

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

THE STATUS OF INDIAN HEALTH

August 15, 2007

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 Q. North, Acting Chief Medical Officer for Indian Health Service (IHS). Today I am accompanied by Mr. Pete Conway, Area Director, Billings Area IHS.

We are pleased to have this opportunity to testify on behalf of Dr. Charles W. Grim, Director, IHS on the status of Indian Health.

The IHS has the responsibility for the delivery of health services to more than 1.9 million Federally-recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs governed by statutes and judicial decisions. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs 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 duty is to uphold the Federal government's responsibility 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 statutes are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): 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 provides the authority for the provision of Federal programs, services and activities to address the health needs of AI/ANs. The IHCIA also includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for urban Indian people and the construction, replacement, and repair of health care facilities.

We are here today to discuss Indian health and the IHS focus on improving the health of Indian people and eliminating health disparities through health promotion and disease prevention, behavioral health and chronic disease management. We will also address issues related to Indian health manpower, access to health care, consultation, contract health services and claims processing, eligibility, medical priorities and the Catastrophic Health Emergency Fund (CHEF).

## **HHS SUMMER 2007 INDIAN COUNTRY BUS TOUR TO PROMOTE PREVENTION AND HEALTHIER LIVING**

This summer, as part of the “A Healthier US Starts Here” initiative, the U.S. Department of Health and Human Services (HHS) is joining local officials and health care partners to raise awareness of the importance of preventing chronic disease and illness, promote Medicare preventive benefits, and provide information about how individuals can take action to maintain and improve their health.

By the end of August, the bus tour will have visited each of the 48 continental states to promote preventive services. While the bus tour is promoting healthier living with the country as a whole, the Indian Health Service has participated to promote and recognize the health promotion/disease prevention activities that Indian Country practices on a daily basis to promote healthier living.

This effort supports the Indian Health Service’s goal to create healthier American Indian and Alaska Native communities by developing and implementing effective health promotion and chronic disease prevention programs. This is accomplished in collaboration with our key stakeholders, the American Indian and Alaska Native people, and by building on individual, family, and community strengths and assets.

On April 18, 2007, HHS hosted a kickoff event with Tribal Leaders and National Tribal Organizations in Washington, D.C. at the Smithsonian’s National Museum of the American Indian. Since this event, HHS has visited over 20 Tribal Communities and we have over 6 tribal stops remaining and with one occurring right after this hearing here at the Crow Tribe.

We are here this afternoon with our prevention tour to recognize the Crow Tribe for the outstanding work it does to promote healthy living in its community. Chairman Venne has been a great friend to the Department by hosting our former Deputy Secretary and our Assistant Secretary for Health and we are to thank his staff for all their efforts to making Indian Country healthier. We will recognize his tribal prevention programs; recognition of 50+ fitness challenge participants; and his Meth activities coordinator.

### **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 (2001-2003) that are significantly higher than the rest of the U.S. general population (2002: National Vital Statistics Reports: Vol. 53 No.5. National Center for Health Statistics):

- Alcoholism - 551% higher
- Diabetes - 196% higher
- Unintentional Injuries - 154% higher
- Suicide - 57% higher
- Homicide - 108% higher

These statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them is 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.

Many issues that face the families nationally also affect families in Indian Country, and these problems are often magnified in the confines of Indian Country. If it is a problem nationally, it is magnified when it comes to Indian Country. Indian families are besieged by the numbing effects of poverty, lack of resources, and limited economic opportunity. Frustration, anger, and violence are among the prominent effects of this situation, and, while very understandable, they are equally unacceptable.

Accordingly, the IHS is focusing on screening and primary prevention in mental health especially for depression, which manifests itself in suicide, domestic violence, and addictions. The agency is also working to more effectively utilize available treatment modalities; and, to improve documentation of mental health problems. We now have more effective tools for documentation through the behavioral health software package. We are also working with Tribal communities to focus on these mental health needs.

Cardiovascular disease (CVD) is the leading cause of mortality among Indian people. This is a health disparity rate that the President, the Secretary of Health and Human Services, and the IHS are committed to eliminating. The Strong Heart Study, a longitudinal study of cardiovascular disease in 13 AI/AN communities, has clearly demonstrated that the vast majority of heart disease in AI/AN occurs in people with diabetes. In 2002, IHS was directed to address the most compelling complications of diabetes, including the most critical complication of heart disease.

The IHS is working with other HHS 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 AI/AN communities. The IHS has begun several programs to encourage employees and our tribal and urban Indian 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.

Good oral health is essential to improving individuals' overall health and well being. The oral health of AI/AN people has improved in some age groups, but has gotten worse in others. While poor dental health is a significant problem for AI/ANs of all ages, the magnitude and long-term effects of the problem are greatest among very young children. The most recent oral health survey administered by the Indian Health Service showed that the AI/AN people experience

some of the highest oral disease rates reported in the world. The 1999 IHS survey of Oral Health Status and Treatment Needs indicate the following:

- The majority of very young children experience tooth decay, with 79% of children aged 2 – 4 years reporting with a history of dental decay;
- Since 1991, there has been a significant increase in tooth decay among young AI/AN children between 2 – 5 years of age;
- The majority of AI/AN children as a group have tooth decay and the prevalence of decay increases with age: 87% of the 6 – 14 year olds and 91% of the 15 – 19 year olds had a history of decay;
- Most adults and elders have lost teeth because of dental disease or oral trauma. 78% of adults 35-44 years and 98% of elders 55 years or older had lost at least one tooth because of dental decay, periodontal (gum) disease or oral trauma; and,
- Periodontal disease is a significant health problem for both adults and elders. 59% of adults 35 – 44 years and 61% of elders have periodontal (gum) disease.

In addition, the vacancy rate for dentists is at the highest level in our 52 year history, with 27.6% of authorized positions are vacant. In addition to the high vacancy rate, there is great concern over the oral health disparities experienced by the American Indian and Alaska Native people.

We need to focus our efforts on these age groups that have shown declines in oral health status. Tribes have increasingly identified access to preventive and curative dental care as a major health priority; and the IHS and tribes will continue to advocate for additional resources for oral health.

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 United States (source: 2003-2004 National Health Interview Survey and 2004 IHS Outpatient database). 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 (source: IHS Division of Program Statistics). As diabetes develops at younger ages, so do related complications such as blindness, amputations, and end stage renal disease. Fortunately, the diabetes mortality rate for the entire AI/AN population did not increase between 1996-98 and 1999-2001, so we are hopeful that we may be seeing a change in the pattern of diabetes mortality. In fact, the overall mortality rate for American Indians and Alaska Natives decreased approximately 3% between these same time periods (source: IHS Division of Diabetes Statistics and CDC Center for Health Statistics). And there is good news in that we have recently measured a slight, but statistically significant, decline in kidney failure in the AI/AN 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 for diabetes patients is staggering. The cost of managing care for treating diabetes ranges from \$5,000-\$9,000 per year with the annual cost per patient exceeding \$13,000 (source: American Diabetes Association).

In 1997, the Special Diabetes Program for Indians (SDPI) grant program was enacted and provided \$30 million per year for a five year period to IHS for prevention and treatment services to address the growing problem of diabetes in AI/ANs. In 2001, Congress appropriated an additional \$70 million for fiscal years 2001 and 2002. The program was funded at \$100 million in fiscal year 2003. Then in 2002 Congress extended the SDPI through 2008, and increased the annual funding to \$150 million for FY 2004-2008 with the directive to address a primary prevention of type 2 diabetes and the most compelling complication of diabetes – cardiovascular disease. We are proud to announce that in FY 2004 our Division of Diabetes Treatment and Prevention launched a competitive grant to implement two demonstration projects. One is focused on primary prevention of type 2 diabetes in people diagnosed with pre-diabetes to determine if an intensive life-style intervention can be successfully implemented in AI/AN communities. This effort is based on the NIH sponsored study called the Diabetes Prevention Program which provided evidence that type 2 diabetes could be prevented with lifestyle intervention. The other demonstration project is focused on cardiovascular risk reduction in people diagnosed with type 2 diabetes. Thirty-six AI/AN communities were awarded diabetes prevention demonstration projects and 30 AI/AN communities were awarded cardiovascular risk reduction demonstration projects in November 2004. These demonstration projects will cover a four year period. The outcomes of the demonstration projects will enable us to learn what may be applicable to other communities throughout Indian country. The last year of the demonstration projects will be aimed at dissemination of lessons learned to other tribal communities across the nation.

With 65% of the IHS Mental Health budget and 85% of the alcohol and substance abuse budget going directly to tribally operated programs, tribes and communities are now taking responsibility for their own healing. They provide effective treatment and prevention services within their own communities.

A primary area of focus is Dr. Grim's renewed emphasis on health promotion and disease prevention. This is our strongest front in the ongoing battle to eliminate health disparities which have plagued our people for far too long.

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 a more a western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population as evidenced by the increasing rates of cardiovascular disease, diabetes, and oral health problems. Most chronic diseases are affected by lifestyle choices and behaviors.

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 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 AI/AN people.

### **Indian Health Manpower**

IHS, Tribal 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 AI/AN health care professionals. Since its inception in 1977, more than 7,000 AI/AN students have participated in the program, with the result that the number of AI/AN 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.

The IHS Scholarship Program has been the starting point for the careers of a number of AI/AN health professionals now working in IHS, tribal, and urban Indian health programs. Many are also involved in academia, continuing to help identify promising AI/AN 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 not a few of the reverse, with 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 (LRP) is very effective in both the recruitment and retention areas. . There are currently 723 health professionals in the LRP. 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; while loan repayments are a way for participants 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.

### **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 drinking 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 AI/AN homes now have safe water and mortality from unintentional injuries has been reduced by 58 percent between 1972-1974 and 2001-2003. Unfortunately, 12 percent of Indian homes still lack adequate sanitation facilities compared to one percent of the rest of the United States population; and the leading cause of death for AI/ANs between the ages of 1 and 44 years of age is unintentional injuries. Improvement in these areas is integral to our mission.

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. There are 48 hospitals, 272 health centers, 11 school health centers, over 2200 units of staff housing, 320 health stations, satellite clinics, and Alaska village clinics, and 11 youth regional treatment centers supporting the delivery of health care to AI/AN people. The IHS is responsible for managing and maintaining the largest inventory of real property in the DHHS, with over 9.6 million square feet (899,000 gross square meters) of space, and the Tribes own over 6 million square feet (571,000 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. Most of these facilities were replacements of inadequate health care facilities. We have substantially improved our health care delivery capability in the newer health care facilities and continue to improve access to services through health care facilities construction—health care facilities construction remains a priority.

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 AI/AN 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, and to plan carefully on how to best utilize any available resources. The IHS Health Care Facilities Construction program is fully prepared to address the needs identified through this process.

## **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. We believe the IHS has implemented the Act in a manner consistent with Congressional intent when it passed this cornerstone authority 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 54 percent of our budget is transferred through self-determination contracts/compacts.

## **Consultation**

A primary goal of the Agency has always been to involve Indian tribes and people in the activities of the IHS. Last year Dr. Grim adopted a revised IHS Tribal Consultation Policy that will enhance the partnership between the IHS and this country's 562 Federally recognized Tribes for the foreseeable future. The policy is the 3<sup>rd</sup> consultation policy adopted by the IHS since 1997. Its adoption fulfills a commitment Dr. Grim made to Tribal Leaders that the Agency's consultation policy and practices will continually be subject to review and improvement.

The policy, which was developed by IHS and Tribal Leaders, contains an improved definition of consultation and the circumstances under which it needs to occur. The policy also commits the IHS to assisting Tribal governments in establishing meaningful dialogue and consultation with other HHS agencies and State governments. It revises the budget formulation process within IHS to allow for more meaningful Tribal participation and it contains requirements that IHS report to Tribes on IHS consultation, its outcomes and effectiveness.

## **Overview of CHS program**

The IHS purchases medical and dental services from providers in the private sector through its Contract Health Service program, which is a component of the Indian health care system. In fiscal year 2007 the CHS program is funded at \$543 million. Patients are referred to the private sector health facilities, programs and practitioners for treatment when needed services are unavailable as direct care through the Indian health care system.

The CHS program is administered through 12 IHS Area Offices and consists of 163 IHS and Tribal Service Units (SU). The CHS funds are provided to the Area Offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to Federal and Tribal operating units (local level) and health care facilities providing care.

The CHS funds are used in situations where:

- No IHS or Tribal direct care facility exists;
- The direct care element cannot provide the required emergency or specialty services; and/or,
- The direct care facility has an overflow of medical care workload.

The CHS program makes payment for specialty services and inpatient care to private sector facilities and providers in accordance with established eligibility and medical priority guidelines.

The CHS program contracts with Blue Cross/Blue Shield of New Mexico as its fiscal intermediary (FI) to ensure payments are made in accordance with the IHS payment policy and quality control requirements. An important and integral function of the FI is to provide highly effective management reports relative to the provision of services to our patient population and provision of services by health care providers from the private sector.

### **Eligibility**

To be eligible for CHS, an individual must be of Indian descent and belong to the Indian community served by the Tribal Contract Health Service Delivery Area (CHSDA). Generally, the Tribal CHSDA encompasses the Reservation, trust land, and the counties that border the Reservation. The individual must also either: 1) reside on a Reservation located within the CHSDA; or 2) if he/she resides within the CHSDA but not on a Reservation, he/she must also be a member of the Tribe(s) located on the Reservation or of the Tribe(s) for whom the Reservation was established, or maintain close economic and social contact with the Tribe(s). The following individuals remain eligible for CHS during periods of temporary absence from their CHSDA residence:

- Students who are temporarily absent from their CHSDA during full-time attendance of vocational, technical, and other academic education. The coverage ceases 180 days after completing the course of study.
- A person who is temporarily absent from his/her CHSDA due to travel or employment.
- Other persons who leave the CHSDA temporarily. Their eligibility continues for a period not to exceed 180 days from their departure.
- Children placed in foster care outside of the CHSDA by court order and who were eligible for CHS at the time of the court order.”

### **Payor of Last Resort Rule**

The IHS is the payor of last resort and therefore the CHS program must ensure that all alternate resources that are available and accessible, such as Medicare Parts A and B, state Medicaid, state health program, private insurance, etc. are used before the CHS funds can be expended. An IHS or Tribal facility is also considered a resource, and therefore, the CHS funds may not be expended for services reasonably accessible and available at IHS or Tribal facilities. In FY’06, IHS received \$681 million in Medicaid, Medicare and Private Insurance collections. And, the agency continues to strive toward maximizing these other sources of payment.

## **Medical Priorities**

To ensure funds are available throughout the year, medical priorities are used to authorize CHS funds. There are five levels of care within the medical priority system; they range from emergent/acutely urgent care services to preventive and chronic tertiary care. Generally, IHS and Tribal funding programs currently reimburse only for Medical Priority I cases, which are for emergent/acutely urgent care.

## **Catastrophic Health Emergency Fund (CHEF)**

The CHS program also includes a Catastrophic Health Emergency Fund (CHEF) in the amount of \$18 million. This fund pays for high cost cases and catastrophic costs. The CHEF is used to help offset high cost contract care cases meeting a threshold of \$25,000. In FY 2006, the CHEF program provided funds for over 671 high cost cases in amounts ranging from \$1,000 to \$875,000 over the \$25,000 threshold.

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