list increases daily. For those waiting in excess of several years, and experiencing continual pain, prolonged usage of pain medication leaves other undesirable results.

4.

3. Prescriptions originating from Contract Health Care referrals are not filled locally. Over the Counter Medications are not provided locally.

Financially strapped individuals are unable to purchase needed medications. Is this a National policy for all Indian Health Service Facilities?

4. Access to proper health care is inadequate or in some cases denied. Each Crow Person in this room, listening to this testimony, can provide examples of unanticipated results of this concern. I personally share with you the following two (2) cases.

Case One: My five (5) year old granddaughter, Ta'Shon Rain Little light, died September 1, 2206. From May of 2006 to August 7, 2006, numerous visits were made to the Crow Clinic for services. During this time, Ta'Shon was being treated for depression. During one of the Clinic Visits, Ta'Shons Grandfather pointed out the bulbous condition of her finger tips and toes. This condition is indicative of a lack of oxygen. June 2006, I spoke with Ta'shons Doctor and I asked the Doctor to eliminate cancer and leukemia. August 7, 2006, My Granddaughter was rushed from the Crow Clinic to St. Vincent Hospital in Billings, Montana for a collapsed lung. The next day Ta'Shon was air lifted to the Denver Children's Hospital, where she was diagnosed with an untreatable, incurable form of cancer. The question remains, what if this tumor was detected earlier, would it have made a difference? Our baby lived with unmedicated pain, the last three months of her life. Even one (1) premature death is too much.

Case Two: June 2003, Ta'Shons Great Grandmother, Ada Rides Horse visited the Crow Emergency Room for stomach pain. After a wait of three (3) hours, her daughter transported her to the Hardin Hospital (12 miles NW of Crow) for care. Ada Rides Horse was admitted, and then transferred to the St. Vincent Hospital in Billings, where she died in the Emergency Room from a ruptured aneurysm. The ordeal did not end here. The RN who was working in the Crow Emergency Room later approached Ada Rides Horse' daughter and said: "I'm sorry, if I were clairvoyant, I would have taken your Mother right in".

5.

5. The excessive waiting time for services (Out Patient Clinic, ER , Pharmacy) needs to be addressed. Throughout the years, the local facility has tried to modify some of the national trends and adapt them for local operations, but rather than producing a positive result, the bureaucratic stratum increases. Case at hand is having a walk in clinic; add walk in clinic plus a speciality clinic; add walk in clinic, speciality clinic, plus prescheduled appointments with specified providers. Tuesday, August 8, 2007, I waited three (3) hours at the Out Patient Clinic, then I Was called to the ER for care. The waiting continues, patients become angry, and providers become defensive.

The problem in waiting, and not having enough providers on a given day could be addressed by having some of the professional health administrators, including the Commissioned Officers Corp provide some “hands on” care. Again, I am reminded of Dr. Grimm’s Statement that Our health care is the “Indian Health Service People”.

I inquired about the list of Medical Professionals posted on the wall in the Crow Waiting Room, and the ER Nurse stated that “ ½ of them have left”. This may be so, however, three (3) of the current Physician’s are employed part-time (Wilson, L. Byron, Upchurch). This certainly affects the level of care, and may also affect the recruitment process, because it ties up 1.5 positions.

Our distinguished Crow Tribal Chairman, Mr. Carl Venne asked Dr. Charles Grimm, the Director of Indian Health Service, “if no additional funding is provided for pay raises, why give it?” Dr. Grimm responded, “We make up for this with third party reimbursements”. What impact does the fluctuations in third party collections have on this reasoning? Futhermore, a pay and time audit may be necessary to fully understand the issues surrounding employee pay. What we do know is that the salary and benefits for Commissioned Officer Corp Members runs much higher than it does for a Civil Service Employee.

There are several other concerns that impact the level of resources, which impacts the level of care.

6.

1. It has been reported to the Crow tribal Health Board that non-beneficiaries receive treatment at the Crow facility. The concern becomes one in determining whether reimbursements are received for these services?
2. Vacant positions need to be advertised and filled according to established procedures and federal requirements; in lieu of filling these Positions, contracts are awarded for services. Is there a sizable cost savings in this procedure? Recently there was controversy in the way the Director of Nursing position was filled, and then “unfilled”. Actions of this sort impact the morale of the service Unit, which in turn impacts the kind of service Crow People receive.

Certainly, we applaud the efforts of this Senate Committee on Indian Affairs and their passionate support in pursuing the: reauthorization of the Indian Health Care Improvement Act; recognizing the effects of Diabetes and addressing the Special Diabetes initiative. Yet the need for quality health care, which resonated in the past, and continues today, is an ever present challenge. How does the equalization in health care occur? As long as we have a dual health care system (the haves and the have not’s); as long as socioeconomic disparities are apparent, there is going to be a continual need for this Committee Senators.

The provision of Dialysis is a health concern, and Indian Health Service can no longer bury its head in the sand, hoping this issue will dissipate. We need one funding source for this, available for all Tribes. Diabetes is the fifth (out of ten) ranked health problem for the Crow Reservation

We need to continually fund the Epidemiology Center serving the Billings Area Tribes. The data collected will be made available to and will be utilized by the specific Tribes.

Funds need to be identified and made available for HPV immunizations. A recent article in the Billings Gazette identified the Crow reservation as having the highest reported cases of HPV infections. Approximately 50% of the Crow Tribal enrollment is under the age of 30. This is the age group with pronounced sexual activity.

7.

Long term planning and resource identification needs to be addressed for the problems associated with aging, especially for the “baby boomers”. It is anticipated that Cancer and Diabetes will have an increased prevalence in this group. Expanded care for this age group includes: nursing home care; assisted living; independent living services (including home monitoring and health tracking measures); ophthalmology; prosthetics; mental health.

Senators, the Crow People have a rich heritage. There is a bit of ethnocentrism, for Crow Speakers still abound, traditional and cultural practices are adhered to. It is this identity has been the cohesiveness quality that has kept the Crow Tribe distinct among other groups.

Again, thank you for this opportunity to share the Health Concerns of the Crow People.

Submitted by: ADA WHITE, DIRECTOR, CROW TRIBAL HEALTH DEPARTMENT, BX. 159, CROW AGENCY, MONTANA 59022
406-638-3966, ADAW@CROWNATIONS.NET

