S. HRG. 110–332

NOMINATION OF ROBERT G. MCSWAIN TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 7, 2008

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NOMINATION OF ROBERT G. MCSWAIN TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

THURSDAY, FEBRUARY 7, 2008

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:30 a.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. We will call the hearing to order. This is a hearing of the Indian Affairs Committee of the United States Senate.

Today, the Committee takes another important and necessary step in fulfilling its commitment to try to improve Indian health care by considering the nomination of Robert McSwain to be the Director of the Indian Health Service.

We talk a lot in this Committee about the challenges and what needs to be done. We talk about the statistics: American Indians die at higher rates than other Americans from tuberculosis, 600 percent higher; alcoholism, 510 percent higher; diabetes, nearly double; suicide, 60 percent higher.

But as we rattle off these numbers, it is important to understand we are talking about individuals, people struggling to deal with their health care needs. When we talk about the 1.9 million Indian Health Service patients, we are referring to a group of people in this country who have been afflicted often with very chronic health conditions. A group who, in exchange for land and other possessions that they once had, secured federally-sponsored health care, a trust responsibility and beyond that, in many cases, a treaty commitment from the Federal Government.

It is our responsibility, it seems to me, to keep this promise and to provide the First Americans with quality health care, and to do so with accountability, efficiency and compassion. Accountability is a major theme that we are going to talk about in regards to the Indian Health Service today. I would say that I think there are some wonderful, dedicated professional people who have committed their lives to the Indian Health Service. I have seen them, I have watched them work and I commend them.

I also believe that the Indian Health Service in some other areas is a Federal agency whose arteries are clogged with bureaucracy,

inefficiency, ineffectiveness, and in some cases desperately in need of reform.

We also face a circumstance where about 40 percent of the health care needs of American Indians is unmet. That means we have health care rationing, which would be scandalous in most areas, but seems to be the norm with respect to delivering health care to American Indians.

We need to do much, much better than that. My hope is that Mr. McSwain, as the leader of the Indian Health Service, will begin to be able to effect some of these reforms. I am terribly disappointed with the President's budget, once again. I don't think the President or the Congress has done their obligation to meet our responsibility, our trust responsibility for Indian health care for many, many, years. My hope is that one day we can look back with some pride to say that we did what was required of us and what we have previously promised: to provide health care to Native Americans.

Today we will focus on the confirmation of Robert McSwain. On December 18th, President Bush sent Mr. McSwain's nomination to the full Senate. Mr. McSwain has worked in the Indian Health Service for 24 years in various capacities. In the field of Indian health itself, he has worked for 36 years. He is a member of the North Fork Rancheria of Mono Indians of California. The Committee has received statements of support for Mr. McSwain's nomination from the California Rural Indian Health Board, that is the organization that Mr. McSwain served as executive director in the mid-1970s, before being tapped to be the IHS California area office director.

The National Indian Health Board, the non-profit organization whose membership is made up of each of the Indian Health Service areas, also has issued statements of support. I ask consent that these and other letters regarding this nomination will be included as a record of today's hearing. Without objection, that will be done.

Also, I understand that Mr. McSwain is a cousin to Ms. Rachel Joseph, who is Co-Chair of the National Steering Committee to Authorize Indian Health Care. She has provided tremendous assistance to this Committee in our attempt to reauthorize the Indian Health Care bill. Before I recognize the Vice Chair of the Committee, I want to state the process for moving forward with this nomination. Today we will have an opportunity to hear from Mr. McSwain and to ask some questions. Once the Committee has received responses, including responses from questions we submit, we will report out the nomination at the next scheduled business meeting.

Senator Murkowski.

STATEMENT OF HON. LISA MURKOWSKI,
U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman.

Good morning, and I want to thank you for moving very quickly to the confirmation hearing of Mr. McSwain. When we learned back in September that Dr. Grim had withdrawn his nomination, I was one of those that expressed great regret. We had a good experience with Dr. Grim in the State of Alaska. But I am very pleased that the President has nominated another very dedicated Native

American for what I think we all acknowledge is a very difficult, very challenging job.

You have indicated, Mr. Chairman, in your opening remarks, some of the statistics that we deal with that we face as a committee here in trying to advance in a positive way, not only the health care needs, but so many of the issues that face Indian Country. We are reminded on the one hand of the very negative statistics. But as I have had an opportunity to point out on the Floor, as we have worked to advance the Indian Health Care reauthorization, we do have some good stories, we do have some good progress to report in Indian health.

I have mentioned before the tele-medicine that we are able to bring into some of our bush communities and into the reservations, some of the sanitation facilities in the remote villages where we are making some progress and helping to reduce the mortality rates. But again, as you point out, the challenges that face far too many are oftentimes insurmountable. We face a time of stringent budgets where the directive "don't get sick after June" continues to be a very chilling reminder that the Indian Health care system has fallen far, far short of what its beneficiaries deserve.

You have mentioned the overwhelming disease rates. These are despite the dedicated efforts of Indian health professionals. We continue to experience far too many unnecessary deaths, amputations, the pain caused by diabetes. We remain haunted by the youth suicides, the unsolved murders, the rapes of countless Native women. We have said, and you certainly, Mr. Chairman, have said that the painful truth is that we still have third world conditions existing in many of our Nation's Indian and Alaska Native communities.

So you have to ask the question, to our nominee, why, Mr. McSwain, would you want to take on this job, knowing the difficulties, knowing what you are facing with the disease rates, the funding levels, even knowing that there is obviously going to be a change of Administration? I have heard it expressed that anyone intelligent enough for this job is probably too smart to accept it. But I believe that your intelligence and that of many of our past IHS directors is unquestionable.

But your presence before us today I think speaks greatly to your dedication to Indian health, to improving the lives of Indian and Alaska Native people and to tribal sovereignty and to self-governance.

With that, Mr. Chairman, I would like to speak to the specifics of Mr. McSwain and introduce him to the Committee, if I may. We had a very good conversation a couple days ago in my office about Mr. McSwain's mission, his vision and his pledge for Indian health. As you noted from the biography that was submitted to the Committee, Mr. McSwain has worked for the IHS since 1976. He reminded me that he began work for the IHS at the same time that the Indian Health Care Act was authorized. You have noted it has been a long time, clearly a long time within IHS that Mr. McSwain has given his service.

During that time, he has received numerous awards, most notably the President's Rank Award for meritorious service in 2004 and the President's Rank Award for distinguished service in 2006. It appears that you have held nearly every managerial position avail-

able in IHS: area director in California, special advisor to the IHS director, various positions in the IHS in the areas of management, human resources, manpower, deputy director of IHS and then now appointed to be acting director.

In my conversation with Mr. McSwain, I noted that he was quite proud of his long and distinguished career with IHS, but he was also proud, and I think rightly so, of his time spent working for tribal health programs from 1971 to 1974 as the director of the Central Valley Indian Health, and then in 1974 to 1976, he served as the executive director of the California Rural Indian Health Board in Sacramento. Mr. McSwain comes from Indian Country and it is too Indian Country that he has remained dedicated. He comes from the North Fork Rancheria of Mono Indians in California, proudly supported by his people and his chairperson, Jacquie Davis Van Huss, who is here with us today and will provide her remarks for Mr. McSwain. We greatly appreciate that.

Mr. McSwain was raised by his grandparents who instilled in him Indian values which gave him the perseverance, the character, to carry him through his career. Mr. McSwain has convinced me that if confirmed, he will remain committed to supporting tribal self-governance and self-determination. As many know here in the room today, self-governance is working successfully, particularly in Alaska, and I expect that success to continue under Mr. McSwain's command.

Moreover, he is committed to the mission of the Indian Health Service, which as we have heard many, many times before, is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to its highest level. That mission cannot be accomplished without the help of tribal leaders and of this Congress.

Between his time with the tribal health programs and his time with the IHS, Mr. McSwain dedicated about 27 years of his life to improving the health of Native people. That, Mr. Chairman, and to those here, that is really a lot of on-the-job training for this very challenging appointment. I have no doubt he will need to draw on those years of experience to carry him through the tough times that he will experience as Director if confirmed.

With that, Mr. Chairman, I thank you and I look forward to hearing from Mr. McSwain this morning, and hopefully to an expeditious process. Thank you.

The CHAIRMAN. Thank you very much.

We will hear from the Honorable Jacquie Van Huss, Chairperson of the North Fork Rancheria, North Fork, California. Ms. Van Huss, thank you very much. You may proceed.

STATEMENT OF HON. JACQUIE DAVIS VAN HUSS, CHAIRPERSON, NORTH FORK RANCHERIA OF MONO INDIANS OF CALIFORNIA

Ms. VAN HUSS. Good morning, Chairman Dorgan, Madam Vice Chair Murkowski and the distinguished members of the Senate Committee on Indian Affairs. My name is Jacquie Davis Van Huss, and I am the Tribal Chairperson for the North Fork Rancheria of Mono Indians, which is the largest restored tribe in California. Joining me today is our Tribal Council Secretary, Katrina Lewis.

I am delighted to be here for several reasons. I am privileged to bring you greetings from each of our 1,680 tribal citizens who share their immense pride as I come forward to introduce and express support for and confidence in one of our enrolled tribal citizens, Robert G. McSwain, or Bob, as we know and love him.

For nearly three years, Bob has proven himself at the highest levels of leadership at Indian Health Services, first as IHS Deputy Director, then as Acting IHS Director. His nomination now to be permanent Director of Indian Health Services serves as both tribute and testimony to his capabilities and to his commitment to improve the health conditions of all American Indians.

Mr. Mike Leavitt, Secretary of Health and Human Services, had the following to say about Bob upon assumption of his current role as Acting Director in September of 2007: "I am pleased that Bob has taken on this position. Over this 30-year career in the Department, Bob has played a pivotal role, most recently sharing responsibility with the IHS Director for managing a $4 billion national health care delivery program. His leadership has helped ensure that IHS is able to provide top quality preventive, curative and community care to approximately 1.9 million American Indians and Alaska Natives. During his tenure, Bob has received two Presidential Rank Awards for distinguished and meritorious service. I am confident he will continue to provide strong leadership for the IHS in serving as its Acting Director."

The North Fork Rancheria takes health management seriously, having helped create and manage innovative programs such as a multi-tribal Temporary Assistance for Needy Families program, and the multi-county Central Valley Indian Health, Incorporated, in which Bob first started his health career. From this perspective, we too have full confidence in Bob's ability to lead, manage and advocate effectively on behalf of the Nation's American Indians and Alaska Natives in hospitals, clinics and other settings throughout the United States.

The State of California is home to one-fifth of the federally-recognized tribal governments in the United States. Mr. Robert G. McSwain brings a unique perspective to this high Federal position as both a Native son of California and someone who has literally worked his way up to the highest levels of Government. We believe this experience and perspective will serve Mr. McSwain well as he represents the diversity and richness of both American Indian health and tribal sovereignty concerns and needs.

We believe that Mr. Robert G. McSwain, our esteemed tribal citizen, will serve the position of Director of Indian Health Services with great honor and distinction.

With this said, I have the honor to introduce my tribal citizen, Mr. Robert G. McSwain.

[The prepared statement of Ms. Van Huss follows:]

PREPARED STATEMENT OF HON. JACQUIE DAVIS VAN HUSS, CHAIRPERSON, NORTH FORK RANCHERIA OF MONO INDIANS OF CALIFORNIA

Good morning Chairman Dorgan, Vice Chairman Murkowski and distinguished members of the Senate Committee on Indian Affairs.

My name is Jacquie Davis Van Huss and I am Chairperson of the North Fork Rancheria of Mono Indians of California, which is the largest restored tribe in California. Joining me today is our Vice-Chairperson Elaine Fink and our Secretary

Katrina Lewis. I am delighted and honored to be here for several reasons. I am privileged to bring you greetings from each of our 1680 tribal citizens who share their immense pride today as I come forward to introduce and express support for and confidence in one of our enrolled Tribal citizens, Robert G. McSwain, or "Bob" as we know and love him.

For nearly three years Bob has proven himself at the highest levels of leadership at the Indian Health Services, first as IHS Deputy Director then as Acting IHS Director. His nomination now to be permanent Director of the Indian Health Services serves as both tribute and testimony to his capabilities and to his commitment to improve the health conditions of all American Indians.

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We believe that Mr. Robert G. McSwain, our esteemed Tribal Citizen, will serve the position of Director of Indian Health Services with great honor and distinction.

With this said, I have the honor to introduce, our Tribal Citizen, Mr. Robert G. McSwain.

The CHAIRMAN. Madam Chairperson, thank you very much for traveling here from California to provide that statement.

Ms. VAN HUSS. We are very honored to be here, and we highly support Mr. McSwain.

The CHAIRMAN. We got that impression from your testimony.

[Laughter.]

The CHAIRMAN. We appreciate it very much.

Ms. VAN HUSS. Thank you.

The CHAIRMAN. Mr. McSwain, would you please come forward?

Mr. McSwain, we welcome you to the Committee. I am going to call on you for a statement in just a moment, but I wanted to recognize Senator Smith, who has arrived,if you have anything you wish to say.

STATEMENT OF HON. GORDON H. SMITH, U.S. SENATOR FROM OREGON

Senator SMITH. Thank you, Mr. Chairman, Vice Chair Murkowski, for providing the Senate Committee on Indian Affairs with an opportunity to hold a confirmation hearing for Robert McSwain.

The issue of Indian health care is critical in the State of Oregon. Whether at my annual tribal summit or visiting tribal lands throughout Oregon, I always hear how important access to quality health care is to Indian Country.

The Indian Health Care Improvement Act brings us closer to fulfilling the need, and I thank the Chairman and Vice Chair and their staffs for working to advance the bill. I look forward to its passage on the Floor, and its swift passage. While I recognize this bill as a step in the right direction, I am concerned that in its current form,the bill maintains an inequity in the distribution of health facility construction funds. Currently, this fund favors a few tribes and a few States, while the majority of tribes, including those in Oregon, have never received agency funds to build a hospital.

I would like to take this opportunity to hear from Mr. McSwain whether the Indian Health Services would have the statutory authority under the Indian Health Care Improvement Act to implement an area distribution fund that would equally distribute a portion of health facility construction funds to all IHS regions across the Country. I am not trying to require the creation of an area distribution fund. That decision must rest with the agency, the tribes and their budget situation.

I do, however, want to ensure that the agency is not legislatively precluded from implementing this fund if it determines that it is in the best interest of Indian Country as a whole. Beyond that, I want to reemphasize that the services in the Act, especially those related to health care delivery, are vital to the health and well-being of tribal families and communities. They need us to finish our work and get this bill signed into law this year.

I look forward to continuing to work with Mr. McSwain and the Chair and Vice Chair and other colleagues to explore ways to address everyone's interest and ensure that all Native Americans, not just some, receive the health care they need and deserve.

The CHAIRMAN. Senator Smith, thank you very much.

Mr. McSwain, thank you for being with us. We will at this point take your testimony and then ask some questions. You may proceed.

STATEMENT OF ROBERT G. MCSWAIN, NOMINEE TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MCSWAIN. Mr. Chairman, Madam Vice Chairman and other distinguished members of the Senate Committee on Indian Affairs, I am truly humbled and honored to have been nominated by President Bush, supported by tribal governments, endorsed by Secretary Leavitt, and for this Committee to consider my term as Director of Indian Health Service. I am quite surprised at the speed at which you have done this, and that speaks to your concern about the Indian Health Service's continuity.

I would like to thank and acknowledge my family, especially my wife, June McSwain, who has been my confidant and closest friend for over 35 years.

The CHAIRMAN. Mr. McSwain, do you have family members here you wish to introduce?

Mr. MCSWAIN. I have family members I will introduce in a moment, Mr. Chairman. My daughter, Kristin Ruud, who is a nurse in Houston, and my son, Major Eric Ruud, who is still in the forces and serving in places around the world. My daughter Elizabeth and my granddaughter Britney Ruud are here today to accompany and shore me up.

On this special occasion, as Senator Murkowski noted, I have been doing a lot of reflecting as the nomination has occurred. I have reflected back many years, not only to my career, but to my roots, so to speak. In this case, I was calling upon my grandparents, Dan and Ella, who raised me, as the Senator noted, with the Indian values of listening, compassion, respect, mutual respect and caring for the environment.

I am proud to pledge before this Committee to both Federal and tribal governments that if confirmed, I will 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 and the Administration and tribal governments toward our shared goals and objectives.

I have had the privilege of having two distinct careers, obviously, as pointed out earlier, the first five years essentially in tribal health, health programming in California, and the second 30 years in actual engaging and working for the Indian Health Service. It is interesting, I want to make two points not quite on my statement, but when I decided to come to the Federal service, tribal folks told me they wanted me to be able to go to the Government and do something back for Indian people in California. Now, I find myself at the crossroads of another, what more can I do for Indian people.

I have had the pleasure of working with and for five of the seven previous directors of the Indian Health Service. All my positions have occurred at stages of change and my nomination today reflects another stage of change. If confirmed, I will work diligently to support the decision of tribes to contract, compact or retain Indian Health Service as their provider of choice. The Indian Self-Determination Act allows tribes to manage their own health programs, and with some rare exceptions, they have done an absolutely outstanding job. Let there be no doubt that I support and advocate for the sovereign rights of tribes to self-govern.

I am also committed to continuing the Director's three initiatives, and work hopefully with Dr. Grim on these three initiatives, as they have a great potential for doing great things. These three initiatives are health promotion and disease prevention; behavioral health; and chronic care management. I firmly believe that the future of tribal communities depends on how effectively Indian Health Service and the health system addresses chronic diseases.

The leadership of the IHS has concluded that we cannot address the health needs of American Indians and Alaska Natives alone. And if I am confirmed, I intend to continue to grow and expand the collaborations with other Federal agencies and private organizations who share our mission and vision.

The key to our successes in the past and our future efforts is based upon two very, very important groups, both Senator Mur-

kowski and Chairman Dorgan have noted, the committed, compassionate, competent work force that we have throughout the system. Indian health care is a labor-intensive process. I would say that our competence goes not only to our Federal but also our tribal employees as well.

The second group is some amazing tribal leaders, we have one of them here today in Rachel, who have provided many selfless hours to the mission of the Indian Health Service. In looking to the future, we must pause and review where we are, namely, that over one-half of the Indian Health Service program over the last 30 years now rests in the hands of tribes. Tribes operate over half of the Indian Health Service program.

The Indian health care delivery system is comprised of many parts. Though outstanding in their individual performance, I believe we can be more efficient and effective if all the parts are working together. Such an example is our experience with IHS tribal and urban Indian communities piloting the chronic care management model in their communities. I have observed the excitement and commitment to a delivery of higher quality care that can only be a plus to American Indians and Alaska Natives in the future that we serve.

I have been reflecting on the seven previous Directors of the Indian Health Service, particularly as we recently celebrated the past 50 years. I come before you on the shoulders of a great legacy of Directors. As my predecessors, I have the same passion about this organization and our mission to raise the health status of our people to the highest possible level. My actions have and will always reflect the honor of being entrusted to provide health services to American Indian and Alaska Native people.

If confirmed, 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 the American Indian and Alaska Native people.

I would be pleased to respond to any questions you may have concerning my nomination, Mr. Chair. Thank you.

[The prepared statement and biographical information of Mr. McSwain follows:]

PREPARED STATEMENT OF ROBERT G. MCSWAIN, NOMINEE TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

I am humbled and honored to have been nominated by the President, supported by tribal governments across the nation, endorsed by Secretary Leavitt, and for this Committee to consider my nomination as director of the Indian Health Service.

I'd like to thank and acknowledge my family, especially my wife June McSwain who has been my confidant and closest friend and daughter Kristin Ruud, son Major Eric Ruud, daughter Elizabeth McSwain and my granddaughter Britney Ruud. On this special occasion I wish to acknowledge my grandparents Dan and Ella McSwain, both passed on, who instilled in me the Indian values of mutual respect, compassion, listening, and caring for the environment.

I am proud to pledge before this Committee, 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. Should I be confirmed, I will remain committed to working with this Committee, the Administration, and Tribal Governments toward our shared goals and objectives.

For those on the Committee and those attending this hearing, I would like to provide some background about myself. I am a Tribal Citizen of the North Fork Mono Indian Rancheria that is located in the Sierra-Nevada mountain range, in North Fork, California. I began my health career in 1971 as the Director of Central Valley Indian Health, Inc., one of 16 original programs of the California Rural Indian Health Board. I then served as the Executive Director of CRIHB, providing leadership for a state-wide Tribal health program.

In 1976 Dr. Emery Johnson, Director, Indian Health Service (IHS), selected me as Director of the IHS California Area Office (CAO). The CAO is one of 12 Area Offices of the IHS. My term as Director of the CAO was marked by significant changes brought about by the enactment of the Indian Self-Determination and Education Assistance Act (ISDEAA) Public Law (P.L.) 93–638; and, the Indian Health Care Improvement Act (IHCIA) P.L. 94–437. In 1986 I transferred to IHS Headquarters where I held several positions of increasing responsibility and authority, culminating in 2005 when Dr. Charles Grim, Director, IHS, selected me to be his Deputy Director. In September 2007, Secretary Leavitt designated me as the Acting Director, IHS.

In the early history of the IHS program, 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 health disparities will be made through health promotion and disease prevention efforts and programs.

If confirmed, I will work diligently 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 tribal consultation with the Department.

I am also committed to continuing the three Director's Health Initiatives: Health Promotion and Disease Prevention; Behavioral Health; and, Chronic Care Management. I firmly believe the future of Tribal communities depends on how effectively the Indian health care system addresses chronic diseases. And, preventing and treating chronic disease is critical to addressing the most serious illnesses faced by the Indian community.

Collaborative efforts are one way to bring the message of prevention to Indian people. As such, they IHS has collaborated with other organizations like the National Boys and Girls Clubs of America to increase clubs on reservations, NIKE Corporation to promote healthy lifestyles, per an Interagency Agreement 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.

Organizational performance is also important to the agency's effectiveness in administering its programs; and the IHS has made consistent progress in addressing management areas included in the President's Management Agenda, a government-wide management improvement initiative. In addition, the agency was rated "Exceptional" by the Department of Health and Human Services for the third year in a row for its overall organizational performance.

The Indian Health Service has had a long history, some 50 plus years, of continually changing and reacting to meet the new challenges and I am excited to report that we have been looking closer at working smarter, more efficiently and effectively. Key to our successes in the past and our future efforts is the committed, compassionate, and competent workforce we have in our Indian healthcare system.

In making the case for change and recognizing the forces driving the need to change we have concluded: The current healthcare delivery structure faces many challenges; such as, increasing needs to meet demographic and health condition trends.

Healthcare is labor intensive and we must focus on filling vacancies in both health care professions and support positions to ensure timely and quality access to health care services for American Indian and Alaska Native people.

The IHS and its Tribal partners through some amazing Tribal Leaders, have been advocates for Indian health: In the past we've simply adapted to the current health care environment without examination of how to improve the entire IHS system. This is a chance to change by design; we need to change in such a way as to maximize our capacity to deliver care; to continue to meet our responsibility to Indian people, we must develop a delivery system to *increase* access to care, and to achieve consistency in services across the system; and, design an integrated Indian health system to serve American Indian and Alaska Native people throughout the United States.

We need a Indian Health Service delivery system that is flexible while considering the national needs of Indian country as well as regional differences. A system where an Indian from the Great Lakes region can walk into a clinic in the Southwest and be seen by a provider who, with access to the patient's health information and records, is able to care for that patient with a level of service equal to that of any other facility or program in the system.

As every previous Director of the Indian Health Service, I have the same 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. Should I be confirmed, I will lead the Indian Health Service, with honor and respect for our ancestors, and 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.

A. BIOGRAPHICAL INFORMATION

1. Name: Robert Gerald McSwain.
2. Position to which nominated: Director, Indian Health Service.
3. Date of nomination: December 19, 2007.
4. Date and place of birth: August 25, 1945—Clovis, California.
5. Marital status: Married—June Clydene McSwain.
6. Name and ages of children: Kristin Denise Ruud—40, Elizabeth Ann McSwain—26, Eric Phillip Ruud—38.
7. Education:

Institution	Dates attended	Degrees received	Dates of degrees
Fresno City College	1963–1966	A.S.	6/1966
California State University—Fresno	1966–1969	B.S.	6/1969
University of Southern California	1984–1986	M.P.A./H.S.A.	6/1986

8. Employment record: List below all positions held since college, including the title and description of job, name of employer, location, and dates.

Office Manager—Kaweah Construction, Visalia, CA (1969–1970).

Director, Central Valley Indian Health Program, Clovis, CA (1971–1974).

Executive Director, California Rural Indian Health Board, Inc., Sacramento, CA (1974–1976).

Director, IHS California Area Office, IHS, Sacramento, CA (1976–1984).

Senior Advisor to Director, IHS, Sacramento, CA (1984–1986).

Director, Division of Health Manpower and Training, IHS, Rockville, MD (1986–1988).

Deputy Assoc. Director, Office of Admin. and Mgmt., IHS, Rockville, MD (1988–1990).

Associate Director, Office of Human Resources, IHS, Rockville, MD (1992–1997).

Director, Office of Management Support, IHS, Rockville, MD (1997–2004).

Acting Dep. Director for Management Operations, Rockville, MD (2004–2005).

Dep. Director, IHS, Rockville, MD (2005–2007)/Acting Director, IHS (2007–2008).

9. Military service: Enter all military service if not included above: service, dates, rank, type of discharge—None.

10. Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement.

President's Rank Award for Meriterious Service (2004).
President's Rank Award for Distinguished Service (2006).

11. Memberships: List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable and other organizations.

Senior Executive Association—1998–2008.
Calif. State University—Fresno Alumni Assn.—1970–2008.
Univ. of Southern California Alumni Assn.—1987–2008.
Federal Executive Alumni Assn.—1984–2008.
American Public Health Association—2007–2008.
Sandy Springs Friends School PTA—2004–2008.

12. Published writings: List the titles, publishers and dates of any books, articles, or reports you have written.—None published.

13. Qualifications: State fully your qualifications to serve in the position to which you have been named.

I have held a number of positions over my career that have brought me to this potential pinnacle of my career. My career, among other things, is marked by change. The highlights of which are the Agency-wide Tribal restructuring workgroups in the 1990's, the Indian Health Design Team (I was one of 6 Federal representatives) and the Restructuring Initiatives Workgroup (I was one of 4 federal representatives). I have always focused on balancing change with continuous improvement in both program (patient care) and administrative support systems.

I began my health career in 1971 as the Director of Central Valley Indian Health, Inc., (CVIH). The CVIH Program was one of 16 original programs of the California Rural Indian Health Board (CRIHB) that marked the re-entry of Federal Indian Health Care into the State of California. At CVIH, I led the establishment of medical and dental centers supported by community health aides. Toward the end of my time at CVIH we added an alcohol and alcoholism residential treatment center. I then moved on to serve as the Executive Director of CRIHB, thereby providing leadership for a state-wide Tribal health program. My biggest accomplishment was to guide growth and the institution of direct medical and dental care supported by community health programs.

In 1976 I was selected by Dr. Emery Johnson, Director, Indian Health Service (IHS), for the position of Director of the IHS California Area Office (CAO). The CAO is 1 of 12 Area Offices of the IHS. My principal role as Director of the IHS CAO was to provide support, advocacy and policy guidance to the California Indian health programs. My term as Director, CAO was marked by significant changes brought about by the enactment of the Indian Self-Determination and Education Assistance Act (ISDEAA) Public Law (P.L.) 93–638; and, the Indian Health Care Improvement Act (IHCIA) P.L. 94–437. ISDEAA enabled Tribes who previously were a part of CRIHB to contract directly with the IHS and IHCIA resulted in more resources coming into the CAO.

In 1986 I transferred to IHS Headquarters where I held several positions of increasing responsibility and authority, culminating in 2005 when Dr. Charles Grim, Director, IHS, selected me to be his Deputy Director. Under the new structure, not only was I second in command, but I was responsible to supervise, guide and rate the performance of the twelve IHS Area Directors. As the principal Deputy Director I participated in setting overall Agency priorities, policies, and strategic direction. I provided significant input in managing the formulation, presentation, justification, and execution of the Agency budget. In September 2007, Secretary Leavitt designated me as the Acting Director, IHS. Finally, as it relates to recognition of my accomplishments, I have received many awards and recognition over the years, but the two that stand out as capstones are the President's Rank Award for Meritorious Service in 2004 and the President's Rank Award for Distinguished Service in 2006.

It is my firm belief that given this experience, both in type and level of responsibility. I feel fully qualified to be considered for the position of Director, Indian Health Service.

B. FUTURE EMPLOYMENT RELATIONSHIPS

1. Indicate whether you will sever all connections with your present employer, business firm, association or organization if you are confirmed by the Senate: Not applicable.

2. As far as can be foreseen, state whether you have any plans after completing government serve to resume employment, affiliation or practice with your current of any previous employer, business firm, association or organization: I fully intend to remain in government service.

3. Has anybody made you a commitment to a job after you leave government? No.

4. If you have been appointed for a fixed term, do you expect to serve the full term? Yes.

4a. If you have been appointed for an indefinite term, do you have any known limitations on your willingness or ability to serve for the foreseeable future? Not applicable.

C. POTENTIAL CONFLICTS OF INTEREST

1. Describe any financial arrangements or deferred compensation agreements or other continuing dealings with business associates, clients or customers who will be affected by policies which you will influence in the position to which you have been nominated: None.

2. List any investments, obligations, liabilities, or other relationships which might involve potential conflicts of interest with the position to which you have been nominated.

My spouse has Stock interest in Westat, Inc., an employee owned research corporation, that has contracts with the U.S. Government including HHS. The company does not currently have any contracts with the Indian Health Service and it's not expected to cause any conflict with my duties. However, as stated in my ethics agreement, I will not participate personally and substantially in any particular matter which will have a direct and predictable effect on the financial interest of Westat, Inc.

3. Describe any business relationship, dealing or financial transaction (other than taxpaying) which you have had during the last 10 years with the Federal Government, whether for yourself or relatives, on behalf of a client, or acting as an agent, that might in any way constitute or result in a possible conflict of interest with the position to which you have been nominated: None (except as a Federal employee).

4. List and describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any legislation at the national level of government or for the purpose of affecting the administration and execution of national law or public policy: None.

5. Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items.

Although I do not believe that I am involved in any issues that present a potential conflict of interest, as described in my ethics agreement, I have agreed to recuse myself from any matters that possibly could cause a conflict of interest. If questions arise, I will seek guidance from the Department's ethics officials.

6. Explain how you will comply with conflict of interest laws and regulations applicable to the position for which you have been nominated. Attach a statement from the appropriate agency official indicating what those laws and regulations are and how you will comply with them.

As described in my ethics agreement, I have agreed to recuse myself from any matters that possibly could cause a conflict of interest. If questions arise, I will seek guidance from the Department's ethics officials.

Robert G. McSwain
Acting Director
Indian Health Service

Robert G. McSwain, a member of the North Fork Rancheria of Mono Indians of California, is the Acting Director of the Indian Health Service (IHS). The IHS, an agency within the Department of Health and Human Services, is the principal federal health care advocate and provider for American Indians and Alaska Natives.

As the IHS Acting Director, Mr. McSwain administers a $4 billion nationwide health care delivery program composed of 12 administrative Area (regional) Offices. As the principal federal health care provider and health advocate for Indian people, the IHS is responsible for providing preventive, curative, and community health care to approximately 1.9 million of the nation's 3.3 million American Indians and Alaska Natives in hospitals, clinics, and other settings throughout the United States.

Mr. McSwain served as the IHS Deputy Director from February 2005 until his appointment as the Acting IHS Director in September 2007. He participated in setting overall agency priorities, policies, and strategic direction. Mr. McSwain provided significant input in managing the formulation, presentation, justification, and execution of the Agency budget. His participation influenced program and resource allocation decisions that impacted the total Agency budget. He was responsible for the development of and justification for testimony presented to congressional appropriation and legislative committees and was a principal witness before such committees. Mr. McSwain also supervised the 12 IHS Area Directors.

Prior to beginning his federal service, Mr. McSwain served as Program Director of Central Valley Indian Health, Inc., a tribal health program in Clovis, California. From 1974 to 1976 he served as the Executive Director of the California Rural Indian Health Board, Inc. Mr. McSwain began his federal career with the Indian Health Service in 1976 as Director for the IHS California Area Office. In 1984 he was named Special Assistant to the Director, IHS, and assigned to long-term training at the University of Southern California. In 1986, he was transferred to the IHS Headquarters in Rockville, Maryland, where he held positions of increasing responsibility and diversity, including Director of the Division of Health Manpower and Training for the Office of Health Programs, Deputy Associate Director for the Office of Administration and Management, and Management Analysis Officer for the Office of the Director. From 1992 to 1997 he served as the Acting Associate Director for the Office of Human Resources. Mr. McSwain was selected as the Director of the Office of Management Support in March 1997. From August 2004 until February 2005, he served as the Acting Deputy Director for Management Operations.

After receiving an associate of science degree in accounting from Fresno City College in Fresno, California, Mr. McSwain obtained a bachelor of science degree in business administration (economics minor) from California State University - Fresno in 1969. In 1986 he earned a masters degree in public administration (health services administration concentration) and pursued doctoral studies in public administration from the University of Southern California.

Mr. McSwain has received numerous honors, including the President's Rank Award for Meritorious Service in 2002 and the President's Rank Award for Distinguished Service in 2006.

September 2007

The CHAIRMAN. Mr. McSwain, thank you very much. We appreciate your testimony.

I personally will be supporting your nomination, and I will hope to move the nomination out of this Committee in an expeditious way and to the Floor of the Senate.

Having said that, you and I talked yesterday, by telephone, and you know that I feel there are some very serious problems at the Indian Health Service. First and foremost, of course, is the problem

of funding. We have unbelievable funding problems, and you inherit a difficult situation. You inherit a system in which we are required to provide adequate health care to Native Americans, the First Americans, and yet about 40 percent of the money that is needed to do that is not available. So we have rationing going on.

Give me your perspective about inheriting a system that is so dramatically under-funded.

Mr. MCSWAIN. Senator, that is an excellent question. I was reflecting for a moment on the fact that you used the word inherited. I did in fact inherit a budget. But I was also very much involved in the preparation of that budget. As you well know, the current climate in which we operate is the fact that we have a budget deficit. We are in a reduction arena. There are a lot of problems that are being gauged about what is important to them.

It is fair to say that we have begun to refocus our efforts toward that which is our primary core mission. The primary core mission of the Indian Health Service is to provide service to the Indian people living on or near reservations. And more importantly, to our clinical care that we need to provide, which is our primary care to American Indians and Alaska Natives. That may mean that other parts of our program will either be eliminated or downsized in order to make sure that we maintain those particular initiatives and program levels, particularly as it pertains to clinical services.

In fact, as you have seen our budget, the increases we have are on the clinical side. And the decreases are on the non-clinical side.

The CHAIRMAN. That is certainly true, overall, of course, there is a decrease in recommended funding with respect to the increased costs of living and so on. We are losing ground here with this budget. It is also the case that our facilities are in tough shape and we are cutting facility funding.

I want to ask you about this, in July of 2007, Dr. Grim, at his confirmation hearing, told the Committee that the IHS Office of Environmental Health and Engineering had finalized revisions to the Health Care Facility's Construction Priority System. That was July of last year, and the final report was being prepared to be submitted to the Department of the OMB for clearance.

Any word about that? What is the status of that?

Mr. MCSWAIN. Senator, what happened was unfortunately, Dr. Grim left, and his withdrawal resulted in him departing from the directorship rather quickly. He had wanted to really sign off on that. But I am pleased to report to you that I have in fact signed off on the basic system, the basic priority system that was recommended by the Tribal-Federal Appropriation Advisory Board that had been working on it for a number of years. And it is now moving through the Department and will be moving for clearance. They are vetting it at the Department level. It will be moving through to certainly OMB and then on down to the committee that requested the new system, which is the appropriations committee.

The CHAIRMAN. Let me refer you to, without using names, a letter that I wrote to the Inspector General of the Indian Health Service, Inspector General of HHS, setting out a series of concerns about one of the regional offices of the IHS. And it dealt with a director of a tribal Indian Health Service facility and the complaints

that had been made by the tribe, by employees, about employee harassment, financial impropriety, and other things.

As I looked into it, it appeared to me, Mr. McSwain, that in a particular area office, there was staggering incompetence. I don't know any of those people, but it seems to me that when you have circumstances of the kinds of complaints that existed, you would expect a regional office to move quickly to find out what is happening. Yet that was not the case here.

As I looked into it, I am told that the very person that was running the Indian health facility at this particular tribe, a tribe, by the way, which passed two resolutions banishing that person from their reservation, I am told that the person had multiple complaints filed against them. There were five EEOC complaints, four of which were determined for the plaintiffs and against this employee, and yet this person has just been transferred along in the Indian Health Service to the next tribe. We here about all of these allegations, and nothing happens.

It appears to me that in that region, and I am not using names, but you know what I am talking about, you have staggering incompetence with a bureaucracy that is just mired in the glue of indifference. I mention this because you know of this case. But I also sense it exists elsewhere in the system. I think this is a bureaucratic system that desperately needs reform. If you find some place where somebody has had four or five EEOC complaints filed against them, I hope you will determine that the person doesn't get transferred, and that he or she gets fired.

I am hoping that you are going to risk your job to do two things. Number one, to say to this Administration privately and publicly, if necessary, we need adequate money in this system to provide health care for Indians that we promised them. Number two, you are going to insist on reform in a system that is hard to reform, and you will take the risks to require that reform. That is what I am hoping from you.

But I have asked you a big, long, formless question here. Give me your impression.

Mr. MCSWAIN. Thank you, Senator. There are two parts to that question, obviously. The first one was about resources.

I am of the belief that part of our challenge as the Indian Health Service is to make the case better and clearer to the people we must report to. And that is something I will work more diligently on. There has to be a better way to tell the story of why we need certain budgets each year. This year, the 2009 budget, we made a case for it, and now it is the President's budget. We will defend it.

We will go back and look and see whether or not there are parts of our proposals that we are missing on, recognizing that it is all about competing, if you will, across the board to ensure that the Government in total, I realize that poor OMB gets a rap every now and then about this whole thing. But they are trying to make a decision across Government, much like the Secretary must make decisions about cross all the octaves. And then for the Director of the Indian Health Service to make decisions about all of Indian health.

So as it rolls up, it is how we make the case. But I can assure you, I will continue to make the case when the time comes during the rules process to do that. I will commit to that.

On the second issue of the example of the EEO complaints and the like, let me just say that after your phone call, a lot of actions took place. I am only sorry that it had to require you to call me to make that occur.

The CHAIRMAN. You are talking about the call four or five months ago?

Mr. MCSWAIN. Yes. It should not have happened. And that I apologize for. But we are in fact looking across the Country, in fact, the concern about, was it systemic, we have looked into it. There are parts in the Country that we have found other, similar situations. It is not systemic, but there are some other examples.

We are moving to, part of the whole of competency at the service unit director level, or the CEO of the service units, is that we have not paid a lot of attention to ensuring that we are getting the best qualified people to operate our service units, particularly in those service units where we actually are providing the care. And we have started a succession planning program that will in fact hopefully ensure that there is a level of professionalism and that they are adequately trained.

As you can imagine, something I have observed over the years is that as you are very good at what you do, you are a good technician, and you do the job extremely well, the next thing someone does is say, well, you ought to run the whole thing, without any training on what it takes to manage people. That is a huge job, when you start to lead and manage people, as opposed to just doing your thing. You can't be the best accountant and expect to be the director of finance without adequate training.

So those are the things that I believe that we are working on and will continue to work and focus on them, particularly at our service units.

The CHAIRMAN. Mr. McSwain, one of the things that I suggest that you consider is writing a letter to the tribes. We have 500 and some recognized tribes in America. Write a letter to those tribes and ask them, give me your perspective, from your level, what is happening in the health care system in your area.

I walked through a clinic in North Dakota about three or four weeks ago with a wonderful IHS doctor—wonderful doctor. This is a clinic with poor structure, inefficiencies, and it needs to be rehabbed. The doctor said, we desperately need a new x-ray machine. I said, well, can you get it? He said, no, the requisition for it has been in for two years, but the request hasn't gotten through. The regional office hasn't assigned it yet, but the money is there. I said, how long has it been? Two years—can't get it through the regional office.

It is just a matter of processing paperwork. But when the paperwork doesn't get processed, all those folks that were sitting in the waiting room, some of whom would want a good x-ray, aren't going to get the x-ray they expected, because somebody sitting in a regional office hadn't found ways to get through their papers. And this poor doctor just shook his head and said, you know, it is beyond my understanding of how people like that keep their jobs.

So my hope is that you will be able to reform some of this. Let's not protect incompetency. If we have incompetent people, let's root them out, get good people in who are dedicated and passionate and

want to do a good job. Because there are some incompetent people in this bureaucratic system of ours. That is true of the Indian Health Service. I believe I have documented some of that. I am not trying to be a policeman for the Indian Health Service. That is not my intention. But I want that service to work well, and I think it can work much, much better than it has.

I have a couple of other questions, but I want to yield to the Vice Chair, Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

You point out one of the obvious problems. If you have incompetency in the system, that in and of itself brings great frustration to all involved. But to the practitioner who wants to be able to provide a level of care, they give up in frustration. So then you don't have that experienced professional there. It builds on further and further problems.

Mr. Chairman, I am notified that Senator Barrasso is going to be submitting a statement for the record and has asked that that be included as part of this as well.

The CHAIRMAN. Without objection.

Senator MURKOWSKI. Mr. McSwain, we had a chance a couple of days ago to talk at some length about the Indian Health Care reauthorization and some of the issues that are still outstanding and our hopes, our very strong hopes, that we will be able to move this legislation through the Senate in an expedient manner, allow the House to act quickly and get it to the President for his signature this year. Senator Smith raised an issue that is out there. As you know, we have been working on some of the few outstanding issues.

What kind of commitment can you give to this Committee that you will actively participate in resolving any of the outstanding issues that are out there, or basically how you can help us get this bill signed into law?

Mr. MCSWAIN. Thank you, Senator. As I mentioned the other day, this is an important bill for me personally and professionally. Certainly as I see the bill, I think I reflected with you the fact that the bill 30 years ago was not as complex as the bill is today, nor is our environment as simple as it was in 1976. It is much more complex. There are so many different pieces to it. In fact, I speak with Mr. Mahsetky almost daily about what is happening as the various issues are addressed in the bill.

But the bottom line is, yes, we do need to have it reauthorized. It provides a framework. It provides a relationship between the tribes and the Federal Government about health services. That is the paramount. The goals that are set forth in the law are as real today as they were 30 years ago. It is about improving and it is about the responsibility the Government has to provide care to Indian people.

Those being the underpinning fundamentals of the bill, there are all the pieces obviously that go into it. There are a lot of other interests that are expressed about the bill. I can assure you that I will work within the Department and within the Administration to the extent possible that I can help resolve those issues that are pending. I will use my office to do that.

Senator MURKOWSKI. We appreciate that. We want to make sure that we have that continued support of the Administration. As you know, there was a set that was released a couple of weeks ago that raised some issues, that caused some concern. We want to be able to work through all of those and know that we have the support from the Administration and the President will sign this bill when we get it successfully moved through the Congress.

You gave a little bit of a status on the health care facilities priority system. You mentioned briefly in our meeting the Barrow facility. Will both the Nome and the Barrow facility retain the priority status that they currently have under the newly-revised system?

Mr. MCSWAIN. Yes, they will. In fact, all the facilities on the current system, some 20 facilities, are set there. As you were talking about facilities, I was also looking at the same five-year plan and realized that we have built a fair number of facilities since 1993. I was counting some rather large numbers. I can certainly submit those for the record.

We have been moving out and building facilities, hospitals and health centers and YRTCs and the like for the last 18 years rather well. While the process is slow, we will continue to move forward with Barrow and Nome as well as the facilities in the lower 48.

Senator MURKOWSKI. You responded a little bit about the budget issue. We recognize that these are times of budget restraints. We have been urging, certainly my constituents as they come to the office in frustration about the IHS budget, we have been urging Alaska Natives to get involved in the process early on, let the agency know what the concerns are. I do appreciate the IHS efforts to conduct these budget consultation meetings and trying to work with the tribes on their recommendations.

But what we are hearing back from so many, from the tribes, is that their priorities are just clearly not reflected in the President's budget. How can we make this consultation process more meaningful? It is one thing for me to say, go and make sure that your concerns are hear, they do, they participate, and then they don't see anything on the other side. If it is not going to be meaningful consultation, it is tough for me to urge them to be a participant, it is tough for them to feel like they should continue to be a participant. How can we make this work better?

Mr. MCSWAIN. That is an excellent question. It is one that we have wrestled with for some time. When the budget ultimately gets presented and the President rolls out the budget, tribes are wondering, raise questions about that.

The process is fairly transparent until it gets up into the decision-making that goes on at the higher levels were the budget is embargoed. But up to that point, we have not done a very good job of relating back to the tribes that have participated in the process that, here are your priorities, this is what you priorities are by region, by area, and this is what they look like in a composite nationally. It is perhaps as simple as Chairman Dorgan says, write a letter back to the 562 tribes that says, for this year, these are the priorities by region, these are the priorities that we have collected for the national purposes, and we are going to rest on those priorities as we move forward.

I can assure you that all the decisions that go on in the process, what goes on in the embargoed stage, we are mindful, ever mindful of the tribal priorities and what those priorities are. We will continue to do that. The unfortunate thing is the process does move into the embargoed state. We are not at liberty to share with them those kinds of decisions that are being made. But I can assure you that I and all the directors before me do in fact rely on those priorities.

We just need to get the message back to them, and I think there is a better way of doing that. The national consultation meeting is going to occur next week out in California, where they will be talking about national priorities again. We will take another look as to how we best represent the priorities.

Senator MURKOWSKI. Consultation is a two-way street. If the tribes don't feel as if they are being heard or that it is a meaningful consultation, again, you are not getting much out of that process. So it seems to me that there has to be a way to ensure that that is meaningful.

We all appreciate that there is that black hole at some point in the budget process, where it is not open and it s not transparent. We wonder what in the world happened to our priorities. But until that stage, I think every effort that can be made to make sure that there is clear understanding as to how we outline these priorities, I think it will be better for all.

I mentioned in my opening statement the comment, don't get sick after June. It just speaks to the need to support the contract health service program. How are we going to address the shortfalls in the contract health services?

Mr. MCSWAIN. A couple of things have occurred. Certainly in the contract health service there is the $9 million increase for 2009. And there is also the increases that we have received for the catastrophic health benefit, which is the CHEF fund. That was the one that for cases over $25,000, they are referred to the headquarters office and they are paid out of CHEF.

We were running out of money in the CHEF fund for those high-cost cases as early as April, not June, but April. What was happening was that we didn't have enough in the CHEF fund to be able to pay for those high-cost cases. Therefore, the areas were required to begin using their other CHS funds. So all you need is a few high-cost cases like that and your CHS budget is sorely affected. We are looking at possibly getting the CHEF fund all the way through August now, because of the increases in the CHEF fund.

Senator MURKOWSKI. That is good, but that gets you through August.

Mr. MCSWAIN. Yes, I know, but we are moving the ball.

Senator MURKOWSKI. Yes, I know. It is just difficult to have to explain that to somebody who is ill and the expectation is that that care is going to be available. If the calendar doesn't jive with when you happen to become ill, again, we wouldn't accept this anywhere else. And yet we talk about it as though, well, it used to be April, now it is June, but soon it will be August and we should celebrate that success. I think we celebrate the success when we are able to provide for the level of health care services year-round, 365 days.

Mr. Chairman, I have some more questions, but if you want to take a turn?

The CHAIRMAN. Go ahead.

Senator MURKOWSKI. All right, thank you.

Third-party reimbursements. As you know, in the Indian Health Care reauthorization, this is a big effort here to make sure that we do allow for increasing Medicaid, Medicare enrollment in Indian Country. I understand that there may be some concern about how effective the enrolment efforts have been in some areas, and that patient care is delayed until they are enrolled. What is the plan of action for increasing Medicaid and Medicare enrollment, so that we don't see these delays?

Mr. MCSWAIN. Senator, I believe what you are talking about is the enrollment, obviously it is getting our patient registration system more robust than what it is. We do know that patients do arrive at our facilities, and in some cases, are immediately screened for alternate resources, namely Medicare-Medicaid, VA, private insurance. I know that some of our systems do just an outstanding job. The best practices, if you will, from those facilities, are being transported to other facilities.

I know that for us, the collections mean a great deal. While they are intended to address deficiencies and accreditation issues in facilities, they are also a great source of additional resources for purposes of providing patient care. We are up close to $800 million in third-party collections now. That is a rather significant amount.

The fact is that we are continually working with CMS on opportunities that CMS will provide, and also through the Tribal Technical Advisory Group, the TTAG, which is tribally, basically a group of advisors to CMS for all kinds of Medicaid-Medicare issues and reimbursements. We are working diligently. We know that some of the statements around the system are, make sure that we are capturing every possible Medicaid opportunity, Medicare opportunity, because it is such an important part of our system.

I know that tribes have been doing an outstanding job, I know Alaska has done just a tremendous job, because they have literally tripled the collections since they have taken over the program. That tells us a lot. And clearly, this is an area that we feel we negotiate the rates each year to ensure that they are forward-moving. We will continue to do that. The business offices throughout the facilities are becoming, I think, better at what they do. The ability to bill and collect is another facet of our business infrastructure.

Senator MURKOWSKI. What about contract support costs? Shortfalls are pretty significant. Under the contract support cost policy that was issued last April, how long is it, do you anticipate, before these shortfalls in contract support costs are addressed?

Mr. MCSWAIN. That is a very difficult question. I would have to go back and look. I have some numbers in preparation, I know they are pulling some numbers together in preparation for the upcoming budget hearing. I don't have the latest numbers. In fact, I know that I was trying to find out where the last shortfall report was. I am of the understanding that the last shortfall report that came to the Congress is probably about 2000, on 2000 data. We are looking for the latest report that should be coming to the Congress. I can report on that at that point.

Senator MURKOWSKI. Is it still the IHS policy to deny the newer expanded contracts based on the lack of contract support costs? Is that still the policy that is in place, then?

Mr. MCSWAIN. Excuse me, will you repeat the question?

Senator MURKOWSKI. Whether or not it is the IHS policy still to deny new or expanded contracts if you don't have sufficient contract support costs?

Mr. MCSWAIN. No, Senator, the position of the Indian Health Service is to have a conversation with the tribe that wants to take over a program service, function or activity under the Indian Self-Determination Act. We share with them the fact we do not have contract support cost money and allow them to say, do they still want to take it over. They can take it over, recognizing we don't have the contract support costs. We have had a number of tribes in fact move forward, assume the program responsibility without the contract support costs. We have not denied any because we don't have the money. I don't know of anyone, anywhere we have denied them.

Senator MURKOWSKI. Mr. Chairman, that is all I have at this point in time. I appreciate the responses from Mr. McSwain.

The CHAIRMAN. Mr. McSwain, the President, either the President or his representatives, have suggested the potential of a Presidential veto on the Indian Health Care Improvement Act. Are you familiar with that and what the reasons for that might be?

Mr. MCSWAIN. I am familiar with the statement of administrative policy.

The CHAIRMAN. Right.

Mr. MCSWAIN. I have only read about the veto. I am not involved in the actual messages from the White House.

The CHAIRMAN. My sense is that we have worked through most of the concerns. Based on the Administration's comments, at least one of them, I believe, they were confused about what the provision actually was. I think that we have worked through most of those. My hope would be that you, inside the Administration with OMB and the White House, would look at our work. Our hope would be to get that through the Senate next week. When we do, I hope you will look at that work and see that substantial changes have been made, changes that will resolve those issues.

You have a responsibility to support the President's actions, I understand that. You have a responsibility to support the President's budget, I understand that. It is always a source of aggravation that those that come to the witness table steadfastly support the President's budget. But then I understand that you work for the President, not for this Committee.

I do think we have very serious funding problems, and it is very hard to run a system that is so dramatically under-funded. The contract health care issue is a very serious problem. I know that there is some effort to improve that.

But in addition to what my colleague, Senator Murkowski, described, "don't get sick after June," any of us who go to reservations understand that this is happening in contract health, and as a result, people's credit ratings are ruined. They have to postpone getting deathly ill in September or August, because there may not be

any contract health money available. The nearest health care facility is not on the reservation, it is an hour and a half away.

So they go, and the contract health money is not there to provide for their needed care. So the debt collectors come after them and destroy their credit. It is an awful thing to see. A lot of folks on Indian reservations have credit ratings that have been completely destroyed because of the inability to provide contract health care.

You are familiar with that, I assume?

Mr. MCSWAIN. Yes, I am, Senator. While you were speaking, I was thinking of a couple of parts of an answer. One part is that we need to fill the vacancies we have. Because if we don't fill the vacancies, we don't provide the care, we go buy the care. So we have some vacancies we need to fill.

The interesting thing about that strange dynamic is that we wind up contracting out to fill those vacancies to even continue the care. So that reduces our ability to collect.

The other thing that comes to mind also is the fat that we haven't seen the full measure of the Medicare-like rights, where we are actually contracting with facilities for Medicare-like rights, and that is another facet of insuring that not as much contract health service is going out as billed charges. But we are still watching, it was only put in place last year. But clearly, this is another area that will at least moderate the out-go for contract health care. It is still a major issue. I agree with you, I think that the fact that we are moving some of our facilities, we are replacing them with health centers now. We are trying to, and I think the last couple of facilities we actually increased the contract health care for those facilities. One was Sisseton and the other was Clinton, they went from hospitals to health centers. We recognize that that is going to require them to go out and buy.

So we put in our actual contract health care budget request some additional funds for those changes, for those two facilities. That is another means that we are doing to make sure that the care that we are providing when we are moving in that direction is actually available.

Now, the overall set certainly is, in terms of the contract health services still operating at the highest level, we are only doing top-level, priority one care. The only good thing about it is that we are not denying any priority one care across the Country.

The CHAIRMAN. Yes, but what is priority one is sometimes a matter of judgment. You are talking about life or limb, right?

Mr. MCSWAIN. That is correct.

The CHAIRMAN. I was at a clinic where they have had a need to secure another pharmacist. They have been waiting for a year, because all the hires have to run through the regional office. The employees at the clinic and the tribe told me that that regional office has been unresponsive. So they have had to contract out pharmacy services, which runs up to $100,000 a month. It has resulted, in some cases, in over-spending to get contract pharmacy services, and four hour waits for getting prescriptions filled after somebody sees the doctor, in some cases doctors have to fill the prescription themselves instead of seeing patients, or some patients go without medicines they need.

That is the thing I hear about with these regional offices that just makes me angry. We need the bureaucracy to work, and we need this thing to function. I think there is so much to do. I think what we will do as a Committee, in addition to trying to get this Indian Health Care Improvement Act passed, because I think that is a first step, is to look at much greater reform. But we have to take a first step in the right direction before you can get some momentum.

I think we also as a Committee will write to all of the tribes and say to the tribes, tell us what is happening out there, give us your perspective. In some cases, their perspective may be just that, a perspective of their vision through a certain prism. But I think we will get a lot of good information. I would encourage you to do the same thing. Let's find out what is really happening out there, where the top performers are and where there is dramatic need for change.

I am going to conclude today with something my colleague has seen me do on the Floor. I want to do it because we are talking about individuals who are having trouble getting adequate health care. Adele Hill Baker, I will show you her photograph. This is not on your shoulders, it is the system you are inheriting now. This lady was having a heart attack on an Indian reservation. She was put in an ambulance, taken off the reservation, 80 miles or so, 90 miles, to a hospital. She didn't want to go in an ambulance, because she knew that she couldn't possibly pay the charge, and she worried that the Indian Health Service wouldn't pay for it. So she begged not to be put in an ambulance, despite the fact that she was diagnosed as having a heart attack.

They put her in an ambulance anyway, and took her to the hospital. When they got to the hospital, she had a piece of paper taped to her leg that informed the hospital that there was no contract health care money available. If you admit this patient, understand it is at your own risk. So a woman comes in on a gurney with a piece of paper taped to her leg. It is just unbelievable.

That is the story of Adele Hill Baker, a real person having a heart attack, who is put into this position of going into the hospital and having a piece of paper with her that says, by the way, admit me, you are in trouble.

The other is a photograph of a young girl from Montana. Her grandmother saw me at the Crow Reservation in Montana. This young girl died, just a young girl, five years old. Her name was Teshon Rain Little Light. Her grandmother came to where Senator Tester and I were holding a meeting. She held up this big picture of this little girl in her Indian dress and she told us her story. This is a little girl. They took her to the clinic four or five times and they treated her for depression. Her grandparents pointed out that her fingers are bulbous and discolored, there is something wrong with the oxygen, something going wrong inside.

And one day, of course, it all collapsed and they sent her to Billings, Montana on an emergency basis to the hospital from the Crow Reservation Clinic. They sent her immediately to the Children's Hospital in Denver and discovered that she had terminal cancer. Her grandmother said she lived the last three months of

her life in unmedicated pain, undiagnosed. Of course, she died shortly thereafter.

It so happened I ran into this young girl's aunt on an Indian reservation in North Dakota about two weeks ago. She again described the case. This is a five year old girl that probably shouldn't have died, probably should have been diagnosed much, much earlier. These things are going on all across the system. Many of these reservations are remote, very remote areas where there is not a good hospital, not a hospital that is close. So the delivery of health service by the Indian Health Service in many cases is the only delivery that is available. I know in many cases it means life or death to have the right service at the right time.

One of the clinics I told you about earlier has a lot of problems. But one of the significant problems is it is only open from 9:00 until 4:00, five days a week. That reservation is very remote. You get sick there, have a serious problem there, you are in trouble.

My point is, we need to do much, much better. I am going to move your confirmation, and I believe my colleagues will be supportive of it. But I do hope you are willing to risk your job and risk your career. By risk, I mean be aggressive, speak out, be loud. The only portion of your testimony today that caused me any problems at all was when you were complimenting the Office of Management and Budget. That almost lost me. But I am still with you, Mr. McSwain. The Office of Management and Budget knows the cost of everything and the value of nothing. That is why we get a recommendation that says, let's cut some of these Indian Health programs and recommendations to spend money in other areas that are so absurd I shall not even describe them today.

Having said all that, you inherit a pretty big load and a big responsibility. This Committee wants you to succeed. We don't want you to fail, we want you to succeed. Chairperson Van Huss described your background with enormous pride, justifiable pride. You come from a background of, I am sure, circumstances where you had to overcome the odds, and you have carved out quite a significant career.

So speaking for myself, I am pleased to support your nomination. But I really do expect a lot out of you. My guess is the Vice Chair does as well.

So justify that faith, because together, we have to figure out a way to make something good out of this health care system and make it work.

Mr. MCSWAIN. Thank you, Mr. Chairman. In fact, as I was looking at those pictures and hearing the stories, one of the things I want to do is stop the stories. We need to stop those stories. We can't have people being moved about the system in most disrespectful manner. And clearly, patients not being seen in appropriate manners. When I say stop the stories, I hope these are the only stories we hear in a long time, that there won't be any more.

The CHAIRMAN. Well, this little girl named Teshon Rain Little Light, her aunt told me that when she got to Denver, finally, after going over and over and over again to the clinic and being treated for depression, they discovered she was going to die because of a terminal illness. The one thing she wanted to do was to go to see Cinderella's Castle. So Make A Wish sent her to Orlando, Florida,

to Disney World. And the night before she was to see Cinderella's castle, she died in her motel room, in her mother's arms.

The point of it all is this. It is such a human tragedy that we can't provide first-class medical help that we all are proud of. These are the first Americans, and it is our responsibility. We have made that commitment, a trust responsibility, and treaty commitments. Senator Murkowski and I and this Committee are just determined to do everything we can to try to effect change here. So when someone new begins to head an agency, you have an enormous opportunity to effect change. We hope that will be the case with your stewardship of the Indian Health Service.

Senator Murkowski, did you have any final comments?

Senator MURKOWSKI. Just to thank Mr. McSwain. You have to appreciate the courage of a man who, even knowing the obstacles that he will face, is willing to take on a challenge. I appreciate a great deal your willingness to face these obstacles, to stop the stories and to take the challenges and to really make a difference within a system that has experienced great difficulty. I appreciate your willingness to serve and do look forward to the opportunity to work with you and other members of the Committee, the Chairman, to really make a demonstrable difference in the lives of American Indians and Alaska Natives. Thank you.

Mr. MCSWAIN. Thank you.

The CHAIRMAN. The hearing is adjourned.

[Whereupon, at 10:43 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

Welcome, Mr. McSwain, and congratulations on your appointment. Your family has a right to be proud of your accomplishments.

As we discussed yesterday during a meeting in my office, I believe all of us have a responsibility to plan for a healthy future. As a physician, I have worked for over two decades to help the people of Wyoming stay healthy and lower their medical costs. In my practice, I saw first hand the obstacles families face to obtain medical care.

Rural and frontier areas have to overcome significant challenges in order to deliver high quality care in an environment with limited resources. Our unique circumstances require us to work together, share resources, and develop networks. I think we can all agree these same principles are critical to support and modernize the Indian health care delivery system.

Everyone here knows the serious problems we face to deliver health care services in a cost-effective, efficient, and culturally sensitive way. Wyoming's Wind River Reservation, located near Riverton, is home to 10,415 members of the Eastern Shoshone and Northern Arapaho tribes. It is the third largest reservation in the United States—covering more than 2.2 million acres. Tribal members in Wyoming have worse than average rates of infant mortality, suicide, substance abuse, alcohol abuse, unintentional injury, lung cancer, heart disease and diabetes.

When I last visited the Wind River Reservation, tribal leaders told me how difficult it is for them to (1) recruit and retain staff, (2) stretch each dollar to deliver essential services, (3) respond to cultural barriers, and (4) give families necessary information to make better lifestyle choices. Additionally, the Wind River Reservation has one of the highest unemployment rates of the twelve IHS areas. The male unemployment rate is approximately 30 percent while the female unemployment rate is approximately 21 percent. I want to put that number into context. The national unemployment rate is hovering around 5 percent.

These statistics arc important because they directly affect the health of Indian communities. Native American families living below the poverty level in areas with high unemployment rates most likely live in sub-standard housing, have poor nutrition, and suffer from chronic health problems.

In order to make significant strides in reducing the health disparities among Native Americans and Alaska Natives, continued and sustained improvements in access to treatment and preventive services are needed. That is why I joined my colleague, Senator Smith, and other members of the Indian Affairs Committee, to send Office of Management and Budget (OMB) Director Jim Nussle a letter requesting increased IHS discretionary funds. I want to make sure that people on the Wind River Reservation, and all Native People across America, have equal access to quality, affordable medical care.

That said, it is equally as important that the care we provide is cost effective and produces results. The IHS is not like other federal health care programs. Congress has only limited access to the research data that is needed to modernize and improve Indian health care. I know this Committee will continue to focus its efforts to improve health care services, but we need good data and research to evaluate the current delivery system—exposing barriers that prevent collaboration, networking, innovation, and sharing of resources.

Today, neither the government nor private Native American/Alaska Native advocacy groups can explain exactly how funds are used to coordinate medical services. If we do not know where our resources are being spent, the number of programs dedicated to provide services, how these programs coordinate health services, or the outcomes achieved, then can we be certain we are maximizing our ability to help Native Americans and Alaska Natives?

It is incumbent upon the IHS Director to provide timely, accurate answers to this Committee and Congress outlining (1) how much money the federal government is spending on discretionary and mandatory Indian health care programs and (2) how

the IHS works with Medicare, Medicaid, SCHIP, states, and the tribes to coordinate programs and services. This way, we can target federal funds to programs making the greatest impact—then focus on additional areas where Native Americans and Alaska Natives need our support.

Mr. McSwain, thank you for your willingness to serve in public office. I look forward to working with you to improve the health and welfare of the individuals living in Indian Country.

NATIONAL INDIAN HEALTH BOARD
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Alexandria, VA 22314
Website: www.nihb.org

February 5, 2008

The Honorable Byron Dorgan, Chairman
Chairman
Senate Committee on Indian Affairs
Washington, DC 20510

The Honorable Lisa Murkowski
Vice-Chairman
Senate Committee on Indian Affairs
Washington, DC 20510

Dear Chairman Dorgan and Vice Chairman Murkowski:

On behalf of the National Indian Health Board (NIHB), I am pleased to support the nomination of Robert G. McSwain as the Director of Indian Health Service (IHS). With over 30 years of service, we believe Mr. McSwain is highly qualified to serve as the Director of IHS. As a member of the North Fork Rancheria of Mono Indians of California, Mr. McSwain has represented the Indian people well within the IHS system. Most recently, Mr. McSwain has honorably served as Deputy Director over a two year period and Acting Director since September 2007. We look forward to continuing work with Mr. McSwain as the newly confirmed IHS Director.

In addition to earning a bachelors degree in business administration and masters in public administration, Mr. McSwain has held many leadership roles in Indian health since the early 1970's. Over the years, as director of different departments within IHS, Mr. McSwain has developed management skills to lead people and programs, in roles such as: the Executive Director for the Rural Indian Health Board, Director for the IHS California Area Office, and Director of Office of the Management Support. Mr. McSwain's distinguished leadership has been recognized by such awards as the President's Rank Award for Meritorious Service in 2002 and the President's Rank Award for Distinguished Service in 2006.

The well accomplished Mr. McSwain has many extensive skills and experiences that will serve as invaluable assets as he assumes the Director position. He has shown his dedication to IHS and to the welfare of Indian people. As Director, the NIHB has confidence that Mr. McSwain will take steps to make significant improvements to the funding levels and management of the contract health services program, address the health care facility construction needs of all of Indian Country, and work to reduce health disparities and the high incidence of suicide, especially youth suicide, in Indian Country. We believe Mr. McSwain will continue to positively represent Indian people's best interest in health for many years to come.

I appreciate the opportunity to offer this letter of support for the confirmation of Mr. McSwain's nomination as the Director of IHS.

Sincerely,

H. Sally Smith, Chairman
National Indian Health Board

Established in 1972, the NIHB serves all 561 Federally recognized American Indian and Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care delivery to AI/ANs as upholding the Federal Government's trust responsibility to AI/AN Tribal governments.

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

February 4, 2008

U.S. Senator Byron Dorgan
Chairman
U.S. Senate Committee on Indian Affairs
838 Hart Office Building
Washington, DC 20510

The Honorable Michael O. Levitt
Secretary
U.S. DHHS
200 Independence Avenue, SW
Washington, DC 20201

Dear Senator Dorgan and Secretary Levitt:

As Chair of the California Rural Indian Health Board Inc., (CRIHB), a Tribal organization established in 1969 and providing health and health related services to twelve member health programs serving 29 federally recognized Tribes in the state, I am writing to express my personal support of Mr. Robert McSwain being elevated from Acting Director of the Indian Health Service (IHS) to Director. Mr. McSwain recently visited the California IHS Area and devoted substantial time to interfacing with Tribes, tribal health programs, and CRIHB on health issues of importance to California Indians. During this time, I personally spent eight hours riding with him to the clinics to see first hand the status of their operations and to discuss how to enhance the services to benefit Indian health clients.

Mr. McSwain has worked for IHS for over 30 years and has accomplished a great deal during this time, including co-managing this $4 billion dollar program and developing and institutionalizing agency priorities, policies, and strategic directions. He is well known for embracing the ideals of leadership, including service, dedication, and a deeply held commitment to the community. He leads by positive example and immense compassion for others, and works diligently to make a difference. He personifies the spirit of leadership.

We are very proud of what Mr. McSwain has achieved thus far in his career and of the fact that he is a descendent of California Indians, specifically a citizen of the North Fork Rancheria of Mono Indians. We are also proud that he received his start at IHS working for the Central Valley Indian Health program and CRIHB in the late 1970s.

It is without hesitation that I recommend Mr. McSwain for the position of IHS Director. I am confident he will continue to provide strong and effective leadership for the IHS in serving in this capacity.

Sincerely,

Reno Franklin
Chairman of the Board

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February 7, 2008

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US Senate Committee on Indian Affairs
Attn: Rhonda D. Harjo
838 Hart Office Building
Washington, D.C. 20510
Fax number: 202-224-5429

Re: Support Letter for Nomination Bid of Mr. Robert G. McSwain

Dear Senate Committee on Indian Affairs,

Toiyabe Indian Health Project is pleased and honored to support Mr. Robert G. McSwain, a California Native. We recognize that Mr. McSwain has a vast experience in the Indian Health Care field and will provide his leadership to ensure that all American Indians across this nation will receive top quality health care.

Respectfully,

David Lent
Acting Executive Director

cc: Jacquie Davis-Van Huss

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. GORDON H. SMITH TO ROBERT G. MCSWAIN

Health Facilities Construction and the Area Distribution Fund

Last July, during Dr. Grim, former IHS Director's nomination hearing, Senator Smith asked him to confirm whether IHS had the authority to implement an ADF. Dr. Grim did not confirm the Agency's authority. One week later Senator Smith sent a follow-up letter which also has not been answered. In 1999, Congress was concerned about the inequities associated with the allocation of health facilities construction resources. In turn, Congress directed the Indian Health Service, in conjunction with Tribes, to revise the Health Facilities Construction Priority System to make it more flexible and to respond and accommodate the wide variances in Tribal needs. Nine years later, the new list is finally complete, however it has not been approved by the Department of Health and Human Services, nor the Office of Man-

agement and Budget. Many Tribes in Oregon and throughout the country are concerned that finalization of the list has been stalled.

Question 1. Does the Indian Health Service have the authority to implement an Area Distribution Fund under the Indian Health Care Improvement Act?

Answer. Section 301 of the Indian Health Care Improvement Act requires the IHS to submit an annual report to Congress setting forth the Service's current Health Facilities Construction Priority System (HFCPS). The report must identify the highest priority inpatient and the highest priority outpatient healthcare facilities construction projects, but does not specify how IHS should fund these projects or whether their funding should have precedence over other high priority Indian Health Service needs. In practice IHS has based its funding requests on this listing of projects, and the Congress has appropriated funds based on these requests. IHS has the authority to adopt a health care priority system that allocates a portion of health facility construction funding to all Service Areas.

Question 1a. What is the Indian Health Service's timeline to begin implementation of the revised priority list?

Answer. The IHS Office of Environmental Health and Engineering has been working on the revision to Healthcare Facilities Construction Priority System (HFCPS) based on the Tribal comments and Facilities Appropriation Advisory Board (FAAB) recommendations. We do not have a timeline for implementation, as the revision requires Department, OMB and Congressional review prior to implementation.

Question 1b. How will the new list work with the current list of pending projects?

Answer. We believe the current system has appropriately identified the priority order of construction projects IHS will undertake. Our goal is to avoid disruption of the current priority list when the new HFCPS is implemented.

Special Diabetes Program for Indians Funds

Question 2. Will you conduct Tribal consultation beyond the Tribal Leaders Diabetes Committee in allocating the Special Diabetes Program for Indians funds under the one year extension (FY 2009)?

Answer. As you know, Tribal consultation is an integral part of the program planning process used by IHS. For the past 10 years, since the Special Diabetes Program for Indians (SDPI) was established, the IHS has conducted extensive and comprehensive Tribal consultation on the development and implementation of this program. Consultation has made SDPI a more innovative and successful program. On February 7–8, 2008, the Tribal Leaders Diabetes Committee met in San Diego, CA to review and discuss issues related to the reauthorization of the Special Diabetes Program for Indians (SDPI) funding for one year (FY09) at the same amount of $150 million. I asked the TLDC to make recommendations to me regarding the new SDPI funding for FY09. Overwhelmingly, the TLDC recommended to me that Area Tribal consultation be held. Thus, I have prepared direction to the IHS Area Directors from my office to host tribal consultation activities in every IHS Area regarding this topic. The IHS Division of Diabetes Treatment and Prevention has developed a consultation discussion guide and background documents based on TLDC direction as well as from previous consultation activities. This was done quickly because Nashville Area was holding their tribal consultation on Tuesday, February 12th.

There is a tight timeline for these Area Tribal consultations to occur. The deadline for providing results back to the Division of Diabetes is March 10th. On March 28th the TLDC is scheduled to review the Area Tribal consultation summaries and to develop recommendations to be provided to me in order for a final decision to be made. At this time, both Nashville and California Areas have completed consultation activities on this topic. IHS will distribute FY 2009 SDPI funds in a manner that provides the best diabetes care and prevention services possible to American Indians and Alaska Natives and in a manner that is consistent with Administration policy.

Question 3. Given the tremendous administrative challenges that the IHS grants management office has with getting awards out in a timely fashion, it has been recommend that the IHS not deviate from its grants process under the one-year extension. Are there plans to significantly alter the grants process for the SDPI?

Answer. It is not clear at this time how the grant distribution process will change under the one-year extension.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM A. COBURN, M.D. TO ROBERT G. MCSWAIN

Question 1. Please describe how you have, or will have resolved the longstanding law enforcement void at the Claremore (OK) Indian Hospital? Provide details on

how the solution will provide adequate protection for patients, employees and area residents?

Answer. Since the Claremore Indian Hospital is Federal Property, the only law enforcement entity with jurisdiction is the Federal Bureau of Investigation, which responds in cases of serious breaches of law at the facility but does not provide on-site security or law enforcement services. As a result, security at the Claremore Indian Hospital currently consists of one individual whose authority and responsibility is limited because of the jurisdictional situation. The Claremore Hospital has contacted the Federal Protective Service, which is willing to provide on-site law enforcement services, but at a prohibitive cost. Consequently, the Claremore Indian Hospital is working to resolve jurisdictional issues so that local law enforcement entities can provide protection to patients and staff at the facility. The Hospital is also pursuing information on the option of contracting through the Department of Health and Human Services Program Support Center, which has delegated authority to contract for security services that will be available on a 24/7 basis to protect patients and staff on the grounds of and in the facility.

Question 2. Recent disclosures by the Indian Health Service indicate that the agency spent $2.8 million on conferences in FY 2006 and $33.7 million on travel for the same period. Please provide the Committee with updated data for FY 2007.

Answer. The Indian Health Service spent $368,000 on conferences in FY 2007 and $38 million on travel for the same period.

Question 3. Do you support an agency-wide reduction in conference and travel spending, so that additional resources can be made available for patient care? If so, how do you plan to achieve this goal?

Answer. Yes, the Indian Health Service significantly reduced conference spending by $2.4 million between FY 2006 and FY 2007. Departmental and agency policies increased oversight of conferences, limited attendance, and promoted the maximum use of technology in place of travel. Internal controls and increased interactive Web sessions, tele-conferencing, and video-conferencing, will continue to enable us to put more of our resources into patient transport and care, health professional coverage, recruitment, and facility compliance.

Question 4. Based on your impressive and extensive experience within the IHS system, please identify programs and/or offices that are in most need of your attention. In addition, please identify any programs that you believe are failing to meet their objective.

Answer. My immediate priority is the recruitment and retention of health care professionals because it is fundamental to the ability of our hospitals and clinics to meet the health care needs of the American Indian and Alaska Native communities we serve. We are experiencing double-digit vacancy rates in physicians, nursing, pharmacy, and dental—all critical to the delivery of our core mission that is patient care to American Indians and Alaska Natives on or near reservations. These vacancies affect quantity and quality of care; continuity of care; and, increase our operating costs as a result of the higher costs of contracting for temporary replacements.

It is my firm belief that all programs currently funded within annual appropriations are meeting their objectives.

Question 5. Do you believe the current Indian Health care system meets our legal commitments to tribes and their citizens?

Answer. Yes, I believe that the current Indian health care system meets our legal commitments to serve eligible American Indian and Alaska Native people. The IHS has focused on those programs that positively impact the health status of Indian people. In 2006 we celebrated 50 years or accomplishments from the transfer from the Department of the Interior to the U.S. Public Health Service, Department of Health and Human Services. During these 50 years we have experienced the increased involvement of Tribes. The current system of care reflects not only our ongoing consultation with Tribes on the status and direction of the Indian health care system, but Tribes now operate more than 50 percent of the system.

Question 6. If your child was gravely ill and you had a choice between sending him/her to the very best physician/clinic (regardless of its status as private, tribal or IHS) with federal funds and sending them to a traditional IHS facility, what would you do?

Answer. I would not hesitate to send my child to an IHS facility, knowing fully that my child will receive immediate care and will be referred out for more specialized care if necessary. All our IHS facilities (both IHS managed and Tribal managed) are fully accredited and staffed by competent, caring, and committed staff.

Question 7. Again, based on your experience, if you were asked to eliminate one program based on poor performance or its relevance to IHS priorities, and shift

those funds to higher IHS priorities: what would you eliminate and where would you send the reallocated funds?

Answer. IHS programs are not poor performers. Six major programs of the IHS have been subjected to the OMB's Program Assessment Rating Tool (PART) evaluation and rated an average score of 80, with none below adequate. In addition, the IHS exceeded almost all the performance indicators for the Government Performance Results Act (GPRA). However, in times of deficit reduction budgets, the IHS chose to prioritize the mission critical health services for those American Indian and Alaska Native people who reside on or near reservations. This choice has resulted in decreasing or eliminating programs that have performed at the adequate or effective levels, such as the Urban Indian Health Program.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO ROBERT G. MCSWAIN

Question 1. Mr. McSwain, please describe your view of the Indian Health Service's obligation to provide urban Indians with appropriate health care services?

Answer. Health care services for American Indian and Alaska Native people who reside in urban areas are part of our broad Federal mission stated in the Snyder Act, "for the benefit, care, and assistance of the Indians throughout the United States" including the purpose "For relief of distress and conservation of health." However, Indians living in urban areas are able to access health care services from a variety of Federal, State, and local providers, including Health Centers operated by HRSA, which are located in every urban area currently being served by an Urban Indian Health Program.

Question 2. You are no doubt aware of the need to revise the current health facilities construction priority system and create a more equitable means of providing resources for every tribal area.

I understand that the Facilities Appropriations Advisory Board has submitted its recommendations to the Office of the Director. This work is the product of years of collaboration with IHS and Tribal representatives.

I am particularly interested in one of these recommendations—the establishment of an Area Distribution Fund. For sure, there are many elements that need to be considered in order to make this proposal work in a way that respects the needs of tribes awaiting facilities funds under the current priority system, as well as the tribes that receive no resources at all.

As Director of the Indian Health Service would you plan to further examine the concept of an Area Distribution Fund?

Would you be willing to implement an Area Distribution Fund?

Answer. As Director of the Indian Health Service, I will continue to examine not only the concept of the Area Distribution Fund, but I would be willing to implement a funding distribution methodology that does not adversely affect the continued funding of ongoing construction projects.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO ROBERT G. MCSWAIN

Question 1. Mr. McSwain, you have one of the most challenging jobs in Government. The last time I visited Wyoming's Wind River Reservation, the issue I heard about most was health care. There is a very long list of needs. I know your department has made progress to improve the health and welfare of American Indians and Alaska Natives, but I think you would agree we still have much left to accomplish. Have you crafted an action plan that will help transform the Indian health care system and the way Indian communities receive health care over the next 4 years? If not, what are your goals? What do you hope to accomplish?

Answer. I appreciate your comments regarding the challenges we face in the Indian health system. This is so important because, as you know, the work that we do in the Indian health system is not abstract or conceptual in any way. The care we provide affects the lives of individuals and the health of families and communities. The dedicated individuals in the IHS and Tribal Indian health programs that serve these communities know why they go to work every day. And yes, we have much left to accomplish.

During his term as Director of the Indian Health Service, Dr. Grim visited a great many of these communities and spoke with and listened to Tribal members, Tribal leadership, and health professionals. Out of these discussions we developed the three Director's Initiatives in Health Promotion and Disease Prevention, Behavioral

Health, and Chronic Care. These three initiatives, together, provide the framework and strategy for improving the health status of American Indian and Alaska Native people.

The Health Promotion and Disease Prevention Initiative is focused on creating the capacity in our communities to support healthy behaviors and wellness through evidence-based practices. Primary prevention is an investment that pays off in improved health for American Indians and Alaska Natives, in reduction in suffering in our communities, and in cost savings to our health system.

The Behavioral Health Initiative addresses the total health of the individuals, families, and communities we serve. A novel and transformative strategy for the Behavioral Health Initiative involves bringing the whole person into focus in our health system through the integration of behavioral health services into primary care.

The aim of the Chronic Care Initiative is to improve the health status of American Indians and Alaska Natives by reducing the impact and prevalence of conditions such as diabetes, depression, asthma, heart disease, and cancer. Through this initiative we have developed a partnership with the Institute for Healthcare Improvement (IHI) to use modern improvement methodologies to transform the system of care for prevention and management of chronic conditions.

The Chronic Care Model (Care Model), developed and extensively validated by Dr. Ed Wagner of the McColl Institute for Healthcare Innovation and colleagues, captures and defines the essential features of a system of care that focuses on the relationship between an informed and activated patient, family, and community and their prepared and proactive health care team. The Indian health system has extensive experience with the Chronic Care Model in diabetes care. In fact, we attribute some of the success we have achieved in improved diabetes outcomes through the *Special Diabetes Program for Indians* to this model. Over the past year we have been working with the IHI to support 14 pilot sites representing a slice of the Indian health system in a learning community that is adapting the Chronic Care Model and developing strategies for implementation to improve care across conditions. These programs (including the Wind River Service Unit) are using rigorous and ongoing measurement to guide their improvement efforts.

We have already begun to see remarkable improvement within the pilot sites in screening rates for cancer and alcohol misuse, and in diabetes care. Just as importantly we are seeing reductions in wait time, improved access and continuity of care, and the development of a truly functional, proactive and prepared care team.

In the coming year we will take the lessons learned from these pioneering programs and expand the collaborative to approximately 40 Indian health facilities, further refining the process and the package of changes and preparing for the spread of improvement in the prevention and management of chronic conditions. Over the next two to three years, we will be spreading this improvement work across the entire Indian health system.

This effort requires that we think differently about how we care for patients, families, and communities, and about how we support the spread of improvement and innovation in our health system. It focuses us on the patient and family at the center of care. It forces us to think about how to create an Indian health system characterized by pervasive and reliable quality; everywhere, every time, for every person. We are guided and supported in this work by the expertise of the Institute for Healthcare Improvement.

I am pleased to report that we are beginning to see true integration of the work being done by some of our *Special Diabetes Program for Indians* grantees with that of the Chronic Care Initiative pilot sites. The Chronic Care Initiative provides the Indian health system with the opportunity to learn from our efforts in diabetes care and transform the prevention and management of other chronic conditions. Our partnership with the IHI offers the Indian health system new ways of working, new ways of thinking, and new hope in the prevention and management of chronic conditions.

We have much left to accomplish. Over the next four years we will use the Director's Initiatives in Health Promotion and Disease Prevention, Behavioral Health, and Chronic Care to build strength and wellness in our communities and quality in our system of care.

Question 2. I want to make sure Native Americans have equal access to quality medical care. But it is equally as important the care we provide is cost effective and produces results. Today, neither the government nor private advocacy groups can explain exactly how federal/state/tribal funds are used to coordinate medical services. It is incumbent upon the IHS Director to provide timely answers to the Committee and Congress explaining how much money we are spending on programs and how the IHS works with Medicare, Medicaid, SCHIP, and the tribes to coordinate

that care. What efforts will it take to ensure we have the information and tools we need to make effective policy decisions?

Answer. I share your concerns and we do make every effort to provide quality care and equal access to care in a cost effective way for all American Indians and Alaska Native patients who use our facilities. We are a comprehensive health care delivery system and provide a broad range of health care services with a focus on primary care. IHS and Tribally operated facilities (facilities compacted or contracted under P.L 93–638) all receive appropriated funds in specific health care categories. Also, both IHS Federal and Tribal facilities collect from Medicare, Medicaid, SCHIP and private insurance for health care provided to patients who are enrolled in those programs. Public and private insurance collected for services provided at each facility is returned to that specific facility and used to maintain accreditation and support the health care delivery system as required by law. IHS works closely with the Centers for Medicare and Medicaid Services (CMS) to enhance collections and ensure health care is delivered in an efficient way. CMS established a Tribal Technical Advisory Group to address Tribal concerns and policy issues and both CMS and IHS work closely with this group. Also, IHS facilities work closely with CMS regions across the country making the process more efficient and effective. Facilities work directly with States and State Medicaid Agencies and SCHIP programs and collaborate on a regular basis to improve health care delivery and health care funding. IHS facilities are accredited and work directly with local Tribes to coordinate the health care delivery system. The IHS collects information on health services and health status and uses this information in the decision making process for program planning and evaluation. The information is also used in budget preparation and allocation to assure funds for Indian health are used in the most effective manner. The IHS also consults with Tribes and Tribal programs to coordinate our efforts in improving the health status of American Indians. We want to be sure Congress has the necessary information and data to make sound decisions. We are committed to working with Congress and to providing you with the information that will assist you in your decision-making.

Question 3. Addiction to methamphetamine and alcohol are very serious problems on the Wind River Reservation. Mexican drug trafficking has substantially increased the supply of Meth in my state. The State of Wyoming is continuing to make strong efforts to address this issue. But, what are we doing—in collaboration with the states and tribes—in terms of treatment and prevention services? Have the IHS efforts been successful?

Answer. IHS has been successful in collaborating with Tribes and States to increase clients' access to substance abuse treatment services. Examples of this collaborative effort would be:

- Efforts by Tribes, IHS and States to increase awareness and knowledge of addictions and treatment to AI/AN communities;
- Certified and licensed counselors are employed;
- The tribal programs are gaining CARF (Commission on Accreditation of Rehabilitation Facilities) certification, a nationally recognized status, as well as State certification; many programs have both certifications;
- Increased use of evidenced-based models such as MATRIX motivational interviewing training are utilized in treatment services.
- Prevention and community education services are shared by mental health professionals, substance abuse counselors, health educators, public health nurses and diabetes professionals. All of these types of chronic diseases, including depression and substance abuse overlap.

Methamphetamine and alcohol dependence are very serious problems on the Wind River Reservation. The problems created by these two addictions impact a large number of individuals and families. The primary agencies and organizations involved in addressing these problems are the Indian Health Service, the Eastern Shoshone Tribe and the Northern Arapahoe Tribe and the State of Wyoming. Collaborative efforts are on the increase. Examples of this effort to work together for the common goal of meth reduction would be the Eastern Shoshone Tribe, which operates the Eastern Shoshone Recovery Program and the Sho-Rap Lodge, an 8 bed facility funded jointly by the State and Tribes, and also the Northern Arapahoe Tribe, which operates the White Buffalo Recovery Center, funded by IHS and the Tribes. Tribal programs are becoming increasingly aware of the value of State certification, such as with the Eastern Shoshone/Northern Arapaho substance abuse program's certification through the State of Wyoming and stronger emphasis by Tribes to certify/license the counselors they employ. These efforts, among many, serve to illustrate the need and value of working collaboratively.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TIM JOHNSON TO ROBERT G. MCSWAIN

Question 1. When individual tribal members in the Aberdeen Area need help navigating the Federal agencies on their specific cases they often turn to their congressional delegation. In order to effectively serve these constitutions we need prompt and fluid communications with the agencies both at the area level and at the federal level, this has been a continuous problem with IHS. I can't mention the names of the individuals involved in the cases without their permission, but some examples include:

- A first letter sent to Aberdeen Area office on July 23, 2004, congressional staff was informed the response was delayed at Rockville, after repeated inquiries a response was finally received on July 2, 2007.
- The first letter was sent to Rockville on Dec. 6, 2006, the third notice of "no response" was sent on June 4, 2007. As of today, there has still been no response. This is an urgent case on contract health appeal to Rockville that desperately needs a response.

These are just two examples. If you are confirmed, what will you do to ensure Congress will receive prompt responses to casework and other inquiries of your office?

Answer. Congressional inquiries are considered to be of utmost importance to the Indian Health Service (IHS), and are treated as a high priority. Many of the responses, however, require extensive research and coordination with IHS staff located in various Area Offices and Service Units throughout Indian country. The IHS headquarters has a system in place to track and monitor Congressional inquiries, and will continue to make every effort to respond to these inquiries in a timely manner.

Question 2. The Aberdeen Area encompasses 6 of the 10 poorest counties in the Nation, all of which are reservation counties in South Dakota. The Healthcare needs are enormous and multifaceted, how do you plan to help these Tribes address some of the largest health disparities in the country?

Answer. South Dakota is where the majority of Native Americans served by the Aberdeen Area IHS reside and where these six (6) poorest counties in the Nation are located. We are developing new methods of healthcare delivery and prevention by redesigning the IHS delivery system. As an example, Aberdeen Area has the only mobile digital mammography unit in IHS, which is beginning its third full year of operation reaching poor, rural communities with bone screening and breast cancer screening delivered in the community. Sioux San Hospital in Rapid City is a pilot site for colorectal cancer screening.

Partnering with tribes, the injury prevention component of the chronic care initiative is being piloted at Sisseton and Santee. These pilot sites have developed screening tools to identify and to increase the use of seatbelts and car seats. They are also working to decrease substance abuse by early identification and referral for services to address alcohol-related injuries, which are a major contributor to years of potential life lost and millions of dollars in Contract Health costs.

In addition, the IHS has implemented a 5 year strategic plan to develop a telemedicine hub that will provide telepharmacy, telepsychiatry, telepain management, teleradiology and other services to increase access to healthcare for these poorer isolated reservations. The telepharmacy Program is functioning on the Pine Ridge reservation and we are advertising for the telepharmacy program Director. We are already deploying "Good Health" videos into health facility waiting rooms bringing timely, community-specific health care and preventive services directly to the Indian communities we serve. Materials are being developed that are culturally relevant. The "Good Health" videos and culturally relevant health materials are already in at least four sites and being well received.

Suicide continues to be a glaring marker of health disparity. The strategic plan employs the public health model to bring evidence-based best practices of community-oriented primary and secondary prevention such as Question, Persuade, and Refer (QPR), Critical Incident Stress Management (CISM), and Applied Suicide Intervention Skills Training (ASIST). The Area telemedicine strategic plan has telepsychiatry as a priority to increase access to care for patients and access to specialty consultation for providers starting with those sites with the highest suicide rates, such as Rosebud. We are developing partnerships with Avera Health, Sioux Falls, South Dakota, Sanford, Sioux Falls, SD, the Department of Veterans Affairs, and others to increase access and educational opportunities for reservation residents. The Behavioral Health Plan includes strategies to address primary, secondary and tertiary aspects of suicide prevention. The Chronic Care initiative focuses on De-

pression and Meth specifically. The Area continues to develop and use many culturally specific CD, DVD, and written materials appropriate to the Northern Plains Tribes which are sought after by other IHS areas.

The Area staff recruitment and retention plan includes efforts to work with various State, Veterans Health Administration, and private partners to address rural health needs and develop strategies to address the changing workforce needs. IHS intends to use telemedicine and telehealth to recruit, train, develop, and support the workforce.

Question 3. Do you have adequate funds to carry out your responsibility to provide healthcare for American Indian Tribes? What do you believe would be adequate funding level?

Answer. The IHS maximizes health care services to Indian people with funds appropriated by Congress. IHS also supplements appropriated funds with collections from Medicare, Medicaid, and the State Children's Health Insurance Programs and other third payers, including private insurance. With combined funding, the IHS system of tribal, and federal health programs annually provide millions of health care services to Indian people. The IHS is the major, often only, source of health care for hundreds of thousands of Indian people and has contributed to remarkable improvement in Indian health status in recent decades. In recent years the IHS has recognized the need to partner with other Federal agencies and private organizations to address the complex health conditions facing Indian people. For example, addressing suicides and methamphetamine abuse requires a concerted effort by the Indian community and Federal health and law enforcement agencies. Each year, when developing a budget request, IHS considers what level of funding is adequate for carrying out its responsibility to provide health care.

Question 4. Do you have adequate staff and personnel to carry out your responsibility to provide healthcare for American Indian Tribes? What do you believe would be an adequate staffing level?

Answer. The health professionals and support staff of the IHS are extremely hard working and dedicated to serving the health care needs of Indian people. Our challenge to meeting the health care needs of American Indians and Alaska Natives (AI/AN) is to assure adequate staffing at our hospitals and clinics. A recent personnel review showed that in FY 2008, the IHS anticipates the need to fill almost 1,500 health care professional vacancies including 181 physicians, 131 dentists, 612 nurses and 65 pharmacists.

Recruitment of these health care professionals is challenging due to a number of factors including nationwide shortages of health professionals such as physicians, dentists, nurses and pharmacists, the pay differential between federal salaries and how much the private sector pays, and the rural settings for many of the IHS health care sites.

To improve staffing at our facilities, the IHS must fill many, if not most of these vacancies. To reach this goal, IHS has initiated an extensive recruitment and retention effort. To raise awareness of IHS career opportunities among health professionals, the IHS launched the "IHS Public Health Professions—Recruitment Campaign" developing new advertisements, recruitment materials and new web sites. These new advertisements were placed in professional journals and on recruitment websites in late FY 2007 and will continue throughout FY 2008.

The IHS Public Health Professions web site at *http://www.careers.ihs.gov/* has several new updates planned for FY 2008, including an updated physician website which will allow physicians and medical residents to request materials and ask questions of recruiters.

Question 5. The Cheyenne River Sioux Tribe has indicated that the Design for the Eagle Butte service unit was done to cost–meaning IHS developed a total cost for the facility and the Tribe then asked the architects to maximize the center's capabilities subject to the permitted cost allocation. As a result, any delay in seeking construction funds for this facility risks inflationary cost increases that will create a need to scale back and re-approve the project plans at additional cost. What steps is IHS taking to ensure that this will not happen?

Answer. The design for the Eagle Butte Health Center has been completed and has been submitted by the architect. These plans and documents were designed not to exceed the IHS Facilities Budget Estimate which is based on the Program of Requirements (POR). The POR defined the required space necessary to provide health services at this new facility. The total cost of this project amounts to $111,100,000.

Prior to FY 2008, Eagle Butte received $7,797,000 for design and initial construction of the new healthcare facility. The FY 2008 congressional appropriation to continue construction activities totaled $17,212,000. The IHS Facilities Budget Esti-

mate has nearly $7,600,000 in construction contingencies which can be used to assist in addressing acts of God and excessive inflation.

Question 6. IHS has release a document regarding the reduction of hours at the Wagner Service Unit claiming that it will allow IHS "to reprogram approximately $600,000 for other services and program support." Will those cost savings go to benefit the Wagner Service Unit?

Answer. The Yankton Sioux Tribal Chairman met with I.H.S. Headquarters staff on December 11, 2007 in Rockville, Maryland, regarding plans to transition 24 hour service at the Wagner I.H.S. Ambulatory Health Care Facility to an Urgent Care Clinic with hours of service from Monday–Saturday, 7:00 am to 11:00 pm. It was discussed at the meeting that I.H.S. can no longer justify 24-hour emergency room (ER) services, and will need to proceed with the transition to an Urgent Care Clinic at the Wagner I.H.S. facility. Last July, Wagner I.H.S. decided that the effective date for this transition would be January 1, 2008. The effective date was moved to March 1, 2008 in order to complete community education. Wagner I.H.S. staff continues to meet with the Yankton Sioux Tribe and Wagner Community Memorial Hospital to keep them informed of the transitional phase. Weekly notices were placed in the local newspaper beginning January 28, 2008.

The Wagner Service Unit is hopeful that any cost savings will allow for more specialty services to be provided on-site which will enhance overall comprehensive care to better meet the needs of the patients.

Question 7. I have been contacted by several IHS employees from South Dakota who have been waiting for sometime to resolve long standing back pay claims. I hope that IHS and these employees through their Union, the Laborers' International Union of North America, will engage in substantive dialogue to resolve these issues. What has IHS done recently to resolve this dispute? Is there currently an employee of the IHS charged with working on this issue?

Answer. The Union and the Aberdeen Area Office have agreed to an arbitration schedule that will start on March 17, 2008. Out of a total of 145 claims listed on the Union's (LUINA) list submitted by Mr. Robert Purcell, the Agency has reviewed and denied 84 claims because the employees were found to be in an on-call status and were paid appropriately and did not meet the requirements in regulations set forth for standby duty. Additionally 36 claims were found to be incomplete as only tolling letters were submitted with no claims or claims submitted without the tolling letter (a tolling letter is required to preserve the claim period). The remaining 17 claims are in a review status.

Question 8. The Cheyenne River Eagle Butte Service Unit has faced some serious problems with its CMS certification. Are these problems being resolved? Why did these problems go unresolved for almost seven years?

Answer. CMS determined in its most recent review that Cheyenne River Service Unit (CRSU) was fully in compliance with the Medicare Hospital Conditions of Participation. CRSU worked hard to achieve this result. However, on January 18, 2008 CRSU was advised by CMS that it was out of compliance with several of the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements, which are separate from the Conditions of Participation and have to do with providing an appropriate medical screening examination and stabilizing treatment for individuals with emergency medical conditions. CRSU is making progress in this area, but further improvements are needed to achieve full compliance.

CRSU is sending the CMS Regional Office weekly updates on its progress in achieving compliance. We understand CMS will make another unannounced inspection of CRSU sometime in the next couple of months, and we expect CRSU to be in full compliance at that time.

Question 9. We all know how chronically under-funded IHS is, yet I understand that the IHS' efforts to collect reimbursement from private third-party payers have been minimal–even though such reimbursements could be as much as $50–100 million a year (based on IHS' own past Budget Justifications). What has been done at the headquarters level to improve that effort and increase those collections?

Answer. In FY 2007 the IHS collected approximately $90 million from private insurance payers. This is 12% of the estimated overall collections with the remaining 88% of collections coming from Medicare and Medicaid, which totaled approximately $677 million. IHS has consistently increased collections in private insurance ever since it received the authority to bill. At Headquarters, the Office of Resource Access and Partnerships (ORAP) provides leadership and support to an IHS-wide National Business Office Committee comprised of 12 Area Office Business Office Coordinators. A major function of this National committee includes making recommendations to improve business operations, training requirements, software improvements and

other major issues that can enhance or correct IHS wide problems that affect the collection of third party revenue at the hospital and clinic level.

We are involved in a number of activities to enhance overall collections in the IHS. Third party training is provided on the Resource Patient Management System (RPMS) business office software applications. These classes are designed to improve skills in Patient Registration, Third Party billing, Pharmacy Point of Sale claims and Accounts Receivable. These skills include identifying alternate resources, provider documentation, procedural coding, billing and aging accounts receivable follow up. Another major training effort occurred when ORAP worked with CMS representatives to provide Outreach and Education Training sessions targeted to Benefit Coordinators and their role in assisting with processing Medicare and Medicaid application forms. When Medicare Part D became a billable service for IHS, training was provided to all of the Areas regarding the changes and issues that each Area needed to know. The Medicare Fiscal Intermediary (FI) and Medicare Administrative Contractor (MAC) also work closely with the National Business Office Committee to provide training both on-site or on-line to assist each of the IHS facilities on denials, new billing rules and system issues for Medicare. Private insurance activities are also addressed in the many training sessions conducted each year.

The Office of Information Technology (OIT) maintains and improves the business office software applications that support electronic billing, payment posting and collections. One of the objectives for the IHS is to implement the electronic health record at all Federal IHS locations. With coding and data capture very important to the revenue process, separate Health Information Management/Business Office training classes are scheduled once a month through IHS. The ultimate objective is to transition IHS clinical providers to coding their encounters and not relying on manual data entry efforts. Moving away from manual data entry will make us more efficient and enhance our ability to bill and collect.

In FY 2008, IHS is actively working with integrating the RPMS data with the Unified Financial Management Systems (UFMS). With this effort, ORAP has recognized the need to enhance and standardize the business process of posting in the RPMS systems the amounts identified on remittance advices issued from the payers. This will also assist Managers with current reports which identify unpaid revenue. These reports will not only assist the local facility managers but also Area and Headquarters staff if there is a major payer who is not reimbursing IHS at its appropriate level.

In FY 2008, the IHS will continue its efforts to capture all private payer and third party payer information including Medicare and Medicaid and SCHIP for reimbursement purposes. The ORAP recognizes the need to work with private insurance payers and to maximize collections to the full extent of the law. Also, IHS collaborates with State agencies to enhance the systems necessary to enroll patients who may be eligible for Medicaid or the State Children's Health Insurance Programs. Ongoing national broadcasts are scheduled in partnership with CMS to share this information and to further provide more leadership to the field staff.

Question 10. I have been informed that the Business Office Report of IHS has many provisions that are not consistent with the statutory authority given the agency to make these collections. Why would the agency voluntarily handcuff itself from collecting these reimbursements that are legally owed?

Answer. The IHS is not sure what "Business Office Report" is referenced in the question and we do not believe that we have voluntarily "handcuffed" the organization from collecting reimbursements. The IHS pursues all alternate resources for payment for services provided at our hospitals and clinics and provides relevant training and support to Areas and Service Unit facilities. To support these efforts, the IHS has established Internal Controls and business operating manuals to guide, monitor and set standards for third party revenue collection. We do recognize that third party collections require management support at all levels of the IHS organization, and IHS management does realize the importance of maximizing collections. Since 1976, the IHS has had authority to collect Medicare Part A and Medicaid reimbursements. In the past 8 years this authority has been expanded to include billing for certain additional Medicare Part B services, SCHIP and Medicare Part D. Currently, third party revenue represents up to 50% of some hospitals' and clinics' operating budgets. Third party revenue is vital to maintaining the current levels of services accessible to AI/ANs at IHS hospitals and clinics. The IHS is making an effort to maximize collections to the full extent of the law.

Question 11. Has the Agency looked at how similar reimbursement issues are handled by other agencies, like the Veterans Administration?

Answer. There continues to be increasing internal collaborative efforts on the utilization of automated systems between the Department of Veterans Affairs (VA) and

IHS in which similar structure and functionality is shared. These include the Resource Patient Management System, Patient Information Management System and the Electronic Health Record. The VistA/Computerized Patient Record System systems are public domain and IHS is adopting these government developed systems. These systems contain core applications for storing codes and recording workload, however to facilitate appropriate coding and billing VA augments these systems with commercial software. Since IHS is modeling its software design based on the VA automated systems, business rules and processes are in progress which include coding systems, vista imaging and other solutions that will enhance the IHS third party revenue data capturing efforts to assure quality claims and accurate payments. Many of our facilities that are located near VA facilities do collaborate on systems development and support with the VA. The VA does not have authority to bill Medicare or Medicaid and concentrates its billing efforts on private insurance patients only. Private insurance is approximately 12% of IHS' overall collections.

Question 12. One of the most alarming circumstances that Indian Country is currently facing is the issue of suicide and the lack of mental health services that provide prevention, intervention and aftercare services. While there are many contributing factors that lead to suicide, what steps should IHS take to alleviate the lack of mental health services?

Answer. The IHS has been working with other Health and Human Service Federal agencies, in partnership with Indian Tribes and tribal organizations, to bring all resources to bear on improving behavioral health services for American Indian and Alaska Native (AI/AN) individuals and communities. Together, we are focusing on developing and expanding access to innovative and effective behavioral health interventions and resources that directly enhance our ability to address critical health issues such as suicide in Indian country.

Increasingly, as more tribes contract to manage their own programs, the IHS is supporting them in the development and administration of suicide prevention and early intervention activities at the community level. Approximately, 87% of the IHS Alcohol and Substance Abuse and 47% of IHS Mental Health funding is distributed directly to tribal service programs. In FY 2008, the IHS Alcohol & Substance Abuse program received $14 million for a methamphetamine and suicide prevention and treatment initiative. Tribal consultation will take place before there is a final funding distribution plan put in place. We project that approximately $5 million of these funds will be used for suicide prevention.

The IHS has historically had high vacancy rates and critical behavioral health personnel shortages in varying locations and professional categories. The IHS is taking the following steps to increase mental health services.

Telebehavioral Health

One technology being aggressively explored to improve access is use of telehealth-based services. Currently over 50 IHS and Tribal facilities in 8 IHS Areas are augmenting on-site behavioral health services with telehealth services. Areas, including Aberdeen Area in the Northern Plains, are building or have built telehealth infrastructure and programming to support this type of service where it has not existed before.

Recruitment

Through recruitment and retention activities, the Scholarship Program, and Loan Repayment Program, the IHS increases the number of Indians entering the behavioral health professions and works toward assuring an adequate supply of behavioral health professions to the Tribes, tribal organizations, and urban Indian organizations. The scholarship program supported a total of 461 students in 2006.

The IHS InPsych Program addresses the need for American Indians in the Psychology field. There are 3 Indians into Psychology Programs. They are located at Oklahoma State University, Stillwater, OK; University of North Dakota, Grand Forks, ND; and the University of Montana, Missoula, MT. They are funded by Indian Health Service and have been in operation for approximately 10 years.

Suicide Prevention Initiative

The IHS Suicide Prevention Initiative is directly related to the Health and Human Services National Strategy for Suicide Prevention. IHS collaborates with consumers, and their families, Tribes and tribal organizations, Urban Indian programs, Federal (e.g. SAMHSA, NIH, BIA and others), State, and local agencies, as well as other public and private organizations to formulate long term strategic approaches, to develop a comprehensive system of care, and to share resources to address the issue of suicide in Indian Country more effectively.

The IHS Division of Behavioral Health is actively promoting a suicide event database to record and track suicide events for IHS, Tribal and Urban Indian behavioral health programs across the nation. This application contains a suicide surveillance tool to capture data related to a specific incident of suicide, such as date and location of act, method, contributing factors and other useful epidemiological information. The Suicide Reporting Form (SRF) provides aggregate report options that can be analyzed and interpreted to inform program planning activities in support of Agency and Department suicide prevention and behavioral health initiatives. The reports are helpful in understanding and better addressing suicide in Indian country.

Direct Care

The overwhelming majority of direct services are provided in outpatient settings, but there are 12 IHS-funded Youth Regional Treatment Centers (YRTCs) that provide residential treatment, and many tribal and urban programs provide similar residential services across the country. IHS provides funding to these 12 Youth Regional Treatment Centers for prevention and early intervention of alcohol/substance abuse and co-occurring disorders, in youth ages 12–18, as mandated by P.L. 99–570 and 100–690. Approximately $14.1 million is dedicated on an annual basis to IHS Area Offices for YRTCs.

Partnerships

IHS has developed formal partnerships in the formation of an IHS Director's Behavioral Health Workgroup which includes representatives from the 12 IHS Areas and is comprised of Tribal behavioral health service providers. The workgroup is tasked with updating the original Alcohol/Substance Abuse 5-year strategic plan and integration of mental health services into the overall Behavioral Health initiative. In addition, the IHS Behavioral Health Program is creating a Tribal Advisory Committee to give guidance and direction to our Behavioral Health Initiative.

IHS will continue to move the focus of behavioral health from a crisis orientation to ongoing behavioral health promotion by seeking new and sustainable resources, maximizing current program effectiveness through collaborations and data-driven models, and integrating technology and clinically sound behavioral approaches with the traditions and healing practices of the communities.

Question 13. What steps will I.H.S. take to ensure that requests for resources are considered when tribes and service units are experiencing suicide clusters?

Answer. The Emergency Medical Services/Preparedness Division (EMS/P) is benefiting AI/AN Communities by responding with emergency personnel (to augment the mental health staff), programming, and logistical support to communities experiencing significant suicide crises. For example, in 2007, the IHS Emergency Medical Services/Preparedness Division provided oversight for an Office of Force Readiness Deployment (OFRD) to two (2) communities. In 2008, the IHS Emergency Services with the support of the IHS Division of Behavioral Health conducted a Suicide Response Assessment on one (1) community and is a part of an HHS Department-wide response to this tribal community.

In 2003, the IHS established the Suicide Prevention Committee (SPC). It is the responsibility of the SPC to provide policy recommendations and guidance to the Indian Health Service Division of Behavioral Health (DBH) regarding suicide prevention, intervention and responding to suicide clusters in Indian country. The SPC is currently working on guidelines for responding to tribal requests for assistance. These guidelines will establish procedures for responding to emergent and non-emergent requests for assistance from tribal service organizations in the area of suicide and suicide prevention/intervention for the DBH within the Indian Health Service.