CENTER FOR NATIVE AMERICAN YOUTH
AT THE ASPEN INSTITUTE

TESTIMONY OF FORMER US SENATOR BYRON L. DORGAN (RET.), FOUNDER AND CHAIRMAN OF THE CENTER FOR NATIVE AMERICAN YOUTH AT THE ASPEN INSTITUTE

OVERSIGHT HEARING ON "REEXAMING THE SUBSTANDARD QUALITY OF INDIAN HEALTH CARE IN THE GREAT PLAINS"

SENATE COMMITTEE ON INDIAN AFFAIRS

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Good afternoon Chairman Barrasso, Vice-Chairman Tester, and members of the Committee. My name is Byron Dorgan. I'm pleased to have been invited to come back to the Committee today. I served here as a member and Chairman for many years, and know how hard you work to deal with significant issues confronting the First Americans.

Following my service in the U.S. Senate, I founded the Center for Native American Youth at the Aspen Institute, and currently serve as Chairman of the Board of Advisors. Although I retired from Congress, I did not want to retire from working on making positive changes in the lives of Native Americans, particularly Native American youth. While in Congress, I had the opportunity to visit the tribal nations in the Dakotas and also many tribal nations throughout this country. I was always impressed with the strength, resilience, and cultural knowledge of the youth I met along those journeys. I realized that they are the leaders of the next generation and we need to make sure that they have the resources available to them to become successful.

You invited me here today to discuss an earlier investigation of Indian Health Service (IHS) health care in the Aberdeen Region. I'm pleased you are reexamining the delivery of health care services by the federal government to American Indians in the Great Plains and throughout the country.

The IHS has the important mission of carrying out our federal government's trust responsibility to provide health care services to Native Americans. Most people living in tribal communities rely on the IHS as the sole source for their health care needs.

It is not an easy task for the IHS to meet these needs. Failed federal policies towards Native Americans over the past two centuries have resulted in this segment of the population having the highest levels of health disparities within our country. It is a travesty! Further, it is a problem that will continue to have negative impacts for generations to come. I spent much of my time as Chairman of this committee focused on increasing funding for the IHS and trying to force some systemic changes in the bureaucracy that plagues that agency. It is an agency that seems far too resistant to change.

In 2010, as Chairman of this Committee, I led an investigation that culminated in a report titled "The Urgent Need to Reform the Indian Health Service's Aberdeen Area" that was issued in late 2010. The extensive investigation was prompted by years of serious complaints about the healthcare services provided throughout tribal communities in my home state and the surrounding states. I have traveled to hundreds of tribal nations and communities, met with thousands of individuals, and tribal leadership. Although histories, cultures, and languages may be diverse, one theme was always consistent – the challenges of accessing healthcare and life-saving services. That combined with very serious allegations about mismanagement, theft, and full-scale healthcare rationing led me to launch this investigation.

Let me be clear about the purpose of the investigation and report: it was not intended to criticize specific employees of the IHS. In fact, I have found that the IHS is full of passionate, committed employees who seek out their positions to serve and care for their families, loved ones, and community members. While there are definitely some problem employees within the IHS, merely replacing employees will not solve the systemic problems.

The purpose of the investigation and report was to identify the systemic problems within the IHS so that Congress could force changes needed to solve the problems and improve the delivery of health care.

The purpose was to let Congress know about patients like Ardel Hale Baker who while having a heart attack could not get lifesaving treatment but instead had a deferral letter taped to her leg saying that if any hospital treated her, the IHS did not have the money to pay for her treatment.

The purpose of the report was to inform lawmakers about the tens of thousands of dollars being spent on expensive temporary healthcare providers rather than hiring fulltime doctors, the lost and mismanaged equipment, and kids not getting mental health services in communities with suicide rates ten times the national average.

The goal of the investigation was to identify challenges and compel major changes within the IHS system in order to save lives. This government has a solemn obligation to our First Americans to provide adequate healthcare and there is an agency – the Indian Health Service – specifically charged with that task. Yet, we continue to see the same problems plague that agency year after year without real progress being made to improve the system. This is unacceptable and I hope the Committee will continue to put a spotlight on the IHS until real improvements are made.

Our investigation included: reviewing over 140,000 pages of documents; visiting and interviewing three IHS service units; and meeting with tribal leaders and IHS employees. Over the course of the investigation, more than 200 individuals also reached out to the Senate Committee on Indian Affairs to share stories related to the IHS' healthcare delivery system.

In September of 2010, the Committee held a hearing on the findings of the investigation. The hearing highlighted deficiencies in IHS management, employee accountability, financial integrity and oversight, which led to reduced access and quality of health care services available in the Great Plains region. Testimony for a second hearing was collected and included in the final report, which was released in late-December 2010.

The findings of the final report revealed policies and practices within the IHS that negatively impact healthcare provided to tribal patients. I will briefly highlight some of the more significant findings today, but encourage people to read the full report. Some of the major findings from the 2010 report are as follows:

- Over a ten year period, IHS repeatedly used transfers, reassignments, details, or lengthy administrative leave to deal with employees who had a record of misconduct or poor performance.
- There were higher numbers of Equal Employee Opportunity (EEO) complaints in the Aberdeen (Great Plains) Area compared to the entire IHS, as well as insufficient numbers of EEO counselors and mediators.
- Three service units had a history of missing or stolen narcotics and nearly all facilities failed to provide evidence of performing consistent monthly pharmaceutical audits of narcotics and other controlled substances.
- Three service units experienced substantial and recurring diversions or reduced health care services from 2007 to 2010, which negatively impacts patients and quickly diminishes limited Contract Health Service (CHS) funding.
- Five IHS hospitals were at risk of losing their accreditation or certification from the Centers for Medicare and Medicaid Services (CMS) or other deeming entities. Several Aberdeen Area facilities were cited as having providers with licensure and credentialing problems, Emergency Medical Treatment and Active Labor Act (EMTALA) violations, emergency department deficiencies or other conditions that could place a patient's safety at risk.
- IHS lacked an adequate system to detect instances of IHS health care providers whose licenses have been revoked, suspended or under other disciplinary actions by licensing boards.
- Particular health facilities continued to have significant backlogs in posting, billing and collecting claims from third party insurers (i.e., Medicare, Medicaid and private insurers). One facility repeatedly transferred its third party payments to other facilities in the Aberdeen (Great Plains) Area.
- There were lengthy periods of senior staff vacancies in the Clinical Director and Chief Executive Officer positions, resulting in inconsistent management and leadership at Aberdeen Area facilities.
- The use of contract providers (locum tenens) was costly ($17.2 million in the last three years). While the overall cost of contract providers had decreased compared to 2009, two facilities had increased their locum tenens expenses in 2010.

The findings of the report paint a very stark picture of the IHS and its ability to provide adequate health care services to Native Americans. Some of my colleagues in Congress at the time read these findings and suggested that maybe one solution was to completely eliminate the IHS. But, that is not a realistic solution. There are some wonderful, dedicated individuals who do their best, amid substantial challenges, to provide necessary, lifesaving care every day. And, there are some IHS facilities that are performing well and have the support of the local tribal community. The reality is that many tribal communities in remote areas need facilities located on their lands to serve their people and others living on their lands. The facilities that are doing well provide services in a culturally appropriate manner, are well-managed, and regularly engage with the local tribal leadership and community about how to improve access to services.

I believe that addressing a few key issues would substantially improve the IHS system: (1) Congress needs to improve the level of funding to the IHS, (2) the leadership of IHS needs to focus on recruiting and properly training individuals who can be good managers of the IHS Service Units, (3) problem employees who are underqualified or violate laws need to leave the IHS, and (4) IHS needs to focus on health professional recruitment.

The IHS is severely underfunded compared to other federal agencies. You may have heard the phrase “Do not get sick after June," because if you do, you will not be able to get care. This, to me, is a rationing of health care – care that is guaranteed by treaty. If we start funding IHS at levels commensurate with need, I believe we will solve a lot of the issues revealed in the 2010 report and the ones occurring elsewhere in this country.

Funding challenges aside, it is also clear that the IHS – and tribal patients – would benefit from improving accountability and oversight within IHS. But, accountability and oversight cannot be improved if you do not have adequate managers. One of the biggest concerns that I heard from on-the-ground employees was the lack of good managers. After investigating the matter, it became clear to me that many problem employees get transferred and promoted in order to get them out of their existing environment. Over time, this led to some of those problem employees being placed in senior positions of the health facilities for which they were underqualified. This situation led to many of the day-to-day employees feeling demoralized, unhappy with their jobs, and many good employees ended up leaving the IHS. The vast majority of the problems identified in the report could be resolved if there was a concerted effort by the IHS national leadership to recruit good, qualified, and experienced managers.

Once you have good managers in place, the issue of problem employees can be properly addressed. When an employee engages in misconduct, there need to be systems in place that deal with, and correct, that behavior. It is not enough to simply transfer that employee to another facility, where they will inevitably engage in the same misconduct, and hope the problem goes away on its own. We saw this pattern repeat itself again and again. And, it led to the good employees within the IHS becoming disgruntled, inefficient, and ultimately poor performing.

I know that there have been genuine efforts by some senior level career IHS officials to address these problems, but the problems persist. I long worked with Robert McSwain at the IHS, to try and address some of these problems, but in some circumstances, the problems have gotten worse. I know that the Winnebago Hospital, which is located in the Great Plains region of the IHS, recently lost its accreditation from the U.S. Centers for Medicare & Medicaid Services (CMS) for its in-patient and emergency services managed by the IHS. I do not know all of the details

surrounding this situation, but am aware that CMS conducted an investigation and concluded that there were deficiencies that represented an immediate jeopardy to patient health and safety. And, unfortunately, the CMS investigation was started only after a death of a patient. Too often these problems are ignored until there is a tragedy. We know what the problems are, and while finding solutions will be difficult, spending the time to solve these problems is worth it.

When I retired from the Senate, I created the Center for Native American Youth to raise awareness of the challenges that Native American children face and to find solutions to teen suicide, substance abuse, high drop-out rates, and many others. We are making significant progress on tackling those issues by partnering with tribal leaders, tribal organizations, community members, and parents who work hard each day – with limited resources – to address the challenges faced by their children. We are also working with federal agencies, like IHS, to ensure that Native youth are a priority and that agencies are doing all that they can to meet their needs.

Over the last five years we have connected face-to-face with more than 5,000 youth to hear directly from them about their priorities; held public events to raise awareness of Native youth issues; convened a quarterly roundtable series with over 30 federal agencies and ten national tribal organizations to increase coordination and collaboration among those important entities; and celebrated Native youth through our Champions for Change program and the Generation Indigenous initiative. Our work is framed around listening to Native American children and working *with* tribal communities to elevate and address their priorities.

During our discussions with youth, we hear time and time again that their health is a priority for them, yet they are unable to receive the healthcare they need. Whether it is dental care, mental health services or routine check-ups, youth are not able to access what they need in order to lead full, healthy and successful lives. This has to change. Native children are already facing a steep uphill climb when compared to their non-Native peers on a variety of issues. Suffering in pain or in sickness because they cannot get into a doctor should not be one of them.

As I mentioned, we interact with young Native Americans every day. Within our Champions for Change program we have some especially talented young people who are addressing health and access to care in their home communities. Cierra Fields, a high school student from the Cherokee Nation works with her tribe to promote diabetes prevention and cancer awareness among her peers. Another Champion, William Lucero, a college student from the Lummi Nation, has spent several years educating his peers and other community members about the dangers of smoking. Lastly, Joaquin Gallegos, a recent college graduate from the Jicarilla Apache Nation and Pueblo of Santa Ana, has worked tirelessly to expand access to much-needed dental care for tribal nations. We need to ensure that amazing young people like these three have the health care they deserve so that they can continue to do great work for their communities.

I want to again thank the Committee for taking the time to examine this important issue, and I would like to offer the Center for Native American Youth as an ongoing resource to you. Thank you.