U.S. COMMISSION ON CIVIL RIGHTS

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NATIVE AMERICAN HEALTHCARE DISPARITIES BRIEFING

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Friday, October 17, 2003

The Commission convened at the Doubletree Hotel, 201 Marquette Avenue, Northwest, Albuquerque, New Mexico, at 9:25 a.m., Mary Frances Berry, Chairperson presiding.

PRESENT:

MARY FRANCES BERRY, Chairperson

CRUZ REYNOSO, Vice Chairperson

JENNIFER C. BRACERAS, Commissioner (via phone)

CHRISTOPHER EDLEY, JR., Commissioner (via phone)

PETER N. KIRSANOW, Commissioner (via phone)

ELSIE M. MEEKS, Commissioner (via phone)

RUSSELL G. REDENBAUGH, Commissioner (via phone)

LESLIE R. JIN, Staff Director

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STAFF PRESENT:

JOHN BLAKELEY
DEBRA CARR, ESQ., Deputy General Counsel
IVY DAVIS, Chief, Regional Programs Coordination Unit (via phone)
BARBARA DELAVIEZ
TERRY DICKERSON, Asst. Staff Director for OCRE (via phone)
JOHN DULLES, Regional Director
PAMELA A. DUNSTON
JENNY PARK
MARC PENTINO (via phone)
JOYCE SMITH, Parliamentarian
ALEXANDER SUN
AUDREY WRIGHT
TIFFANY WRIGHT

COMMISSIONER ASSISTANTS PRESENT:

KRISTINA ARRIAGA
LAURA BATIE
PATRICK DUFFY
JOY FREEMAN
CHRISTOPHER JENNINGS
KIMBERLY SCHULD
MELISSA SHARPE (via phone)
KRISHNA TOOLSIE

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1 P-R-O-C-E-E-D-I-N-G-S

2 9:25 a.m.

3 CHAIRPERSON BERRY: We begin the

4 briefing. We'll reconvene and begin the briefing.

5 Is there anyone in the audience who need

6 sign interpretation at this time? Is there anyone

7 in the audience who needs sign interpretation at

8 this time? There's no one at this time, but thank

9 you very much.

10 INTRODUCTION AND REMARKS

11 Okay. Earlier this year the Commission

12 issued a report on federal funding and unmet needs

13 in Indian Country, which is called Quiet Crisis,

14 which has gotten considerable publicity in Indian

15 Country. And some of you may have heard of it. And

16 it found that federal funding directed to Native

17 Americans through the programs administered by

18 several federal agencies, including HHS, is

19 insufficient to meet the basic needs of Native

20 Americans. And access to adequate health care is an

21 area where the Commission found inadequate funding

22 or unmet needs.

23 And as a result of this, and the

24 information that we have available to us about the

25 health needs of Native Americans, the Commission

1 undertook to have this particular hearing, briefing
2 today and to come to New Mexico to go on a site
3 visit yesterday.
4 The problems, you know, diabetes, mental
5 health disorders, cardiovascular disease, pneumonia,
6 influenza and injuries. And the numbers and the
7 disparities, and the over representation of Native
8 Americans or Indians having these diseases, and also
9 having the unmet needs, we found that it was
10 absolutely horrendous. And today we will have a full
11 and productive discussion of these issues: Scope,
12 causes, possible solutions to the health care
13 disparities experienced by Indians.
14 We will hear from a number of decision
15 makers at the Indian Health Service including the
16 top man, Dr. Charles Grim who came and several
17 members of his staff.
18 We will hear from policy wonks and
19 researchers, and health care advocates and analysts.
20 We will hear from tribal leaders.
21 And Panel One will discuss the current
22 status of Native American health. And the panelists
23 will talk about specific disparities, the scope of
24 the disparities and some root causes.
25 Panel Two will explore the extent to

1 which access to health care, including geographical
2 and structural barriers contribute to disparities in
3 Native American health status.
4 And then Panel Three will talk about the
5 quality of health care provided, and those issues.
6 And then there will be a fourth panel on
7 the funding structure for the Native American health
8 care system.
9 And the final panel will talk about
10 proposed and potential changes to the system
11 providing health services to Native Americans and
12 how those changes will impact current health
13 disparities. The focus will be on the proposed
14 Indian Health Care Improvement Act reauthorization,
15 the One Department Initiative within HHS and
16 internal restructuring efforts within IHS.
17 Following the conclusion of the second
18 panel, there will be a brief break for lunch. And
19 then we will convene the other panel.
20 The public will have an opportunity to
21 make brief comments and present relevant written
22 materials to the Commission during an open session,
23 which will begin at the end of the panels of the
24 day, which will be around 4:30 or so. And if you
25 wish to make brief remarks during the open session,

1 please see a Commission staff member in the Hardin
2 Room downstairs to sign up on a sheet.
3 PANEL ONE: DISPARITIES IN HEALTH STATUS AND
4 OUTCOMES FOR NATIVE AMERICANS
5 CHAIRPERSON BERRY: And the
6 witnesses have already come forward for the first
7 panel. They are Dr. Jon Perez, whose commencement I
8 spoke at 30 some years ago, he reminded me, at the
9 University of Maryland.
10 DR. PEREZ: When we were both kids.
11 CHAIRPERSON BERRY: When I was a mere
12 child they had me speak at a commencement for some
13 reason, and he was a toddler.
14 But anyway, Dr. Perez is the Director of
15 Behavioral Health Services for IHS. And he is a
16 clinical psychologist and was educated at the
17 University of Maryland and the California School of
18 Professional Psychology in Los Angeles.
19 He is responsible for the overall
20 management of Behavioral Health Services for IHS,
21 including budget, policy and program management.
22 And he began his career with IHS in
23 1992. And for the last 20 years he has provided
24 national leadership in the areas of American Indian
25 and Alaska Native mental health issues, and

1 psychological trauma. He has a long list of
2 articles and publications that he somehow found time
3 to put together in addition to all this other work.
4 And in addition to his academic,
5 volunteer and civic honors, he is recipient of the
6 Public Health Service - Indian Health Service
7 Outstanding Mental Health award, and several other
8 awards.
9 Mr. Lyle Jack is a Tribal Councilman
10 from the Oglala Sioux Tribe, which is Commissioner
11 Elsie Meeks tribe, at Pine Ridge in South Dakota.
12 Mr. Jack is a member that tribe. It is also
13 referred to as the Oglala Lakota.
14 He's one of two tribal councilmen
15 representing the Pine Ridge Reservation. .
16 He has a degree in computer science from
17 Oglala Lakota College.
18 Before being elected to the tribe
19 council he worked in food distribution.
20 He was first elected to the council in
21 2000 and was reelected in 2002. And on the council
22 he serves as Chairman of the Education Committee and
23 Vice Chairman of the Judiciary Committee. He is
24 also a member of the Health and Human Services
25 Committee.

1 We want to thank both of you for coming.
2 And Commissioner Meeks would like to
3 make some comments, and I turn to you Commissioner
4 Meeks. Go ahead. You could have introduced them,
5 but they didn't tell me that. You know more about
6 them than I do.
7 COMMISSIONER MEEKS: Actually, I thought
8 we would all get a chance to reintroduce ourselves.
9 I really wanted to open this by saying
10 then, I'm really glad that the Commission has
11 decided to focus on these health care issues for
12 reservations. And, you know, I want to
13 start by saying I'm missing a funeral today of a man
14 that I grew up and whose family is very close to me
15 in Pine Ridge because last weekend he had a heart
16 attack. It wasn't severe, and he drove from his
17 place of work to his house. And his wife had to hunt
18 down the ambulance, but they met the ambulance in
19 about 20 minutes. He walked from the car to the
20 ambulance and told them what was wrong. And from
21 that point on, you know, he went into a coma. He
22 didn't get oxygen. And they had to first transport
23 him to Pine Ridge, which is about 50 miles. And then
24 he got to Pine Ridge and they had to transport to
25 Rapid City. And in the meantime, he had brain damage

1 from lack of oxygen.

2 So I think in some ways, I mean we

3 already had this planned, but this really just

4 summarizes for me and really brought home the point

5 of what -- and it didn't matter what reservation we

6 went to or what area we went to, we would come

7 across the same problems. And, you know, although

8 his heart attack wasn't really that serious, you

9 know, he still died in spite of it and his funeral

10 is today.

11 So I thank you all for coming.

12 CHAIRPERSON BERRY: All right.

13 Vice Chair Reynoso, would you like to

14 make some comments?

15 VICE CHAIRMAN REYNOSO: No. I am just

16 looking forward to the testimony today. Yesterday

17 we had occasion to visit some health services, the

18 sites of health services provision. And, of course,

19 we're all conscious of the responsibility that the

20 federal government has taken onto itself with

21 respect to the health services to Native Americans

22 who are Indians. So I'm very interested in hearing

23 from the witnesses today.

24 Thank you very much.

25 CHAIRPERSON BERRY: Okay. Other

1 Commissioners are on the telephone, who could not be
2 here. And Commissioners' assistants are here for
3 some of the Commissioners who are not here who are
4 sitting in the audience. Commissioners' assistants
5 for Commissioner Kirsanow and Commissioner Braceras,
6 and Commissioner Thernstrom I think are here also to
7 listen to the testimony. Could you folks stand up
8 in case anybody wants to know who you are. Kristina
9 Arriaga, Chris Jennings and Kimberly Schuld.
10 Okay. Thank you very much.
11 Each panelist has 10 to 15 minutes for
12 opening remarks, and there's a timer up here, which
13 will tell you when your time has expired. And
14 Commissioners with questions are asked to reserve
15 their questions until you both make your
16 presentations. And this is true for all the
17 panelists.
18 Mr. Perez, could you please proceed?
19 DR. PEREZ: Two days ago was my
20 birthday, talking about when I was young. And I
21 don't feel so young anymore. And I have these new
22 glasses, so we'll see if I might be able to read the
23 testimony a little bit better. They're still a
24 little uncomfortable.
25 Madam Chairperson and members of the

1 Commission, I am Dr. Jon Perez, Director of
2 Behavioral Health for the Indian Health Service.
3 Today I am pleased to report on behalf of the IHS by
4 outlining, in broad-brush strokes, the current state
5 of health among American Indians and Alaska Native
6 populations around the country. I will do this by
7 highlighting some of the leading general health
8 indicators and mortality and morbidity information
9 about American Indian and Alaska Natives, as well as
10 point out representative disparities among those
11 data when compared with other racial and ethnic
12 groups.
13 I will then be followed in subsequent
14 panels by the IHS Director, Dr. Charles Grimm, Mr.
15 Duane Jeanotte, Acting Director of Headquarters
16 Operations and Dr. Richard Olson, Acting Director of
17 Office of Clinical and Preventive Services who will
18 further illuminate the health issues affecting our
19 tribes and tribal groups.
20 I trust you will find the information
21 useful.
22 It is no small task speaking on behalf
23 of American Indian and Alaska Native health needs,
24 considering it requires speaking for over 560 tribes
25 spread from the Arctic Circle to Florida, with

1 distinctly different cultures and beliefs, economies
2 and life circumstance, with populations spread from
3 remote villages and reservations to major urban
4 areas. Today, I will provide an overview of the
5 disparities in health of these diverse native
6 nations of people.
7 To understand American Indian and Alaska
8 Native health disparities, one must understand some
9 history, in particular current history. If there is
10 a single unifying historical experience among our
11 extant tribes and cultures, which more than any
12 other affects and defines them today, it is this:
13 Unlike any other racial or ethnic group in this
14 country, American Indian and Alaska Natives did not
15 come here, they pre-existed here, and remained
16 despite concerted attempts at their removal.
17 The health impact from physical to
18 spiritual, from individual to community cannot be
19 overstated.
20 The American Indian and Alaska Native
21 health disparities are real and highly visible to
22 native people. But, where resource and effort are
23 applied thoughtfully and over time, there is
24 positive, life saving impact. I will address the
25 successes and challenges now.

1 The successes in improved health are
2 demonstrated by dramatic improvements in mortality
3 rates between 1972 and '74 and again in '97 and '99
4 including:
5 Maternal mortality rates reduced 79
6 percent from 31.6 to 6.7 per 100,000;
7 Tuberculosis mortality reduced 86
8 percent from 10.7 to 1.5 per 100,000;
9 Gastrointestinal disease mortality
10 reduced 72 percent from 6.7 to 1.9 per 100,000;
11 Infant mortality reduced 65 percent from
12 25 to 8.8 per 1,000 live births;
13 Unintentional injuries mortality reduced
14 54 percent from 206.7 to 95.1 per 100,000; and
15 Pneumonia and influenza mortality
16 reduced 51 percent from 41.1 to 20.1 per 100,000.
17 Also significantly, the incidence and
18 prevalence of many infectious diseases once the
19 leading cause of death and disability among American
20 Indian and Alaska Natives, have dramatically
21 decreased due to increased medical care and public
22 health efforts that included massive vaccination and
23 sanitation facilities construction programs. Now,
24 however, as the population lives longer and adopts a
25 more western diet and sedentary lifestyle, chronic

1 diseases emerge as the dominant factors in the
2 health and longevity of Indian people with the
3 associated increasing rates of cardiovascular
4 disease, Hepatitis C and diabetes.
5 When compared with the U.S. general
6 population, these improved outcomes were achieved in
7 the face of several complicating factors including:
8 Lower per capital expenditures for
9 health;
10 Limited availability of providers, for
11 example, half the physicians and nurses per capita;
12 Higher costs for providing health care
13 in isolated rural settings where you have losses of
14 economies of scale;
15 Lack of facilities in numerous locations
16 and many outdated existing facilities. For example,
17 average age of IHS facilities is about 32 years in
18 comparison to 9 years for the private sector;
19 Lower utilization of health care
20 facilities. For example, 25 percent annual
21 utilization of dental service for American Indian
22 and Alaska Natives compared to about 60 percent for
23 the U.S. population overall;
24 Significantly higher health care needs
25 because of poor health status, significantly higher

1 rates of diabetes, alcoholism, injuries, oral
2 disease, and overall death rate;
3 High unemployment, poverty, substandard
4 housing, and other recognized contributing factors
5 to reduced health status.
6 While the mortality rates of Indian
7 people have improved dramatically over the past ten
8 years, Indian people continue to experience health
9 disparities and death rates that are significantly
10 higher than the rest of the U.S. general population.
11 The most recent fully analyzed mortality data for
12 fiscal year 1999 available from the National Center
13 for Health Statistics adjusted for misreporting of
14 American Indian and Alaska Natives on state death
15 certificates shows an increase in deaths of American
16 Indian and Alaska Native people for the period of
17 1997 to '99 compared to the period from 1994/96 from
18 cancer, diabetes, suicide, unintentional injuries,
19 and gastrointestinal disease. It reveals alcoholism
20 deaths at almost eight times the national rates;
21 diabetes a four times; accidents almost three times;
22 suicide twice; and homicide at over double the rate
23 of the nation as whole.
24 The net result of these categorical
25 increases is an overall 4.5 percent increase in

1 death rates American Indian and Alaska Native people
2 from 698.4 per 100,000 population for the period
3 1994-96 to 730.1 per 100,000 population for the
4 period of 1997 to '99.
5 Cardiovascular disease is now the
6 leading cause of mortality among Indian people, with
7 a rising rate that is significantly higher than the
8 U.S. general population. This is a health disparity
9 rate that the President, the Secretary of Health and
10 Human Services, and the IHS are committed to
11 eliminating.
12 Diabetes mortality rates have been
13 increasing at almost epidemic proportions. American
14 Indians and Alaska Natives have the highest
15 prevalence of type 2 diabetes in the world. The
16 incidence of type 2 diabetes is rising faster among
17 American Indians and Alaska Native children and
18 young adults than in any other ethnic population,
19 and is 2.6 times the national average.
20 As diabetes develops at younger ages, so
21 do related complications such as blindness,
22 amputations, and end stage renal disease.
23 There are preliminary indications,
24 however, that we may be seeing a change in this
25 pattern. In calendar year 2000 we have observed for

1 the first time ever a decline in mortality. It must
2 be noted that these are preliminary mortality data,
3 that need to be thoroughly examined, but very
4 promising nonetheless in that they may indicate
5 arrest of the deadly spiral.
6 What is most distressing, however, about
7 these statistics is that type 2 diabetes is largely
8 preventable. Lifestyle changes, such as changes in
9 diet, exercise patterns, and weight can
10 significantly reduce the chances of developing type
11 2 diabetes. Focusing on prevention not only reduces
12 the disease burden from a suffering population, but
13 also lessens and sometimes eliminates the need for
14 costly treatment options. The cost-effectiveness of
15 a preventative approach to diabetes management is an
16 important consideration, since the cost of caring of
17 diabetes patients is staggering. Managed care
18 estimates for treating diabetics range from $5000 to
19 $9000 per year. Since the Indian health system
20 currently cares for approximately 100,000 people
21 with diagnosed diabetes, this comes out to a
22 conservative estimate of $500 million just to treat
23 one condition.
24 Another area of concern is in behavioral
25 health. If we look at the top ten causes for

1 mortality and morbidity in Indian Country, fully
2 seven of those ten causes are directly related to,
3 or significantly affected by individual behavior and
4 lifestyle choices. Depression, and all its
5 manifestations from sadness, to anger, to loss of
6 function is a significant problem with prevalence
7 rates at approximately double the rate for the rest
8 of the nation. Alcoholism and drug abuse, as
9 already noted, are the most significant behavioral
10 health concerns and, I would advocate, among the
11 most pressing overall health concerns facing Indian
12 people today.
13 They are also among the most
14 intransigent and difficult to treat. Unlike many
15 other diseases with direct and, by behavioral health
16 standards, fairly uncomplicated causes and
17 treatments, behavioral problems represent
18 extraordinary arrays of interconnections between
19 biology; psychology; history; the individual,
20 families; communities; economics; politics;
21 spirituality; and the interplay between hope and
22 possibility versus hopelessness and commensurate
23 helplessness.
24 Simple and quick answers will not be
25 found here. But answers are available and effective

1 interventions from the individual to community level
2 can be found. They are not necessarily simple, easy,
3 nor quick, but they are there.
4 In summary, the overall picture is
5 troubling, but not without possibility. You will
6 hear much today about health and disease, prevention
7 and treatment. Allow me to end this statement with
8 this message: There is hope, there is courage, and
9 there are possibilities.
10 And this concludes my written statement.
11 I will be happy to respond to any questions you may
12 have.
13 Thank you.
14 CHAIRPERSON BERRY: Thank you very much,
15 Dr. Perez. And there will be questions.
16 Mr. Jack, please proceed.
17 MR. JACK: First of all, I'd like to say
18 good morning.
19 ALL: Good morning.
20 MR. JACK: Chairperson Berry and
21 Commissioners, I'll say it's an honor for me to be
22 here to testify in front of you. It's also an honor
23 for the Oglala Sioux Tribe to have one of our tribal
24 members sitting on your Commission.
25 I'm not going to go into statistics this

1 morning, because Mr. Perez has already stated them.
2 And I think they're worse than what he's stating.
3 So what I will do is I'll give you a little history
4 of why health care is guaranteed to the Oglala
5 Lakota Tribe, and also give you some personal cases
6 that I know of.
7 Okay. In the 1860, early '60s the
8 Oglala Sioux Tribe or the Lakota Nation fell at war
9 with the United States government. It was a war over
10 the Bozeman Trail, which the United States opened up
11 in Sioux country. This war was known as the Powder
12 River War or the Red Cloud War. And what it
13 resulted in was the United States closing the trail
14 and signing the 1868 Fort Laramie Treaty with the
15 Lakota Tribes.
16 This treaty resulted in the Lakota
17 Nation ceding millions and millions of acres of land
18 and natural resources, such as timber, gold and
19 water. In return, the Lakota got a reservation
20 that's expanded from the east base of the Missouri
21 River into North Dakota, Wyoming, Montana and
22 Nebraska.
23 Under the treaty the Lakota Nation was
24 guaranteed basic infrastructure rights, such as a
25 school teacher, a doctor, carpenter, a boxsmith and

1 a dentist, which today we interpret today as health
2 care, school, education, housing.
3 So what I'm saying today is that the
4 health care that is the tribe receives is not a
5 handout to the Lakota people. It is something the
6 Lakota have already bought and paid for with
7 millions of acres of land. So that is not an
8 entitlement, and it's not a handout. It is
9 something that we have already bought and paid for.
10 Unfortunately, the United States
11 Government has not lived up to its treaty
12 obligations and we see this everyday. The story
13 that Elsie has told you is just one of hundreds that
14 go on every month.
15 I recently lost an uncle who is a
16 Vietnam veteran 2 weeks ago. He was a diabetic. He
17 had his leg amputated and he was scheduled for heart
18 surgery, which was an angioplasty. However, IHS
19 refused to pay for it because they said he was a
20 veteran and he must use VA resources.
21 Now, the VA was going to pay for it, but
22 he had to go to Rochester, Minnesota to get his
23 surgery done, and he didn't want to go. He felt
24 that was too far and he didn't want to be alone. So
25 he wanted to go to Rapid City Regional. And finally

1 after weeks, IHS relented and agreed to pay for it.
2 By then my uncle had so much stress,
3 that it resulted in a heart attack. So he was taken
4 to the hospital. And IHS cleared him for surgery.
5 However, when he got to Regional, they performed 14
6 hour surgery on him, and they find a sinus infection
7 in him which spread into his heart cavity or his
8 chest cavity. And after hanging on for 4 hours, he
9 ended up dying.
10 You know, it was a simple surgery, a
11 common surgery that it shouldn't have went that way.
12 Also I have stories of a woman who was
13 pregnant, a young lady, went to IHS, thought she was
14 in labor. She lived 45 miles out of Pine Ridge.
15 They told her it was false labor and sent her home.
16 On her way home, 40 miles outside of Pine Ridge, she
17 went into labor and gave birth by a bar in the back
18 of a car.
19 These are just some of the horror
20 stories that we hear. And the tribe also hears this
21 everyday.
22 The current package or funding formula
23 for IHS we feel is detrimental to the Oglala Lakota
24 Tribe. The contract has money. Because this is
25 based on a formula which has taken out poverty and

1 poverty, as you know, has to do with health. If
2 you're in poverty, you're going to have bad health.
3 One thing that is held against Oglala
4 Lakota Tribe is that we had a new hospital built 8
5 years ago. A wonderful building, however it is not
6 staffed. We have a state-of-the-art intensive care
7 unit with no doctors to run it. But when the
8 funding formula comes up, IHS penalized the tribe
9 for this building. In essence, it's like giving a
10 person keys to a car but no gas to run it is where
11 we sit.
12 We also feel that IHS doesn't look into
13 preventive measures. They look more at treatment.
14 And as for our reservation as well as others, I'm
15 sure there's a high alcoholism rate on our
16 reservation.
17 Recently our tribe is in the process
18 right now of building 140 bed detention center with
19 a detoxification center in it. And this will allow
20 us to treat our alcoholics so it won't result into a
21 further -- it will be cheaper to treat them than to
22 wait until they get cirrhosis or other alcohol
23 related diseases. However, IHS has balked at trying
24 to find us money for this detox center. We cannot
25 even get them to come to the table and meet with us.

1 This is a $13 million building, and we might have to
2 give the detoxification center up because of IHS's
3 refusal to live up to one of our treaty rights or
4 treaty obligations.
5 With that, I do have a lot of other
6 written testimony. I have people, you know, under
7 the law it states that our people must use Indian
8 Health Service that is the closest nearby. And if
9 you cannot use, if there is none -- if there isn't
10 anything nearby, then you can go to another
11 hospital. However, that does not guarantee IHS will
12 pay that bill.
13 Numerous bills from collection agencies
14 that are hounding our people who have had to go to a
15 different service that IHS cannot provide, they are
16 now being referred to credit collection agencies.
17 Again, this is a violation of our treaties.
18 Our treaties specifically state health
19 care will be provided to our tribe.
20 We also have services that cannot be
21 provided, policies. The IHS will refer our people
22 if they need surgery, but there's -- again, no
23 guarantee they'll pay for it. There is a priority
24 one the IHS has, and it's either life or limb. If
25 you're life in jeopardy or if you're not in jeopardy

1 of losing a limb, we won't pay for it. You got to
2 priority 2, and you must find other resources to pay
3 for it.
4 We literally have young men and women in
5 Pine Ridge walking around limping because they can't
6 get a basic knee surgery for torn cartilage, because
7 IHS refuses to pay for it.
8 I know, because I have recently had six
9 knee surgeries. Fortunately, I have private health
10 care insurance and I was able to get that done. But
11 unlike a lot of our tribal members, they do not have
12 health care or health insurance.
13 The Oglala Lakota Tribe, we provide that
14 to our employees at a cost, but that is all we have.
15 Again, I don't feel we should have to
16 provide our own health insurance. Because, like I
17 said, we have already bought it and we have already
18 paid for it.
19 And once again, I said there is nothing
20 I can say that this gentleman over here hasn't
21 already told you. I don't dispute the facts. I think
22 they're worse than what he's telling you, however.
23 So I will conclude with this: I will get back to
24 the 1968 treaty.
25 First of all, let me say that the United

1 States Government cannot provide health care. They
2 cannot manage health care. They have failed at this
3 for 100 years. And I'm going to say this and I hope
4 you can back me up or do something, recommend
5 something. But I want the United States to live up
6 to their treaty obligations that they made with our
7 tribe. And if they cannot, I'm asking the United
8 States to return everything they've taken from our
9 tribe, which includes the gold in the Black Hills
10 and the Black Hills; the millions of acres, the
11 hydroelectric dams that are built on the Missouri
12 River. Because the 1868 Treaty says that river
13 belongs to us. It's on the east bank of the Missouri
14 and everything west. Return that back to Lakota and
15 we will take care of our own people.
16 Thank you.
17 CHAIRPERSON BERRY: Thank you. Do any
18 Commissioners have any questions for members of the
19 panel? Yes, Vice Chairman?
20 VICE CHAIRMAN REYNOSO: Dr. Perez, I was
21 impressed yesterday in visiting the facilities for
22 what, I guess, is pretty well acknowledged that the
23 funding is simply not what it needs to be even to
24 have treatment for American Indians be as an
25 average, the same as for other Americans.

1 My question to you is what in your
2 judgment can be done to bring this reality, stark
3 reality to the attention of our Congress and the
4 House of Representatives and Senate for purposes of
5 trying to ameliorate that situation?
6 DR. PEREZ: I could answer it as a
7 psychologist. I could answer it in my position, and
8 I do not know that I can speak on behalf of the
9 agency, so let me tell you personally.
10 To put a face on policy is always hard
11 back there. I have been there for about a year, so
12 I am just learning as I go along.
13 I know that there's recognition, in fact
14 I think it was 3 weeks ago there was a meeting with
15 you in Senator Daschle's office, and he brought
16 together Congressional appropriations, BIA, SAMHSA,
17 and us to talk exactly about that issue of the detox
18 center, which makes perfect sense. It would appear
19 to be cost effective. But it doesn't have a funding
20 mechanism. We can't fund it, given the way the
21 building is going to be built in our current funding
22 authorizations. And then goes to Congress and says
23 "Well, can you earmark this?" But they said it's
24 going to be a very difficult thing to do given the
25 other exigencies of what Congress and the rest of

1 the nation is dealing with right now. So you get
2 somebody caught in the middle and then you ask the
3 question "Well, how do you do this?" We did put a
4 human face on it.
5 And some of this, I think, is going to
6 be glacial in terms of trying to implement it
7 forward. And some of the other, I think the more
8 that we keep the issues at the forefront, the more
9 that we continue to have people recognize the
10 effects that it has nationally, the better off we're
11 going to be. I don't see that there are necessarily
12 quick answers, but I don't think that we can stop
13 from putting it forward.
14 VICE CHAIRMAN REYNOSO: I guess part of
15 my question has to do in part to what Mr. Jack said,
16 that is the government doesn't dispute and it's not
17 even a matter of controversy that it's got to pay
18 interest on the loans it gathers, whether it's $87
19 billion or other money. It's not even a matter of
20 political discussion. All parties agree.
21 Yet here we have a series of treaties
22 where one would think it would be a given that the
23 government would simply say "You know, that's the
24 best, it's like interest, that's an obligation that
25 we have" rather than having the need for a detox

1 center, for example, simply be competing with a
2 thousand other matters. Somehow, there are matters
3 in government of priorities and even the very fine
4 article that I read that Senator Daschle wrote, he
5 was really speaking of that issue as one of many
6 issues that we need to put a higher priority. One
7 could disagree with that, but it seems to me it's a
8 matter of categorizing in a different category of
9 responsibility.

10 Any thoughts of how that could be done?

11 DR. PEREZ: Well, let me first say I
12 agree with you, and I agree with what you're saying
13 and the approach becomes the issue. And it's vexing
14 me. I don't have an immediate answer. I wish that I
15 did. Because I can very easily look for enemies,
16 and I think what I see is not that I can put faces
17 on individuals.

18 For example, congressional support
19 appears to be there. But there is a genuine concern
20 about what's happening in Indian Country, taking
21 that next step and turning that into some other kind
22 of action. It gets into those thousands of other
23 priorities.

24 The treaty obligation, as far as I am
25 concerned, is sacrosanct. But, again, turning that

1 into action, there is a disconnect there somehow and
2 I don't quite know how to take that next step. And
3 that may also be a couple of levels above my pay
4 grade as well.

5 VICE CHAIRMAN REYNOSO: Yes, thank you.

6 I have the same question for Mr. Jack,
7 because he mentioned what we've heard on other
8 occasions in other circumstances. We have had
9 hearings in South Dakota. We've had hearings in
10 Alaska. We've had hearing in Hawaii pertaining to
11 the obligations that the government took upon itself
12 and then it sets those obligations across or vis-à-
13 vis many other obligations that it has -- general
14 obligations, but not specific obligations as taken
15 on by treaty. As, and my example pertained to
16 interest, once the federal government takes on an
17 obligation, you think that would sort of come off
18 the top of the budget and then you say what else do
19 we have for discretionary matters like $87 billion
20 for Iraq. But somehow that's not the approach that
21 the Administration, by that I mean the Executive --
22 and I'm not going to go by the current
23 Administration I'm speaking historically. That the
24 Executive has taken or the legislature has taken.

25 Mr. Jack, any notions of how we could

1 parcel those debates out so you weren't simply
2 arguing against a thousand other needs in the
3 country, but you say hey, this is an obligation that
4 if taken, it ought not -- the obligation ought not
5 to be a matter of concern, how to meet it, the
6 amount of money and so on can be obviously, but it
7 needs to be placed in a different category, it seems
8 to me.
9 MR. JACK: Well, it's like I said. You
10 know, the United Stats has never lived up to its
11 treaty obligations. You know, they've taken the
12 Black Hills, the Supreme Court ruled in 1980 that it
13 was the ripest case in the history of the United
14 States, you know the sell or starve policy; either
15 we sold or we starved to death and our people
16 starved to death. They never sold. However, we
17 never got our hills back, even though the Supreme
18 Court rules and said it was illegal.
19 One of the things is, look at the
20 Constitution, Article 6 is what we usually go off
21 of, which says that treaties will be regarded as the
22 highest or the supreme law of the land, you know.
23 And a lot of these things that are,
24 these diseases that are effecting our people today,
25 you know, we never had to deal with them. Our

1 ancestors never had to deal with them. So we never
2 developed an immune system to some of these
3 diseases, such as we never had diabetes or
4 alcoholism. Now you got a new one called West Nile
5 Virus, you know.

6 But under the treaty, you know, it says
7 -- and there's a joke that goes around back home.
8 It says as long as the grass grows the river flows.
9 Okay. Well, we see the United States damming up
10 the rivers and they'll probably put concrete on the
11 ground to get out of this treaty. And that's
12 basically what we see.

13 I don't know where we can go. We go to
14 Congress all the time, try to remind them of
15 treaties. We asked Senator Johnson, read it in, the
16 difference between treaties and entitlements.

17 VICE CHAIRMAN REYNOSO: Yes. The reason
18 I raised the question with you as well as Mr. Perez,
19 is that again in the article by Senator Daschle,
20 which is a very good article in terms of the needs
21 and all that, that concept didn't find itself into
22 that article saying hey wait a minute boys and girls
23 of the Senate, this is not just a matter of need as
24 they're needs in California for urban Indians, for
25 example, and so on. This is a matter of an

1 obligation like paying interest on money we owed. It
2 ought not to be a matter of dispute that the
3 obligation is there, now what do we do about it. And
4 that didn't find itself there. So I'm suggesting
5 that maybe there needs to be a little bit of a
6 different approach on the debate that takes place in
7 Congress.

8 MR. JACK: Well, as you know, Mr.
9 Commissioner, federal prisoners receive almost twice
10 as much in health as Native Americans.

11 VICE CHAIRMAN REYNOSO: Yes.

12 MR. JACK: You know, there's also a
13 joke, people should go to prison to get better
14 health care. And, unfortunately, that's true, you
15 know. The general population --

16 VICE CHAIRMAN REYNOSO: Well, in South
17 Dakota we found out that there was a
18 disproportionate number of Indians in prisons. So
19 apparently those folk are getting better treatment.

20 MR. JACK: But even the average American
21 receives twice as much in federal funding for health
22 care.

23 VICE CHAIRMAN REYNOSO: Sure.

24 MR. JACK: You know, other minorities
25 receive higher funding, even health care. And

1 again, I say we give some of, we bought and paid our
2 health care, yet we're on the low end again. So I
3 don't know what else we can do besides keep going to
4 Congress.
5 CHAIRPERSON BERRY: Commissioner Meeks,
6 do you wish comment?
7 COMMISSIONER MEEKS: Yes. Actually some
8 sort of specific questions relating to testimony.
9 Dr. Grimm, you said --
10 CHAIRPERSON BERRY: Perez.
11 COMMISSIONER MEEKS: Oh, Perez. I'm
12 sorry.
13 DR. PEREZ: We're interchangeable.
14 COMMISSIONER MEEKS: You said in your
15 testimony that lower utilization of health care
16 services, for example, 25 percent annual utilization
17 of dental services for American Indian and Alaska
18 Natives compared to 60 percent of U.S. population.
19 What does that mean?
20 DR. PEREZ: Meaning using it less?
21 COMMISSIONER MEEKS: Yes. You mean, they
22 just don't go?
23 DR. PEREZ: Right.
24 COMMISSIONER MEEKS: And why do you
25 think that is?

1 DR. PEREZ: Not sure. Not sure.

2 COMMISSIONER MEEKS: I mean, we heard

3 testimony yesterday, actually, of people waiting in

4 line.

5 DR. PEREZ: For a dentist.

6 COMMISSIONER MEEKS: I mean, you have to

7 show up at 6:00 in the morning and, you know, I know

8 at Pine Ridge, people give up going to the dentist

9 because they just can't get in.

10 DR. PEREZ: I don't want to speak

11 particularly to dental services.

12 COMMISSIONER MEEKS: Okay.

13 DR. PEREZ: Let me get over to something

14 I do know something about, which is behavioral

15 health.

16 CHAIRPERSON BERRY: Should she hold that

17 question for the next panel?-

18 DR. PEREZ: Well, no, because they may

19 be related.

20 CHAIRPERSON BERRY: Okay.

21 DR. PEREZ: I just wanted to speak to

22 something that I was a little more cogent of instead

23 of just a statistic.

24 Some of it's wait time. Some of it's

25 being able to access care. But it's not just

1 necessarily our care, some of it's rural in nature.
2 Some of it is approaches to health care. Some of it
3 is education. It's a matrix. There are a bunch of
4 different things.
5 At least in my experience, certainly for
6 behavioral health, they come together. Dental I'm
7 not exactly sure, but I can certainly find out for
8 you. But when we're talking about accessing mental
9 health care, for example, and the alcohol services,
10 it's how quickly you can get, who the people are
11 there you're seeing, whether it's going to be
12 stigmatizing, non-stigmatizing and whether you
13 receive a benefit for it.
14 COMMISSIONER MEEKS: Which doesn't
15 exactly relate to dental services.
16 DR. PEREZ: I'm sorry?
17 COMMISSIONER MEEKS: Which doesn't
18 exactly relate to dental service.
19 DR. PEREZ: No.
20 COMMISSIONER MEEKS: But I'll hold that
21 question. I mean, there's going to be plenty of time
22 for questions. But, you know, I mean I think this
23 was a really good panel in my view because it sort
24 of shows IHS and their operation, and then the
25 frustration from the tribal level. And, you know, I

1 know that the HHS committees at the tribal level
2 have a lot of frustration with, you know, they hear
3 daily from their tribal members that, you know, are
4 denied. They have to go to a hospital somewhere and
5 their payments are denied. I mean, this affects
6 their ability to get health care in some of the
7 border towns, for instance, because those hospitals
8 don't want to be left holding this bill forever
9 either.
10 I hope we can somehow open up this
11 communication and figure out -- and that's just one
12 issue. I mean, the other one is just poor quality
13 of service and overworked health care providers.
14 But on a little bit different subject,
15 now I keep hearing conflicting reports about the
16 ability of IHS, hospitals to do third party billing.
17 Insurance, actually billing insurance companies.
18 And I'd like clarification on that from people in
19 the know.
20 DR. PEREZ: Let me see if we have people
21 in the know, because I can answer some of it.
22 COMMISSIONER MEEKS: Maybe I can hold
23 that question.
24 DR. PEREZ: We've got the brain trust
25 right here. Well, no.

1 CHAIRPERSON BERRY: We could hold it
2 over to the next panel.
3 COMMISSIONER MEEKS: Yes. Sure.
4 CHAIRPERSON BERRY: Let's just hold over
5 anything and it goes to the next panel.
6 DR. PEREZ: Let me give you at least an
7 introduction to that. Every IHS facility that I've
8 ever worked in has the capability of billing third
9 parties.
10 COMMISSIONER MEEKS: Okay. You know, on
11 this issue of behavioral, are you aware of the study
12 by -- it just came out in the NPR Radio a couple of
13 days ago about the study by Duke University and
14 published in the *Journal of American Medical*? It
15 showed a link between children's improved health
16 care and relief from stresses of poverty in the
17 North Carolina Cherokee case where they started
18 receiving revenues?
19 DR. PEREZ: I am, indeed.
20 COMMISSIONER MEEKS: I mean, I was just
21 really fascinated by that. Because, I mean I think
22 it shows a pretty clear link between, you know,
23 people's income rising and their mental health
24 improving.
25 DR. PEREZ: I agree. The data are

1 preliminary. I'd really like to take a good look at
2 them itself. I got two summaries actually before it
3 became an article, but I'd like to talk to the
4 people who actually wrote it and take a look at the
5 data themselves. But what it indicates, I mean part
6 of it is like a no-brainer like intuitive sense.
7 But the other part of it is, and particularly when
8 we're talking about -- I'll get on a soap box for a
9 second.
10 When we look at the seven of the top 10
11 M&M figures for Indian people, they're behaviorally
12 related. And what you see in terms of behavior, is
13 it's not like getting a blood test. You have all
14 kinds of things that get involved.
15 A minimum level of resource is critical.
16 Now what that is, and it changes from community to
17 community, but what we end up in the health care
18 community, for example, we end up taking care of
19 many messes that are created far before people ever
20 hit the door. And this, and what you're citing in
21 the article, is one of those.
22 If you have resources, if you have
23 possibility. What I said in the testimony, I really
24 meant it. I didn't mean it as poetic. Is it's
25 really a struggle between hope and hopelessness. If

1 you have a sense that you can impact your community,
2 and you hear the frustration. We go back, we go
3 back, we go back and nobody does anything. At what
4 level do you just finally say forget it? And, it's
5 not just saying forget it, because psychologically
6 all these other things start to happen.

7 So, if we extrapolate a little bit from
8 those data, which I kind of want to do but for
9 conversation I will, to say if those resources are
10 there, that you're better off and the answer is
11 clearly yes.

12 I don't know if that's responsive to
13 your question or comment.

14 COMMISSIONER MEEKS: That's fine. It
15 was just a comment.

16 I mean, we will have a million questions
17 and we have the rest of the day to --

18 CHAIRPERSON BERRY: I have some that I'd
19 like to ask and then I'll recognize. Would you like
20 to--

21 VICE CHAIRMAN REYNOSO: Well I have one
22 other question pertaining to the turnover of medical
23 personnel. I was interested in hearing from the CEO
24 of a facility that we mentioned that their fortunate
25 to have a lesser turnover there than in most

1 hospitals rendering services to Indians. But I was
2 interested that when the gentleman in charge of the
3 medical staff got up, the first thing that he
4 mentioned in terms of problems was turnover. And he
5 mentioned the obvious. That in the medical
6 profession folk worked in teams. And then when you
7 have a turnover of a member of that team, it simply
8 becomes a lot harder to provide the same sort of
9 services.

10 And he mentioned, I appreciated his
11 frankness, though much has been written on this,
12 that the highest incidence of things going wrong, is
13 human error in terms of medical services. And that
14 human error can happen more frequently when one of
15 the team has left and they're training a new person.
16 To me that seems pretty common sense. But I was
17 just interested that even in that facility where the
18 CEO said they had lesser turnover, that was the
19 first concern mentioned by the gentleman in charge
20 of the medical personnel.

21 And I know that there are structures. I
22 know we've heard enough about why that happens. I
23 wonder whether you have any suggestions for how to
24 slow down the turnover? How to keep folk a little
25 bit longer there? Instead of having the cycle of

1 folk graduating from medical school, going there for
2 2 or 3 years apparently to help pay off their loans,
3 and then they leave.

4 So I just wonder what suggestions you
5 might have along those lines?

6 DR. PEREZ: There seems to be, at least
7 in my experience and I'll defer to the experts
8 behind me who know better, that there is a group of
9 providers, and I'm not just talking about docs now,
10 but people who will cycle into the system for a
11 couple of years, they'll pay off their obligations
12 and so forth and leave.

13 VICE CHAIRMAN REYNOSO: Right. Right.

14 DR. PEREZ: But there's a critical
15 point, and I think it's about 4 years down that if
16 you maintain somebody in the system for about 4
17 years, in all likelihood they'll stay 10, 15, make a
18 career. And how we can try and keep more of those
19 people that just cycle in to the longer term; job
20 satisfaction, patient load, feeling like they're
21 making a positive impact, not feeling like they're
22 coming into a medical crisis zone every time they
23 walk through the door. These are all related. Some
24 of it is also the nature of where we do provide
25 service, which is primarily rural and in isolated

1 locations. These are all connected together and the
2 answers are in there.
3 And there are some programs, which I
4 won't speak to but people will be speaking to later
5 about that.
6 VICE CHAIRMAN REYNOSO: Thank you.
7 CHAIRPERSON BERRY: I had a number of
8 questions for both of you. But as I listen to you
9 talk, and as I reflected on what we saw yesterday
10 when we made the site visit and we had the forum,
11 and what we heard and reading the staff briefing
12 paper on the subject, that what you do, Dr. Perez,
13 your area of responsibility is the most important
14 area of responsibility in IHS, and it does not seem
15 to be funded as a priority in the sense that it
16 seems to me that it's probably the most important
17 thing that goes on there. Everything else in IHS
18 where disease is treated, physical manifestations of
19 disease, seems to me to be on the surface. But what
20 you treat or you try to treat, or the folks who work
21 for you try to treat, is what's going on underneath
22 and what the root cause is of many of the things
23 that happen to the people that we encounter happen
24 to be. Because of the root causes weren't there,
25 then they wouldn't be treating diabetes and all

1 these other things, alcoholism and all the rest. It
2 just seems to me.
3 And here's a connection I made as I was
4 sitting up here thinking, and I had not thought
5 about this before. In communities of people who
6 have a history of subordination there often deep
7 psychological trauma. And in the case of some
8 Latinos, especially people who live along the
9 border, there is always a deep sense that their land
10 was taken away from them, what we call the Mexican
11 cession.
12 I know there used to be a man on the
13 Commission who was from New Mexico, and he used to
14 talk about -- who was Hispanic. And he talked about
15 how their land had been taken away from them. It was
16 clear to him that this was land that belonged to
17 them and the United States came and took it. He
18 wasn't thinking about the Indians. But he was
19 thinking about the land. But for him there was this
20 deep psychological trauma and no matter what
21 happened, from then on he always wanted to go back
22 and talk about what was there before.
23 And for African-Americans, for many of
24 us, there's this deep psychological trauma about
25 slavery. You know, people say why don't you forget

1 it or whatever. But it's there. It's in the heart.
2 And no matter what anybody does or anybody says for
3 many of us, there's a wound, that thing about
4 working and not getting paid, especially when you
5 can trace your family all the way back and you know
6 how many of them worked and didn't get paid. And
7 you know how many got beaten, and you know how many
8 got sold away, and you know -- when you know that
9 and it's deep in your heart and then people say
10 forget about it and move on.
11 And so for Indians the trust
12 relationship, that idea. Now I understand better why
13 this woman testified yesterday that even though she
14 had insurance, she always went to Indian Health
15 Service because they owed this to the Indian people.
16 But this was supposed to be the place where they
17 were supposed to go to get, even if she had to stand
18 in line. What if she did? She felt comfortable
19 being there and it was something that was owed.
20 And when you explained it again, Mr.
21 Jack, I understood it in a way that it's deep in the
22 heart and it's in the psyche.
23 And so what you're dealing with and what
24 many of these manifestations of disease that we talk
25 about, and you said poverty, Mr. Jack, that too is

1 on the surface. There are a lot of things that
2 happen to people because they're poor. But there
3 are other things, the hopelessness that you talked
4 about and the lack of hope, and it's not just the
5 lack of hope because of today's poverty, but for
6 many people it's intergenerational, I suspect. And
7 now I think I understand it better than I ever did
8 before. Not that it doesn't give me more grief,
9 because it does.
10 And one Indian said to me yesterday, she
11 could look at me and tell that I had listened to too
12 much grief in my lifetime. And that's true. About
13 time for me to go home.
14 But in any case, so if you have the most
15 important function, and I don't expect you to say
16 you do because there's the bureaucracy and you're
17 not supposed to say that because there are people
18 you report to and all that stuff, I know that. But
19 if that's true, how come the resources that are
20 allocated within IHS don't reflect that? That's
21 number one.
22 And what do you do about it? What can
23 you do in terms of advocating the position of what
24 your folks are doing so that on the ground out here
25 when we go out we don't see this lack of services,

1 this people staying a few months and leaving and
2 relationships torn asunder? Because, as you know,
3 with psychological treatment part of it is the
4 relationship between the care provider and the
5 person who is getting the care. And it leads to all
6 of these physical manifestations of disease that
7 then it costs so much to treat. So what do you do
8 about that? Do you agree with any of what I said,
9 that's number one. And number two, are you able to
10 say whether you do? And two, what are you doing
11 about it within the structure and what do you hope?
12 What's your hope?
13 VICE CHAIRMAN REYNOSO: Those are the
14 easy questions.
15 DR. PEREZ: Well, but it gets basically
16 at the meat of what I struggle with on a daily
17 basis.
18 I can speak ideally. I can speak do I
19 have enough money? No, I never have enough money.
20 Do I have enough for the programs that I want? No,
21 I do not. Do I live in a real world? Yes, I do.
22 Am I competing with all kinds of other demands?
23 Yes, I am.
24 I don't know that that's a bureaucratic
25 answer, but it's as good as I can give you right now

1 in terms of the funding. The funding, yes, we could
2 always use more. We could use it very effectively.
3 Ninety-seven percent of the alcohol and
4 substance abuse budget, 95 percent of the mental
5 health budget goes directly to tribes. They run
6 their operations now, not me, not somebody from D.C.
7
8 The future of behavioral health for
9 Indian health is in the tribes and villages, not
10 with me. I have a State Department function more
11 than anything else. I communicate these needs back
12 there and turn it into something that Washington can
13 understand. And I take what Washington has to say
14 and send it back to the tribes to communicate those
15 needs.
16 CHAIRPERSON BERRY: So you have a very
17 painful job, too. So all you're doing is taking the
18 money, which is a short amount of money, and then
19 giving it to the tribes who then have a short amount
20 of money. I'm not blaming, but I'm just --
21 DR. PEREZ: Oh, no, no. No.
22 CHAIRPERSON BERRY: And then when they
23 get the money, they do the best they can with it.
24 And then there are glitches everywhere. But on the
25 front end the problem is that the amount of money

1 that is there to serve the people and to keep the
2 staff there, and to have the staff you need and all
3 the rest of it, isn't there. So your position is not
4 that you can go get the money. Is that basically
5 what you're telling me?
6 DR. PEREZ: Yes.
7 CHAIRPERSON BERRY: Within the IHS
8 system what is the mechanism for you or somebody
9 being able to explain what you and I just shared
10 about the importance of this function compared to
11 all the other functions and how it relates and
12 underpins the others so that maybe within the
13 resources that are available, a greater amount can
14 be devoted to it?
15 DR. PEREZ: I think without turning over
16 and looking at my boss, that there is a--
17 CHAIRPERSON BERRY: Well, that's a
18 problem.
19 DR. PEREZ: That there is a certain
20 honor left here. That there is becoming a greater
21 awareness of it.
22 One of the things that Dr. Grim has done
23 since he's come on board is to really start focusing
24 on health promotion.
25 You know, so often in our history in IHS

1 we're triaging care. We still are. But I mean,
2 we're triaging from the most serious to the least
3 serious. And I think for a long time in terms of a
4 real medical model, while we're healthy and we're
5 not going to worry about. Well, they may not have
6 been so healthy, they just hadn't been diagnosed
7 yet. So that you're taking all of what you do have
8 to deal with the most severe. That's exactly what
9 Lyle was talking about in terms of our Contract
10 Health Services.
11 But increasingly now, and I think
12 particularly in the last year, that there is a real
13 focus on if we can prevent, for example in the
14 testimony I was talking about preventing type 2
15 diabetes. If you can prevent one case, that's a
16 whole lot of money over a long period of time. So
17 it makes economic sense. We're not even just
18 talking about the personal price with it.
19 So I think you're going to see that
20 start to change. And when it comes back to my
21 budget and trying to deal with knowing the
22 difference between what you should do and what you
23 do do, we get close and we can kind of nibble at the
24 edges of it and we can start to put some behavioral
25 things in place, so I'm not feeling hopeless about

1 it. But we're talking about stuff that's not going
2 to be easy to change and go around.
3 Back to the funding issue, again. It's
4 one of choices that happen with many different
5 people and many different places.
6 CHAIRPERSON BERRY: I understand.
7 I wanted to ask Mr. Jack something. The
8 analyses in another direction, the social science
9 data that I have seen and the examples I have before
10 me indicate that people in the communities that are
11 subordinated that I just described in terms of the
12 trust relationship and so on and the slavery issue
13 and so on, those people who are better able to defer
14 that pain and to mask it or to forget about it and
15 to move on seem to do better in the larger society
16 since the problem never gets solves. I mean, nobody
17 ever pays you for the slavery and nobody ever really
18 abides by all the treaties, and nobody ever gives
19 the Mexican cession territory back. So that those
20 who are able to somehow move on, whether they go
21 into therapy all the time and move on or whether
22 they drink too much and move on, or whatever they
23 do, whatever they do or need to do or if they lie to
24 themselves -- or whatever they do, or tell the truth
25 to themselves, they're able to move on.

1 What do you do as a tribal council
2 member and what do the tribes do to try to help
3 people to move on? In other words, instead of
4 endlessly debating the fact that the trust
5 relationship hasn't been abided by, which is true,
6 whether endlessly debating the justice of that, what
7 do you do to say to people we know that's true and
8 we know that IHS isn't doing all it should do, and
9 we know the education isn't all it should be, and we
10 know all this stuff but as many of us as possible
11 have got to move on. So what do the tribes do to
12 try to alleviate the alcoholism, to try to tell
13 people that, you know, this diabetes thing is not
14 going to get you over? To keep people from going to
15 White Clay and getting the booze from that town down
16 there we visited? What is it that you do to try --
17 what structures or what mechanisms, or what modeling
18 or what do you guys do?
19 MR. JACK: Well, first of all, the
20 moving on part. You know, I'd like to respond to
21 that. I'd like to say the United States will quit
22 being hypocritical and return everything that they
23 gave -- that we've given to them, and then we'll
24 move on.
25 CHAIRPERSON BERRY: I see. Okay.

1 MR. JACK: Second, we are into
2 prevention. We have alcohol prevention programs
3 running. We have diabetes prevention programs
4 running. That's, the only way we see out of it, is
5 to prevent it rather than letting it happen.
6 Now, I'm frustrated, like I said. The
7 United States Government cannot manage health care.
8 They have a lot of lawyers up there making health
9 policies.
10 Our response to Elsie's question about
11 dental, why do people, only 40 percent. I could tell
12 you why. It's because there are no dentists up
13 there. We have a population of 40,000
14 people and 2 dentists. And if they need braces or
15 if they need root canal, that's called cosmetic
16 surgery and it's not covered by IHS, because it
17 ain't priority one. So that's one of the reasons.
18 The second, I have literally hundreds of
19 people --
20 VICE CHAIRMAN REYNOSO: Excuse me. A
21 root canal is cosmetic?
22 MR. JACK: That's what they call it. We
23 need to go to an outside to a dentist outside. We
24 can't perform it there. That's what it's called.
25 It's not priority one. It's not life or death.

1 Second, I literally have hundreds of
2 people who are afraid to go to IHS. They'll stay
3 home and die before they'll go to IHS. Because of
4 mistrust, misdiagnosis.
5 I know a gentleman who had cancer for 2
6 years, kept going to IHS, all they'd give him is
7 pain killers telling him he had back pain until
8 recently when they opened him up and he was full of
9 cancer, and he died 3 weeks later.
10 I have a grant that's been run by the
11 Rapid City Regional Hospital through the University
12 of Wisconsin on cancer research. They want to know
13 why the Native Americans get to their cancer
14 institute, why they're already full of it. Why
15 hasn't it been diagnosed earlier? Well, we could
16 tell you why. Because you don't have nobody trained
17 in IHS that can spot cancer. We don't have a cancer
18 specialist in IHS. By the time they spot it, it's
19 too late.
20 You know, 80 percent of cancer patients
21 can be saved if it is spotted early.
22 So are some of the things I've done.
23 You know, we are trying to move on. But at the same
24 time, we got to keep reminding the United States
25 Government of their obligations.

1 They say the Supreme Court of the land
2 is run by the Constitution, and then you throw it
3 out or only use it when you need it.
4 Like I said, we give up too many to just
5 move on. You give everything back, we'll move on.
6 Thank you.
7 CHAIRPERSON BERRY: Okay. All right. We
8 want to thank you. Thank the panel very much for
9 your presentations. Thank you.
10 PANEL TWO: CAUSES OF DISPARITIES -
11 ACCESS TO HEALTH SERVICES
12 CHAIRPERSON BERRY: We would like to
13 call forth panel number two on Causes of Disparities
14 - Access to Health Services.
15 Dr. Charles Grim, Mr. Norman Ration, and
16 Mr. Michael Bird, please come forward.
17 Our panelists, let me introduce them.
18 Dr. Charles Grim is a native of Oklahoma and a
19 member of the Cherokee Nation of Oklahoma. And he is
20 Director of the Indian Health Service where he
21 administers a huge budget for health care delivery
22 programs. And the IHS, as you know, is responsible
23 for the health care of the Indian people.
24 He is a graduate of the University of
25 Oklahoma College of Dentistry, and also from the

1 master's from the Health Services Administration
2 program from the University of Michigan, where he
3 probably didn't go to any football games. But
4 anyway.
5 He began his career in the IHS with an
6 assignment in Oklahoma at a service unit. So he's
7 done that. Started out there, and he's been at many
8 posts since that time until he finally became the
9 Director of this agency.
10 Mr. Ration is Executive Director of the
11 National Indian Youth Council here in Albuquerque.
12 He is a Navajo Laguna, is that right? And he's
13 originally from Smith Lake, New Mexico on the Navajo
14 Nation.
15 He attended the College of St. Joseph on
16 the Rio Grande, the University of New Mexico and the
17 University of Phoenix. He is a licensed attorney
18 with the Navajo Nation.
19 He is currently the Executive Director
20 of the National Indian Youth Council, which
21 advocates on behalf of Native Americans in the areas
22 of health care, education, housing, civil rights,
23 voting and the like. He's also worked with the
24 Office of Navajo Economic Opportunity. He has served
25 as Executive Director for the Dineh Peoples Legal

1 Services, Window Rock and the Executive Director for
2 the Ramah Navajo School Board.
3 He has many professional affiliations of
4 the Navajo Nation Bar Association, various bar
5 associations and the like.
6 Mr. Bird is Executive Director of the
7 National Native American AIDS Prevention Center,
8 which is a non-profit corporation in Oakland,
9 California that provides technical assistance and
10 training to Native American organizations, agencies
11 and communities to develop successful HIV prevention
12 programs.
13 Mr. Bird is a Santo-Domingo - San Juan
14 Pueblo Native American from New Mexico.
15 Mr. Bird earned a master's in social
16 work at the University of Utah and a master's in
17 public health at the University of California,
18 Berkeley.
19 He worked with the Indian Health Service
20 for 21 years. He was Director of Preventive Health
21 Programs in the Santa Fe Service Unit and the
22 Albuquerque area IHS office. In over 25 years of
23 public health experience, he's worked on a variety
24 of health activities including medical social work,
25 substance abuse prevention and the like.

1 He served as the first American Indian
2 President in the history of the American Public
3 Health Association, which is the oldest and largest
4 association of public health workers.
5 Thank you very much all of you for
6 coming. You have the same time limitations with the
7 clock that will indicate how much time has expired.
8 And Commissioners who have questions will ask them
9 after the entire panel has spoken.
10 We will begin with Dr. Grim, please.
11 Proceed.
12 DR. GRIM: Thank you, Chairperson Berry.
13 Thank you members of the Commission. I also wanted
14 to thank all of you for taking time yesterday out of
15 your schedules to visit one of our facilities, talk
16 with our staff, talk with patients there about some
17 of the issues.
18 My name is Charles Grim. I'm Director of
19 the Indian Health Service, and I'm going to discuss
20 with you today the extent to which access to health
21 care contributes to the identified disparities in
22 our population, and also to provide an overview of
23 the Indian Health Service within the context of an
24 Indian health care system.
25 I also have submitted a written

1 statement for the record.

2 The Indian health care system is
3 composed of health care services that are
4 administered by IHS, those administered by tribes
5 under the authority of the Indian Self-Determination
6 and Education Assistance Act, and those administered
7 by Urban Indian health programs.

8 Much has been said in your report "The
9 Quiet Crisis," and the request adequately documented
10 the funding available for the Indian health care
11 programs with much substantiation and validation,
12 but the major cause of our health disparities are
13 not just a funding issue, and you were delving into
14 some of the issues with the questions that you asked
15 earlier.

16 Since I've been Director of Indian
17 Health Service, I've placed a renewed emphasis on
18 health promotion and disease prevention. I think
19 that's going to be our strongest front on the battle
20 to eliminate the health disparities that are
21 currently plaguing our people.

22 I think there is a health crisis in
23 Indian Country. I think just as there is a health
24 crisis in the country, and I think that we will
25 bankrupt our national health care system if we don't

1 start helping people make healthier choices, in
2 addition to ensuring that there is adequate access
3 to health services.
4 We must reduce or remove the factors
5 that influence health status and perpetuate the
6 health disparities among people of nation and
7 between American Indians and Alaska Natives and the
8 rest of the nation.
9 Establishing culturally relevant
10 preventive programs at the community level, which
11 research has proven to be more effective than having
12 a generic program imposed on a community to promote
13 healthy lifestyles, as well as strengthening early
14 disease detection and treatment efforts must be the
15 focus of our efforts to address health issues in the
16 nation and in Indian Country.
17 Many factors contribute to poor health
18 and act as barriers to accessing health care
19 services throughout the country, such as racial and
20 lifestyle discrimination, high unemployment rates,
21 and/or few meaningful employment opportunities,
22 educational status, financial status, historical
23 trauma, as you touched on earlier, intergenerational
24 trauma that our people face, and other mental health
25 issues, as well as lack of a medical infrastructure

1 and erosion of the traditional culture in the family
2 support systems. Many of these factors exist
3 throughout Indian Country and in many regions of
4 Indian Country all of these factors are present.
5 Other factors that effect health
6 disparities and access that are particularly
7 relevant to Indian Country include geographic
8 isolation, insufficient transportation
9 infrastructure, cultural and language barriers
10 between Indian communities and surrounding
11 communities and lack of political influence at the
12 state and national level.
13 The Indian Health System shares with the
14 rest of the country the problems of staffing
15 shortages. Staffing levels are a factor in access
16 to health care services and programs. Patients
17 hesitate to come in for care if there are long
18 waiting lines at the clinic. They also prefer to see
19 the same provider for every visit. And in some
20 cases, as the turnover of professional staff is
21 high, it contributes to lowered compliance with
22 treatment orders and patients don't come in for the
23 needed follow up of chronic health problems.
24 The IHS professional staff includes 900
25 physicians, 2,600 nurses, 300 dentists and 430

1 pharmacists. Those professions have annual vacancy
2 rates that range anywhere from 8 to 23 percent,
3 depending on the discipline.
4 Primary care and community health
5 services are the main focus of our care system. Few
6 of our hospitals provide secondary care with
7 specialists such as surgeons and obstetricians, but
8 the majority of our services are provided by
9 generalists, such as family physicians,
10 pediatricians, general practice dentists, physician
11 assistants, and others. Much of the specialty care,
12 both inpatient and outpatient, is purchased from the
13 private or other public sector providers through our
14 Contract Health Services program. The CHS program
15 uses various assessment tools at the local level to
16 prioritize those services that can be covered by the
17 limits of the available CHS funds.
18 Approximately 20 percent of the Indian
19 Health Service budget is used to purchase medical
20 services through the CHS program. When CHS funds
21 aren't available, the agency tries to assist the
22 family with identifying other local health services
23 and programs that they might be eligible for at the
24 federal, state and local level. The final choice
25 available to our families, which many can't afford,

1 is to pay for the care themselves. This barrier to
2 access is to health services outside of our system,
3 and it's one of funding programs and services for
4 people who don't have health insurance and are
5 unable to pay.
6 Some of the factors that influence
7 health status, health disparity and health access
8 have less of an influence within the Indian health
9 system which include the Indian Health Service,
10 Tribal and Urban Health Care programs, because the
11 programs and practices that we have instituted,
12 which I believe can be instructive for other health
13 systems to consider.
14 Cultural and language barriers, even
15 with the more than 560 tribes we serve, many with
16 unique cultures and challenges, have become less of
17 a factor for accessing the Indian health system as
18 we've learned the importance of respecting and
19 addressing cultural differences, which may explain
20 why more than 61 percent of the Indian population
21 has the IHS as their primary health care provider.
22 The IHS recognizes the values of
23 traditional beliefs, ceremonies and practices in the
24 maintenance of wellness and the healing of the body,
25 mind and spirit. And the IHS encourages a climate

1 of respect and acceptance in which traditional
2 beliefs are honored as a vital force within Indian
3 communities and an integral component of the healing
4 process.
5 Many of our new facilities that are
6 being constructed include space that is customized
7 for the traditional practices and needs of that
8 local tribal community for spiritual healing
9 practices.
10 Because a large percentage of our staff
11 is Indian, cultural competency is not usually a
12 major issue. Of the approximately 15,000 employees
13 that we have, 69 percent are American Indian and
14 Alaska Natives. If you exclude medical and
15 engineering professionals, where there's not a lot
16 of Indians in those professions, 88 percent of our
17 staff are Indian. However, since many of our
18 provider staff aren't, as I just mentioned, and most
19 of the CHS providers that we refer into the private
20 sector are not Indian, cultural training concerns of
21 the local customs and beliefs is offered at many of
22 our locations as part of orientation.
23 The Indian Health Service and the Indian
24 Health System can serve as a model of how health
25 systems can develop programs and standards to reduce

1 or remove cultural and language barriers that
2 contribute to the disparities in accessing and
3 receiving health services.
4 The Indian Health System also attempts
5 to reduce geographic and transportation barriers
6 through our Emergency Medical Services program.
7 There are approximately 80 EMS programs in Indian
8 Country, and all but a few are managed by the tribes
9 themselves. The EMS programs an integral part of the
10 comprehensive care provided in the IHS and tribal
11 system because in many places there are no public
12 transportation services available, and the EMS
13 program is the key to the pre-hospital care and
14 transport of injured or gravely ill patients.
15 In addition, geographic and
16 transportation barriers are also addressed through
17 our Telemedicine and Community Health Representative
18 programs. And also the Community Health Aid program
19 in our Alaska region.
20 The development of an electronic health
21 record is another aspect where telemedicine will
22 expand our access to expert medical consultation
23 services and virtually eliminate geographic and
24 transportation issues during the diagnostic and
25 possibly the treatment phase of providing care.

1 Telemedicine as well as Internet access also address
2 somewhat the issue of professional isolation for
3 some of our staff at our more remote health
4 facilities. However, in some of our rural locations
5 they lack the technological infrastructure to
6 support some of the options of telemedicine and
7 technology.
8 Also, a little over half of the local
9 health departments in rural areas do not have high
10 speed Internet access, broadcast communication
11 capacity and facilities and equipment that allow
12 this distance based training.
13 Another factor in health status and
14 access to programs is the poverty level in most
15 rural communities and the lack of a significant
16 population base to influence decisions at the state
17 and national level. Approximately 43 percent of all
18 Indian people live in non-metropolitan areas, which
19 makes the Indian population the most rural
20 population in the United States. And unless
21 statutory language specifically identifies rural or
22 tribal communities for service, cost factors and
23 lack of awareness often leads states to direct funds
24 to areas where there's greater perceived benefit for
25 the expenditure.

1 Another factor is allocation formulas
2 that are based on number of clients or anticipated
3 costs, which tend to be biased against rural
4 communities with small numbers of participants and
5 the inability to spread costs across a larger client
6 base.
7 And many federal programs require
8 matching funds from the community that's being
9 served, and many rural communities often have fewer
10 public and nonprofit entities from which to build
11 the coalitions that can generate the needed match
12 funding for the initiation and maintenance of
13 programs that could benefit these rural communities.
14 Further, with a small number of
15 community-based organizations, including faith
16 based, in rural communities across the U.S., there
17 are less organizations likely to be eligible to
18 apply for and receive federal and other human
19 services grants.
20 Another aspect to accessing care is
21 knowing what services are available, and without
22 outreach, language and authorizing statutes, states
23 may not be encouraged to serve rural communities,
24 and these communities frequently never learn of the
25 opportunities.

1 The costs of providing care to rural
2 communities are also higher, and as a result of
3 poverty, the individual usually requires greater
4 resources, thus raising the per client cost we see.
5 The higher per client cost sometimes exceeds
6 statutory payment caps in some programs, and as a
7 result, further discourages providers from having
8 larger low-income client bases.
9 Providing care in rural areas also
10 entails greater transportation costs because of the
11 need to transfer the client over greater distances
12 to facilities that can provide the necessary
13 services.
14 Most IHS and tribal facilities are
15 located in rural or isolated areas, and because of
16 the low population densities, the medical
17 infrastructure to respond to the health needs of
18 individuals and communities is not as comprehensive
19 as it is in urban areas.
20 The Indian Health System I think is an
21 effective individual and public health partnership
22 between the federal government and tribal
23 governments to meet many of the health needs of
24 American Indian and Alaska Natives. The total census
25 identified the number of American Indian and Alaska

1 Native people in the U.S. at approximately 2.6
2 million. The Indian Health System serves those who
3 are members of the more than 560 federally
4 recognized tribes in 35 different states, which
5 include approximately 1.6 million of the 2.6
6 American Indian and Alaska Natives residing on or
7 near reservations.
8 In addition, approximately 330,000
9 Indian people are served in our urban Indian health
10 clinics. Those are somewhat independent of the IHS
11 and receive only a portion of their funds through
12 the federal appropriations process. We have 34
13 programs that span anywhere from just referral and
14 outreach programs to programs that have full
15 ambulatory type services in urban areas. So there's
16 a broad spectrum of what's provided there. These
17 programs are able to reach out and apply for other
18 grants, unlike many of our federal programs. And the
19 mission of those programs were set out early on in
20 the Indian Health Care Improvement Act to act as
21 seed money in locations where many, many urban
22 Indians are. But over the years we've seen
23 demographic shifts of more Indians into the urban
24 areas. So the Indian Health Service system serves
25 approximately 62 percent of the total Indian

1 population in the U.S.

2 Services that are provided by the IHS

3 and tribes are administered through a decentralized

4 system of 12 area offices, 155 service units or

5 service areas, 60 of which are managed by the Indian

6 Health Service. Ninety-five are managed by tribes

7 now.

8 The Indian Health System consists of 49

9 hospitals, 236 health centers, 176 Alaska Village

10 Clinics, 133 health stations, 33 residential

11 treatment centers.

12 Over all, approximately 48 percent of

13 our appropriation is retained to provide direct

14 services to tribes. The remaining 52 percent is

15 transferred to tribes to operate their programs and

16 facilities directly that they've either contracted

17 or compacted from the IHS to provide for their

18 members.

19 In addition, there are 34 Urban Indian

20 Health Projects that provide some medical, dental

21 and other individual health care services.

22 The Administration and the Department of

23 HHS has established the goal of eliminating health

24 disparities for all Americans by 2010. The interest

25 of the Commission on Civil Rights in achieving that

1 same goal is welcomed. Through partnerships at the
2 national, state and local levels, investments in
3 rural health programs and community development an
4 emphasis on health promotion and advances in
5 technology all of the barriers that have been cited
6 today I think can eventually be overcome so that
7 good health care is a choice for all Americans.
8 As I began my statement, let me close it
9 with the same words. We must reduce or remove the
10 factors that influence health status and perpetuate
11 the health disparities among people of our nation
12 and between the American Indian and Alaska Natives
13 and the rest of the nation.
14 That concludes my statement on access to
15 health care for our people. And I'd be pleased to
16 answer any questions you might have.
17 CHAIRPERSON BERRY: Thank you very much,
18 Dr. Grim. There will be questions.
19 Mr. Ration, please proceed.
20 MR. RATION: Chairwoman Berry, members
21 of the committee, and people in attendance, and Dr.
22 Grim and Mr. Bird, thank you for inviting me today.
23 I am greatly honored to be here to talk with you
24 today about the health disparities and the health
25 care for urban Native Americans here in the city of

1 Albuquerque.

2 Today we've listened to a lot about
3 tribal programs. We've listened about IHS and how
4 they've run the programs. And I think, I believe
5 there is a big segment of Native Americans that are
6 being left out of this health care cycle. And so
7 I'd like to start my statement by stating
8 Albuquerque is a city that offers many opportunities
9 for Native Americans who continue to relocate to
10 this area to take advantage of opportunities that
11 are not available on Indian reservations.

12 Approximately 36,000 Native Americans
13 live in and around the Albuquerque metropolitan
14 area. Of the 36,000 Native Americans, approximately
15 40 percent or 15,000 are Navajo, while the remaining
16 21,000 Native Americans represent over 200 tribes
17 from across the country.

18 Native Americans come to Albuquerque to
19 find work, to pursue educational opportunities, and
20 to build a better life for themselves and their
21 families. In general, health care for Native
22 Americans including urban Indians has been a dismal
23 reflection on the commitment of the U.S. Government,
24 which the U.S. Government brings to its trust
25 responsibility. The Indian Health Service, the

1 primary provider of health care for all Native
2 Americans continues to abdicate its responsibility
3 in the delivery of health care services to urban
4 Indians of Albuquerque; not to mention its
5 irresponsibility and poor stewardship of the past
6 six years when the Albuquerque Area Indian Health
7 Service steadily and covertly eroded health care
8 services to the urban Indians of Albuquerque. This
9 erosion occurred through a series of funding
10 management problems, diversion of funds from patient
11 care priorities, and continued neglect of the health
12 care needs of the 36,000 urban Indians of
13 Albuquerque -- a population it is supposed to
14 provide comprehensive health care services to.
15 Additionally, when Albuquerque Area Indian Health
16 Service began to contract health care services under
17 Public Law 93-638 to tribes and pueblos, it
18 subsequently reduced not only the health care
19 workforce, but also reduced health care services to
20 urban Indians. It is important to note urban
21 Indians do not oppose, but in fact support the
22 contracting to tribes to handle their own health
23 care services.
24 Nevertheless, Indian Health Service
25 continues to fail to fulfill its fiduciary

1 responsibility to provide health care services to
2 36,000 urban Indians of Albuquerque. What's more,
3 the Indian Health Service did not conduct an impact
4 study on the health care services for urban Indians
5 when the tribes and pueblos contracted health care
6 services under Public Law 93-638. Nor did Indian
7 Health Service conduct public hearings on these
8 important matters. Essentially Indian Health
9 Service did not follow the regulations as outlined
10 in the legislation of Title 25, U.S.C. 1631(b).
11 Furthermore, while Congress created the
12 Snyder Act and Public Law 94-437 to provide funding
13 for health care service and to ensure quality health
14 care of all Native Americans equivalent to the
15 general public, Native Americans including urban
16 Indians still do not receive the necessary health
17 care funds, quality health care services. Indian
18 Health Service should be advocating for funds to
19 make certain its clientele, especially the urban
20 Indians, receive improved health care services.
21 In the past years, of its own initiative
22 and through tedious effort and without financial
23 support except out of its own pocket, the urban
24 Indian community successfully acquired through a
25 special congressional appropriation $1 million for

1 primary dental care services provided by SIPI Dental
2 Clinic. Urban Indian representatives have not
3 stopped here, but continued to voice their concerns
4 regarding the reduction of health care services
5 provided to urban Indians by the Albuquerque Area
6 Indian Health Service. However, our concerns have
7 fallen on deaf ears all the way up to the U.S.
8 Health and Human Services Department in Washington,
9 D.C. Although, the rallying cry of Indian Health
10 Service in its rewrite of the Indian Health Care
11 Improvement Act, also known as Public Law 94-437, is
12 "Speaking With One Voice..." it continues to ignore
13 the concerns of urban Indian clients and patients
14 whom it serves. Moreover, Indian Health Service set
15 in motion dissension within the American Indian
16 community by pitting tribal government leaders
17 against urban Indian representatives and urban
18 nonprofit organizations against urban Indian
19 representatives. Urban Indian representatives, who
20 are caught in the middle, have simply tried to bring
21 this critical matter to the attention of all who are
22 involved with Indian health care delivery system.
23 This being the case, the urban Indian community
24 desires top level management personnel of the Indian
25 Health Service to be ones who are compassionate and

1 who are willing to listen to and work with urban
2 grassroots Indian community and not the "good ole
3 boy" system that is presently in place hindering
4 efforts of tribal and urban Indian communities.
5 Although, the trend in this country
6 indicates movement of Native Americans from the
7 reservations to urban regions in alarming numbers,
8 the Indian Health Service still does not get it when
9 it comes to addressing the health care needs of
10 urban Indians. The 2000 U.S. Census Bureau states
11 that over 60 percent of Native Americans who claim
12 to be "Indian alone" and 75.1 percent of Native
13 Americans who claim to be "Indian in combination"
14 live in urban areas.
15 On the other hand, the funding by Indian
16 Health Service to the 34 urban nonprofit
17 organizations serving some of the urban Indians get
18 only about one percent of the national Indian Health
19 Service total annual budget. The services provided
20 by most of these urban nonprofit organizations are
21 not comprehensive care services, and they charge
22 sliding fee scales and are available for both Indian
23 and non-Indian clientele. Those of us in the urban
24 areas that continue to use the Indian Health Service
25 facilities in urban areas do not have data available

1 to show how much of the Title II funds are used to
2 provide health care services.
3 Unfortunately, the Indian Health Service
4 and the U.S. Department of Health and Human Services
5 are not trying to improve or to restore the needed
6 health care services to urban Indians of
7 Albuquerque, except to engage in lengthy rhetoric
8 about "partnerships," which has not produced any
9 results. There has been no attempt by Indian Health
10 Service and the larger government department to
11 request additional funding for its own urban Indian
12 clientele. Indian Health Service has not taken any
13 initiative to propose amendments to Public Law 94-
14 437 to guarantee direct funding to existing Indian
15 Health Service facilities that provide primary
16 comprehensive care services for urban Indians.
17 So, as the story continues, the health
18 care "rug" is slowly and assuredly being pulled from
19 under a large segment of the Indian population, who
20 can least afford to pay for health care services and
21 who were promised "prepaid" health care services
22 through the Snyder Act and treaties.
23 Finally, we took the liberty to offer
24 some recommendations for your review and
25 consideration as follows:

1 First, legislation or regulation
2 regarding health care for Native Americans,
3 including Public Law 94-437, must be changed to
4 specifically address "urban Indians" in its
5 legislative and direct funding terminology with
6 specific language for involving urban Indians,
7 through the consultation process to assure funding,
8 delivery and evaluation of quality of health care
9 services as this population are users of existing
10 Indian Health Service facilities.
11 Second, to establish a national health
12 care card system for Native Americans including
13 Native Americans living on Indian reservations and
14 urban/off reservations areas.
15 Third, to do away with the Public Health
16 Commission Corps as recommended in the 1996 GAO
17 study, and to place them in civilian employment with
18 the Public Health Service as this action would save
19 the Indian Health Service around $60 million
20 annually.
21 Fourth, to secure additional increased
22 funding for the SIPI Dental Clinic and funds to
23 establish a mobile dental unit for the urban Indians
24 of Albuquerque.
25 Fifth, the Indian Health Service to

1 secure additional funding for health care services
2 specifically for Albuquerque area urban Indians and
3 to make sure that such funding is utilized for urban
4 Indian health care.
5 In closure, as a reminder, some
6 documents regarding these matters have been
7 forwarded to the Washington, D.C. Office of the
8 Commission on Civil Rights. If you have any
9 questions regarding these documents or you need
10 additional information, please do not hesitate to
11 contact us.
12 Thank you.
13 CHAIRPERSON BERRY: All right. Thank you
14 very much. And there will be questions.
15 Mr. Bird, please proceed.
16 MR. BIRD: Chairman Berry and
17 Commissioners, and interested members of the
18 community. I am very happy to be here with you this
19 morning and appreciate the opportunity.
20 I also want to compliment the Commission
21 on your report on American Indian health and your
22 interest in holding these hearings.
23 I guess, I wanted to say I guess I'm
24 glad I resigned from the Indian Health Service when
25 I did, otherwise I might have gotten blamed for that

1 one. So, my timing was good, as has been the case.
2 I also want to congratulate Dr. Grim in
3 terms of being established as a new director of the
4 Indian Health Service. I think the Indian Health
5 Service clearly is in need of some ethical and
6 visionary leadership, and after spending 21 years in
7 the Indian Health Service if there's anyone who
8 knows the Indian Health Service both the upside and
9 the downside, I can tell you I can testify to that.
10 There are some health care providers out
11 there, Indian and non-Indians, who are inspirations
12 and who are dealing with extremely difficult
13 situations and circumstances. Again, like any
14 system, it can be improved upon.
15 I am happy to offer my comments to you
16 today. In this age of discussion of homeland
17 defense, faith based initiatives and personal
18 responsibility, after all, who knows more about
19 homeland defense than American Indians? We've been
20 defending our homeland for over 500 years and not
21 getting much help, I might say.
22 The reality for American Indian people
23 today, be it the history of sacrifice of native
24 people historically from Ira Hayes out of Arizona to
25 Lori Piestewa, the first American Indian woman

1 killed in combat in Iraq leaving two small children,
2 Indian people know homeland defense. But we also
3 recognize that often times that trust
4 responsibility, that relationship and the deal that
5 was made in terms of treaties, the United States
6 Government has fallen short and has not fulfilled
7 its moral and legal obligation commitment to native
8 people. We hold them accountable.
9 When you talk about faith-based
10 initiatives, the first prayers in this land were
11 made by native people. The first prayers that were
12 offered for their families, for their communities,
13 for rain and for life, and all people; the first
14 prayers were made by American Indian people, and
15 those prayers are made everyday to this day. And,
16 again, they're made for all people and it's a global
17 prayer.
18 We talked about personal responsibility.
19 Those of us who have come out of difficult
20 circumstances, i.e, substance abuse families. My
21 father was an alcoholic, died of cirrhosis. Many of
22 my family members have been impacted. And those of
23 us who did not come from power and privilege, we
24 could give some lessons to people who assume they
25 know something about personal responsibility. Not

1 that I do not believe -- I believe in personal
2 responsibility. I was the Director of Health
3 Promotion and Disease Prevention at the Albuquerque
4 area office for a number of years. We developed
5 some of the most culturally relevant and appropriate
6 approaches to promoting the health of community
7 members. But the fact of the matter is many people
8 truly do not understand what it means for Indian
9 communities, the sort of difficulties that Indian
10 communities face. The fact of the matter is today
11 in many of our communities there are children who do
12 not believe, and many people who do not believe that
13 they have the ability to make a choice and that it
14 can make a difference for themselves in their lives,
15 and in benefiting the community. If you do not
16 believe you have the ability to make a choice, much
17 of what is being promoted falls on deaf ears.
18 I wanted to talk about very quickly the
19 fact of the matter is, you know, we are indigenous
20 people and we may be a small percentage of the
21 population in this particular country. The fact of
22 the matter is when you look globally, when you look
23 at Native Hawaiians, you look at Maoris of New
24 Zealand, you look at the Australian aboriginal
25 people, you look at the aboriginal populations of

1 Canada and native populations throughout South
2 America, one interesting fact that is not taught in
3 our schools and is not promoted is in fact
4 dispossession promotes and creates health
5 disparities for indigenous populations.
6 When you dispossess people of their land
7 or labor, their culture, their language, their
8 traditions and their religion you set into motion
9 powerful forces that impact them in a very negative
10 and adverse way. And when you look at the data for
11 all of those other native and/or aboriginal
12 population you see much of the same sort of
13 statistics. You see much of the same pattern being
14 played out across this world, across the globe in
15 terms of poor health outcomes and poor educational
16 achievement, high incarceration rates per indigenous
17 people throughout the world.
18 And clearly Native Americans have a
19 unique historical and cultural context to their
20 lives. After thriving for thousands of years as
21 independent nations, they have been subjected to
22 mass genocide, forced resettlement and compulsory
23 acculturation as a matter of federal policy. I'm
24 not going to go into the demographics. We know the
25 data. Quite honestly, data is important and useful,

1 but we've been talking about this sort of data since
2 the days of President Nixon.
3 President Nixon in 1970 had this to say
4 to the Congress. "The First Americans - the Indians
5 - are the most deprived and most isolated minority
6 group in our nation. On virtually every scale of
7 measurement; employment, income, education, health.
8 The condition of the Indian people ranks at the
9 bottom. This condition is the heritage of centuries
10 of injustice. From the time of their first contact
11 with European settlers, the American Indians have
12 been oppressed and brutalized, deprived of their
13 ancestral lands and denied the opportunity to
14 control their own destiny."
15 While the statement was made in 1970, it
16 unfortunately holds true today. So, I'm not going to
17 go into the data. We know the data. We have more
18 data than we possibly could need. What we need is
19 resources.
20 I want to speak now specifically of
21 HIV/AIDS in Indian Country, because that is what I
22 deal with.
23 There are many people in Indian Country
24 and within the federal and state governments who
25 believe that HIV/AIDS is not a pressing problem in

1 the American Indian and Alaska Native population.
2 The American Indian population is relatively small
3 compared to the total U.S. population, and Indian
4 people are often misclassified as other races. As a
5 result, those infected with HIV/AIDS are often
6 overlooked when the subject of AIDS treatment and
7 prevention is addressed.
8 And according to the Centers for Disease
9 Control, the number of reported AIDS cases among
10 Native Americans has steadily increased since the
11 early 1980s, growing by 62 percent in just five
12 years. Also I might mention, there's been a
13 cumulative total of 1,070 deaths in persons with
14 AIDS, with 70 in year 2000. In that year, the age-
15 adjusted death rate for HIV for Native Americans was
16 2.7 versus .7 for American Asian and Pacific
17 Islanders, and 2.8 for whites. According to the CDC
18 in 2001 there was an estimated 1296 Native Americans
19 living with AIDS. Rates for HIV were three times
20 higher for Native Americans than it was for whites.
21 The data in itself, I have to say, is in
22 my testimony. But I want to talk also about the
23 response of tribal governments to the threat of
24 HIV/AIDS has been slow, in part, to the historic
25 under funding that IHS has made and tribal leaders

1 are reluctant to devote limited resources to HIV
2 efforts.
3 I might mention the Native Americans
4 AIDS Prevention Center has been actively working for
5 over 15 years in this area. I just came from a
6 meeting in Atlanta with the CDC in which we will be
7 meeting with the Center for Disease Control to begin
8 an Indian initiative. Because one of the things
9 that happen with American Indian populations is our
10 populations are small. People do not see us. They
11 do not recognize. We are invisible and we are
12 without voice often times.
13 In conclusion, funding is not keeping up
14 with the increasing rate of HIV infection. Tribal
15 care providers do not have the money necessary to
16 adequately care for infected persons, much less
17 increase effective prevention efforts. In fact,
18 funding is so low that in many IHS and tribal areas
19 salaries cannot be paid to HIV and AIDS
20 coordinators.
21 In the year 2000, then Surgeon General
22 David Satcher said "We must work together to prevent
23 the further spread of HIV/AIDS in these communities
24 that are already at tremendous risk due to under
25 counting, under reporting and the high risk mix of

1 other sexual transmitted disease, drug use and
2 alcoholism." American Indians have shown tremendous
3 resiliency as a people and have survived despite
4 incredible adversity. This program is another
5 effort in working together to overcome health
6 disparities and improve the health of Native
7 American communities.
8 Thank you very much for your interest
9 and your commitment to this area.
10 CHAIRPERSON BERRY: Okay. Thank you
11 very much.
12 Do you have any questions for them,
13 Commissioner Meeks?
14 COMMISSIONER MEEKS: I do, but go ahead.
15 CHAIRPERSON BERRY: Vice Chairman.
16 VICE CHAIRMAN REYNOSO: Yes. Dr. Grim,
17 I appreciated your remarks because you gave a quick
18 summary, really, of many of the issues that we've
19 heard about. Let me ask you about a couple of them
20 and see what your thoughts are.
21 You mentioned, for example, the
22 professional isolation that medical providers have,
23 and we've heard quite about that. And just visiting
24 the sites, one can see that reality. I just wonder
25 if the Service is thinking of ways of keeping folk

1 there a longer period of time, maybe when they've
2 served for 2 or 3 years, that they have something
3 akin to a leave of absence to go work in an urban
4 hospital, both to learn more techniques, but also as
5 a change for their families and then come back to
6 the same hospital where they worked before. Because
7 the reality, as you mentioned and others have
8 mentioned, the continuity of service is so
9 important. So I just wonder what your thoughts on
10 that? As Mr. Ration mentioned, you obviously have a
11 lot of experience in this area.
12 DR. GRIM: I think that is a good
13 suggestion. And I know there are some hospitals and
14 other locations that use that particular process to
15 help maintain their provider staff.
16 If we were doing that, it would probably
17 be in tribal locations. I'm not aware of any federal
18 locations. We're not doing that as a policy across
19 the Service, although it's a good recommendation.
20 What we have is a little more
21 traditional. We have scholarship programs to get
22 people into the system that incur payback
23 obligations. We have loan repayment programs.
24 VICE CHAIRMAN REYNOSO: Right.
25 DR. GRIM: But we're looking more and

1 more at that sort of thing. We've started a recruit
2 initiative up in the Aberdeen area, one of the areas
3 that has some of the highest vacancy rates in our
4 system. We're working with the tribal leaders there
5 and with others to try to improve recruitment and
6 retention of provider staff.
7 VICE CHAIRMAN REYNOSO: Do you have any programs to
8 try to get more Native Americans themselves into the
9 medical profession? I remember, I'm in the legal
10 profession. And I remember about a program in the
11 extreme northern part of Canada to train some of the
12 native folk there to be lawyers. A lot of it by
13 Internet, and that sort of thing, because tribal --
14 I have a question for you on that, too. But tribal
15 and so on is so difficult. And I
16 heard a very exciting report; it'll only be 2 years
17 ago, at the American Bar Association annual meeting
18 about that effort.
19 So, sort of what's going on in that
20 respect. Because if you get, of course, a Native
21 American particularly from that tribe, then very
22 often they want to stay there?
23 DR. GRIM: I very much believe in that
24 concept that we need to train our own people and
25 those from the local community so that they'll stay

1 there.

2 We do have, as I said, a scholarship
3 program that targets Indian youth to go into the
4 health professions, and so we do have a program like
5 that internally. Many tribes are doing that on their
6 own, too, with local tribal funds trying to get an
7 increased level of education in their communities.

8 One of the problems with the concept
9 often is, though, you have to send that person off
10 to somewhere to be trained, especially in some of
11 the higher levels of the health professions. So
12 they get into an urban area, they get used to it,
13 they get trained there with many of the technologies
14 that urban areas have. And then, you send them back
15 to the reservation to treat, their people. And
16 sometimes they stay and many, many times they stay,
17 but other times they've gotten used to the
18 technologies that are available and the other
19 amenities of urban areas. And so after the payback
20 period, we lose them.

21 VICE CHAIRMAN REYNOSO: But sometimes
22 there's even resistance. I talked to a young Indian
23 who was in the law school where I was teaching at
24 that time. And he mentioned that his tribe had been
25 somewhat resistance to his going to law school. On

1 the other hand, he did finish law school; he went
2 back to the tribe. And, in fact, he had been part
3 of the tribal council and he was reelected back to
4 the council. And they saw that, in fact, he could
5 do a lot of good for the tribe, which he has done.
6 So, as you say, everybody is an
7 individual and you can't predict what they will do.
8 But I've seen good effects very often from that.
9 DR. GRIM: We're trying very hard to do
10 that. And as I said, we have 68 percent of our
11 workforce that is American Indian and Alaska Native.
12 I think that's a huge percent. You take out
13 positions of engineers and other medical professions
14 that have very small Indian percentages overall and
15 we're up in the 80s plus, 88 percent range. And so
16 we're trying very hard to do that, yes.
17 VICE CHAIRMAN REYNOSO: If for the
18 future there are greater facilities for Native
19 Americans in the urban areas, as is being
20 recommended, then one could even see sort of a
21 transfer system from the rural more isolated area to
22 an urban area where the docs can continue to treat
23 or the nurses can continue to treat the Indian
24 population.
25 DR. GRIM: I think that idea is good and

1 deserves further study within our system to be able
2 to do it. And the only problem we usually lack is
3 resources.
4 VICE CHAIRMAN REYNOSO: Yes.
5 DR. GRIM: You can send a person off and
6 need to pay them their year's salary to retain them
7 and we still need to backfill them in that location
8 which requires additional funding. That's often one
9 of the barriers for that. We would need to look at
10 sort of a pilot project to see how that might work.
11 VICE CHAIRMAN REYNOSO: Let me ask you a
12 different sort of question, which has to do with
13 formulas. And we heard concerns about this in
14 Alaska, for example pertaining to police protection
15 where so often the legislature will say "Well, we'll
16 have one highway patrolman for every 5,000 people or
17 whatever." And it was pointed out that was a very
18 difficult situation in many of the smaller
19 communities in northern Alaska, where if you had one
20 officer for every 5,000 people it would be one
21 officer covering 2,000 miles. And we've heard some
22 of the same concerns with respect to the smaller
23 populations in the U.S. on health services.
24 I just wonder if your department could
25 do sort of a story about what extra resources are

1 needed to serve Native Americans populations or
2 rural populations, transportation and so on so a
3 formula can be changed in terms of what's needed to
4 provide proper services for them. Or other
5 vehicles. For example, in Alaska there was a
6 concern that sometimes members of the local
7 community, native community, would be deputized as
8 officers, but because they didn't have the same
9 training as say highway patrolmen and women, they
10 wouldn't be given the same authority. So those
11 sorts of considerations. But these matters are
12 often a matter of formulas for funding. And it
13 seems to me that you're suffering, your service is
14 suffering because Congress, apparently, or maybe
15 it's administrative, it's operating under some
16 formulas that don't quite fit your services. I just
17 wondered what your thoughts are on that regard?
18 DR. GRIM: I think that it is both of
19 the things that you said. The formulas are some of
20 the issues, and I spoke to that a little bit.
21 The Department of HHS is now focusing on
22 rural America, as is the President, on ways to
23 increase access, especially to health and social
24 services there. There has been an emphasis on the
25 increase in the number of community health centers

1 in the President's focus.

2 We've also in the Department been

3 looking at our grants process. The Secretary,

4 realizing the rural nature of our population, has

5 also reinstituted a group called the

6 Intradepartmental Council on Native American

7 Affairs. I'm the Vice Chair of that council, and

8 it's made up of all the operating and staff division

9 heads in the entire department. So the head of CDC

10 and NIH, and FDA, and HRSA, and SAMHSA, and other

11 programs, set on this council and we talk about

12 crosscutting policy issues that effect the American

13 Indian and Alaska Native population. And this

14 Administration has really been focused on trying to

15 not just look at the Indian Health Service budget as

16 the only budget available, but all of the HHS

17 budget. We're trying to expand the amount of SAMHSA

18 grants that are going, for example, to substance

19 abuse and mental health services issues in Indian

20 Country. We're looking at Centers for Medicare

21 and Medicaid services and policy and regulatory

22 issues that effect our populations.

23 And so we're looking at all those

24 things. Still we run into the issue of just, as you

25 pointed out, the formula of one officer per 5,000

1 people and that may take 10 communities spread over,
2 you know, who knows how many thousand square miles
3 to come to that number, and they can't realistically
4 cover it in that particular example you used. And so
5 we're looking at things like that, but it's a mix of
6 formulas and statute and other things like that
7 which all have to be addressed.

8 The council takes a look at regulatory
9 and policy things that we can change. And if there
10 are statutory things that need to be changed, then
11 we try to tackle those issues also.

12 VICE CHAIRMAN REYNOSO: My last question
13 is for all three of you. I would normally say it's
14 a $64 million question, but it's actually a lot more
15 than the $64 million question.

16 How do you think the aim of wiping out
17 the disparity between medical services for the
18 Indian population and the American population and
19 many argue that Americans themselves on the average
20 don't get all the services they should, but
21 nonetheless, we've been dealing more with the
22 disparity. From what we heard yesterday, the
23 disparity is one at about the 200 percent level, I
24 would say, that is needs to be more than doubled to
25 wipe out that disparity. So my question for each of

1 you is: One, how do we get there; and two I hate to
2 say, what are your hopes it'll get there?
3 CHAIRPERSON BERRY: By 2010?
4 VICE CHAIRMAN REYNOSO: Yes. By 2010.
5 DR. GRIM: Would you like to start at
6 the other end of the table or you want me to --
7 VICE CHAIRMAN REYNOSO: Yes. Let's
8 start with Mr. Bird.
9 MR. BIRD: Well, let me try and answer
10 your question. I think that it's been said that the
11 definition of insanity is doing the same thing over
12 and expecting different outcomes.
13 I have less and less faith in the fact
14 that this country will act in a moral manner. And so
15 what I think that that really puts the burden, which
16 the burden has always been carried by Indian people,
17 but it even raises a higher burden for native
18 populations, for Indian populations to begin to
19 really try to attempt to understand what it is we're
20 dealing with.
21 I think that what we need to be doing,
22 we need visionary, strategic sort of thinking. We
23 need visionary, strategic sort of leadership. And
24 we, as Indian communities and native populations,
25 really need to come together and begin to work

1 together. There's not enough of us to make the kind
2 of difference that other populations -- the pool for
3 Indian leadership is about this deep in terms of
4 those people with training, experience and
5 knowledge. It is very shallow. I see it all across
6 the country, unfortunately.
7 So there's a need for us to really be
8 more strategic and to come together to collaborate
9 and to work together more closely. There's a need
10 for us, I think, to look internationally to working
11 with other indigenous populations.
12 By brothers and sisters, the Maoris,
13 gave this gift to me when I was in New Zealand about
14 two months ago. Many of the issues, many of the
15 problems that are confronting them are more similar
16 than different. I do not think that this country
17 will ever deal in a moral manner and in an ethical
18 manner with the native populations unless there is
19 pressure, unless they in fact are goaded and made to
20 feel embarrassed and shamed in a manner to be more
21 responsive. I think we've got a long way to go, but
22 what else is new?
23 You know, hope springs eternal. And,
24 you know, I'm reminded of one of the tribal leaders
25 here, Frank Tenorio Noria from San Felipe Pueblo was

1 quoted was saying a number of years back, he said in
2 terms of the sort of a pueblo indigenous
3 perspective, and that is in terms of the issues.
4 And that is he said well first the Spanish came and
5 then they went. They're gone. Then because we were
6 under Spanish government. Then the Mexican
7 government came in and they came, and they're gone.
8 Now we're dealing with the Americanos, they're
9 here. You know, we'll see what happens.
10 MR. RATION: I would agree, you know,
11 what has just been said in terms of tribes and
12 tribal members and IHS coming together to talk about
13 how to solve the problem.
14 You know, we have the legislation in
15 place that authorizes more dollars to be
16 appropriated. Whether we use it, or whether we use
17 it and it hasn't come to fruition, I'm not really
18 sure. Realizing that money isn't going to solve all
19 the problems, some of it has to be done in working
20 together. And so far it seems like we, as urbans,
21 get this feeling that somehow we're not part of the
22 tribes. We talk about sovereignty, we talk about
23 membership, we talk about you guys and us guys. And
24 sometimes I sit with the tribal leadership and say,
25 "It's not you guys and us guys, it's us guys." I'm

1 a member of a tribe. I'm a Navajo. You count me,
2 you get benefits and all these things happen along
3 the way.
4 The thing about it is how do we share in
5 these benefits? How do we promote the welfare of
6 our people? Because, you know, the line doesn't
7 stop at the state line or the tribal line and say
8 "Okay, sorry grandson, you're no longer my grandson.
9 You're now on the other side. So I have no
10 responsibility for you."
11 And then we have all our Indian people
12 that are also in the Indian Health Service who
13 should be thinking about us and how they're going to
14 take care of us and include us in those decisions,
15 which really doesn't happen. Somebody else makes
16 those decisions and usually oversight is by federal
17 members or government members or IHS members. They
18 don't go to the guy that's on the street that's sick
19 that can't get the health care and all this type of
20 thing to say what can we do for you, how can we work
21 with you. And they don't worry about this person
22 needs health care, this person needs to be made
23 whole.
24 We look as a priority one, as a priority
25 two, what priority is it. You know, this guy is

1 dispensable, you know, let him stay on the street.

2 But I think everything evolves around

3 how are we willing to come together? How are we

4 willing to listen to each other and move forward

5 together? If we're divided, and it's reservation

6 against urban, well you know sometimes we say "Well,

7 the white guys like it that way because they don't

8 have to do anything." They just watch us fight

9 among ourselves and we're our own worse enemy.

10 This morning I was telling John

11 Blakeley, I got up and the first thought that came

12 to my mind was, you know, here in New Mexico they

13 introduced legislation to save the silvery minnow.

14 You can't eat the thing. You can't do anything

15 except watch it swim around. And they're about the

16 same number as we are. So maybe we should get on

17 that list and let's see how much money they can get.

18 So, you know, sometimes you look at those kind of

19 things and say, well are they more important than

20 us?

21 So we're willing to introduce

22 legislation that's going to put the whole city of

23 Albuquerque out of water. So what happens to the

24 people there? So, you know, somehow we need to talk

25 about these things and come together and make them

1 happen together.

2 I never say there's no hope. I always

3 hope that something's going to happen, that we're

4 going to get together and that we are going to make

5 these things happen together.

6 DR. GRIM: I think whenever you've

7 talked with any of the people that you will talk to,

8 you will hear frustration but you'll hear a level of

9 hope; that we all still have hope about things.

10 The health of a people, the health of a

11 community is more than just going to a hospital or a

12 clinic. It's a complex web of things like safe

13 housing, adequate education, economic opportunities

14 on reservations; things like that. Just having

15 access to a health clinic is not going to make a

16 population healthy. And even if we were to have

17 health clinics in all locations, which I hope

18 someday we do, psychological issues that Mr. Jack

19 referenced earlier of part of the population that

20 won't go there anyway because of mistrust or, things

21 like that, those are very complex things to deal

22 with. You can't deal with just by putting more

23 money into a system.

24 I do, however, have hope as well. You

25 talked earlier on the previous panel and you were

1 asking a similar question, how might we reach a
2 level of funding that we need. And right now the
3 Indian Health Service is considered a discretionary
4 part of the federal government budget. There is a
5 part of the new 94-437 that's up for reauthorization
6 that would authorize a blue ribbon panel that would
7 look at whether Indian Health Service budget should
8 be considered an entitlement like Medicare and
9 Medicaid.
10 There is certainly not universal
11 agreement on that across Indian Country. With
12 entitlement programs comes some sort of
13 requirements, either there's a potential that there
14 would be some sort of financial or monetary limits,
15 like Medicaid. There would be a set of service
16 packages that might be subscribed or prescribed, by
17 the federal government. So it's something that
18 Indian people want to study. And so, should 94-437
19 pass and our budget went from discretionary to
20 entitlement, we would get certain sorts of monies
21 more like Medicare and Medicaid and would keep pace
22 with inflation.
23 The other thing that we do right now is
24 that we work in concert with Indian Health Service,
25 Tribal and Urban programs when we do our budgeting

1 process annually. We realize that priorities have
2 to be made and we start out at the local level and
3 we work with them. We roll our budgets up from the
4 local level to the regional, through the national.
5 And we try to take into account what the local
6 people want in their budgeting. So when you say
7 this particular part of your budget is not
8 adequately funded, then we have taken a look from
9 the ground up that when we have to make those tough
10 decisions, where does Indian Country want us to make
11 them? Where do we place the resources that we're
12 going to be given? Do we place it in mental health
13 or do we place in Contract Health Services when
14 those tough decisions have to be made?
15 And I appreciate the many, many
16 suggestions that we receive, the many
17 recommendations that come up from those sources of
18 processes. And we use those whenever it comes time
19 to make those tough decisions. So, I would just say
20 while this is ideal, we are focusing right now on
21 partnerships, just like many private sector
22 organizations that don't have enough money either.
23 We're trying to expand the number of partnerships we
24 have. We're looking to Intradepartmental Council to
25 spread more of the Department's monies from other

1 agencies into Indian Country. So we're out there
2 trying to do what we can. We're working with
3 Congress. We're working with the Administration.
4 And we're working with Indian Country to try to
5 address the many, many needs out there within the
6 priorities that we have to live under.
7 CHAIRPERSON BERRY: Thank you. Thank
8 you.
9 Elsie?
10 COMMISSIONER MEEKS: Yes. I know that
11 we're short of time, but I really have a lot of
12 questions.
13 And I've always been told that if you
14 want to get something done, you go right to the top.
15 So Dr. Grim?
16 DR. GRIM: At your service.
17 COMMISSIONER MEEKS: You know this just
18 still brings it back to the local level and the
19 local cases. But I think there are good examples for
20 how you improve. You know, I mentioned before that
21 the HHS committees of the tribes are always
22 frustrated because it seems like they don't have a
23 good communication with the local IHS -- I mean,
24 Pine Ridge Health Service, for instance.
25 And I think about one instance, this

1 relative of mine, actually, went -- you know, we
2 have PAs out in the districts because we have nine
3 districts at Pine Ridge and they're isolated and 15
4 to 1800 people in the service area. So I have no
5 objections with the PAs.
6 My relative went with a sore shoulder.
7 And he was diagnosed as having bursitis and given
8 aspirins at home, a couple of different times. And
9 it got worse and worse and his wife worked in a
10 grocery store and had limited coverage, insurance
11 coverage. So she took him to Rapid City. And he had
12 by that time advanced bone cancer and subsequently
13 died.
14 Where she made the mistake, is she
15 should have went back to IHS then and then had him
16 referred on. But her insurance did cover 80 percent
17 of it. But, I mean, could just not even talk to
18 Indian Health Service about paying that other 20
19 percent, and she just really doesn't have -- I mean,
20 she was a clerk in a grocery store.
21 I mean, why can't there be some sort of
22 flexibility within IHS to deal with issues like
23 that? I mean, it goes into the contract care
24 issues.
25 DR. GRIM: First, let me say that I've

1 always hated to hear stories like that. It has
2 touched me over time. I hope one day that every
3 single story like that is not out there anymore
4 where we have cases like that.

5 Let me quickly add that medical care is
6 an art as well as a science, too. And that in very
7 rural areas we do have limited abilities to use
8 early detection devices, for example, that we might
9 in more urban settings, where they have tertiary
10 care type centers.

11 The thing that I say when I hear stories
12 like that, too, is that people do need to go back,
13 and that's not always easy. They need to continue
14 to ask questions of their provider until they have
15 them adequately answered. And I know that's easier
16 said than done. People accept what is said and then
17 they leave and they think that they're going to be
18 okay.

19 But what we face in those sort of
20 settings and then with our Contract Health Service
21 budget, which has been referenced several times, is
22 just the fact that we do have to prioritize or
23 ration care in that particular line item. We have
24 what I would call across our system universal
25 eligibility but limited availability. All of the

1 Indian people that are from federally recognized
2 tribes are eligible for care in our location, but we
3 have limited availability, limited locations and
4 also limited services in many of those locations.
5 Our Contract Health Service budget in
6 many, many locations across the nation never gets
7 off priority one, which has been mentioned, is life
8 or limb sorts of services. We don't get to many of
9 the services that are considered in the other CHS
10 priority levels such as the knee surgeries that
11 sometimes need to be done and the other things that
12 Mr. Jack mentioned.
13 So, to an extent one of the answers is
14 resources. To the other extent, you know, the
15 isolated rural nature of the population makes it
16 very difficult to provide a level of care similar to
17 what one finds in an urban tertiary care center.
18 COMMISSIONER MEEKS: But a misdiagnoses
19 is just -- I mean, you heard about the study that
20 Lyle Jack referred to where -- University of
21 Wisconsin thing, that study about why so many of the
22 Indian patients, they find they're in the bad stages
23 of cancer. I mean, like we went to the moon. Why
24 can't there be some mechanism that --
25 DR. GRIM: We're trying to expand our

1 telemedicine capabilities, which takes money, too,
2 and time. But we see that as a potential to really
3 help out in the very isolated locations that don't
4 have access to the types of services you find in the
5 tertiary medical centers. Many of our locations are
6 starting to be tied in now to telemedicine to some
7 of those centers, and we hope that someday that will
8 deal with the isolation issues, it will deal with
9 the level of care issues, the fact that we don't
10 have certain types of services in all locations
11 across the agency. So we're looking at things like
12 that as ways to expand the level of services out
13 there.
14 COMMISSIONER MEEKS: And just one more
15 question about the local, and then I've got another
16 question for you. You know, the Emergency Medical
17 Services, you know, I know most of them are
18 contracted out. You know, I think for instance, the
19 man whose funeral is today. It just seems to me
20 that there could be some sort of an emergency
21 mechanism at the local level. I mean, heart attacks
22 can be treated. I mean, they didn't even have a
23 paddle in the ambulance and didn't administer oxygen
24 to him. I mean, why that couldn't have been done at
25 the clinic there even?

1 I just think that that is an important
2 issue that causes so much grief for so many people.
3 Okay. So then the other issue, I know
4 that IHS is restructuring, the One HHS Initiative.
5 And it's a streamline operation and I think there's
6 been some concern about that. I think Senator
7 Campbell stated some concerns. And it was that he
8 thought that, you know, when Indian programs got
9 folded into other programs, that a lot of times the
10 resources somehow disappeared.
11 And how do you think IHS is going to be
12 effected by this One HHS Initiative?
13 DR. GRIM: I was there that day Senator
14 Campbell made those comments on several occasions
15 about the One HHS Initiative. What I would say to
16 that is that there are varying components to that
17 One HHS Initiative, too. One of them is what I
18 mentioned, the Intradepartmental Council on Native
19 American Affairs. It has seen many, many good
20 things coming out of it for Indian people.
21 The issue that tribal leaders and that
22 Senator Campbell were focusing on at that particular
23 time at that hearing was the human resources
24 consolidation within the Department. When Secretary
25 Thompson came in, he saw the number of personnel

1 offices across the department that people had to
2 access to have to apply for a job within Health and
3 Human Services and said "That's ridiculous for the
4 population. We need to cut that down." Initially he
5 saw 40 different personnel centers and he wanted to
6 limit it to four HR centers across HHS so that the
7 general populous could access jobs and things easier
8 within the Department.
9 The concept of that, I think, is a very
10 sound one. It makes sense, it saves administrative
11 dollars, it makes it easier on people wanting to
12 apply for jobs. And I and my staff have gone to all
13 the meetings on that particular consolidation. We
14 have brought the issues that are specific to Indian
15 Country. And we've been refining how Indian Country
16 will participate in that particular initiative.
17 Initially all the people were going to
18 be transferred to Baltimore. The change was that we
19 were going now going to leave all of our human
20 resources people in the field, where they were in
21 our regional offices or out in our hospitals, our
22 larger hospitals and clinics.
23 We thought at one point in that process
24 that our employees might lose Indian preference.
25 We've worked out a process with the Department so

1 that Indian preference will not be lost to the
2 people that are working within the HR program.
3 And I guess what I'm trying to say with
4 several examples is that we continue to work with
5 the Department to try to get the best out of the
6 concept of these processes while still ensuring the
7 integrity and the services to Indian Country and to
8 our system, are not going to be damaged. And I feel
9 confident that we're meeting those goals right now.
10 COMMISSIONER MEEKS: Yesterday we heard
11 some testimony, it was actually a social worker, I
12 believe. And he said I just feel like Indian Health
13 Service is never going to be able to provide what
14 the Indian community really needs. And he sort of
15 posed this universal health care or single plan. And
16 I just wondered if Norman or Michael had any
17 reaction to that, any thoughts about that? Or,
18 actually, I'd like to hear from both of you.
19 MR. RATION: A universal health care
20 card or plan of some sort, I think we would have to
21 look at where the original dollars are going to.
22 Are they going to stay in the same agency? Will
23 they rebuilt to that same agency, or will they be
24 put into a bigger agency where there's a potential
25 of maybe some of the funding being lost or some of

1 it being used for other kinds of purposes. But I
2 think that that might be one way that some of the
3 health concerns might be reached and it might make
4 it easier for both on reservation/off reservation
5 Indian to access to health care. But I think it
6 would take some study and some putting together in
7 terms of how it would finally look at the end. But
8 it may be a better way of providing health services.
9 MR. BIRD: Obviously, there are a lot of
10 legal questions about how that would be played out.
11
12 I think one of the fascinating things is
13 the number of tribes that have contracted their
14 programs and their services. Because, at least my
15 understanding, is many of them want control over
16 their own programs and their services. And I think
17 part of that comes a frustration with what they see
18 as a bureaucratic system that is not responsive to
19 their needs. And in that sense, I think having that
20 kind of control is important.
21 The issue, again, always goes back to
22 not being resourced. And in light of the fact that
23 there are 44 million people in this country without
24 health insurance and not to mention the working
25 poor, sort of our issues is Indian people. And then

1 the ongoing war against terror and the deficit and
2 the fact the economy is, excuse my language, in the
3 toilet. And, you know, and will have a single payer
4 plan, but this country -- I mean, it's not working.
5 There are executives in managed care programs that
6 are making millions of dollars and people are
7 getting denied services and are not being taken care
8 of. And we will have managed care.
9 I think it's really up to the tribes to
10 really look at all the options that are potentially
11 available to them and what's really going to work
12 for their people and their community. And maybe it
13 is a single payer plan that if it comes out. It
14 will be real interesting to see how that unfolds.
15 Because I think eventually this country will move to
16 that.
17 But it was Winston Churchill that says
18 about this country, he said "The Americans are great
19 at doing the right thing after they've exhausted
20 every other possibility."
21 COMMISSIONER MEEKS: There's so many
22 more things that I could ask.
23 MR. BIRD: Can I just add one thing?
24 COMMISSIONER MEEKS: Yes.
25 MR. BIRD: When I was President of the

1 American Public Health Association, they dedicated a
2 journal to indigenous health for 2002, it was a
3 specific issue that I'm happy to say that the first
4 time in the history of the American Public Health
5 Association that they dedicated a journal specific
6 to indigenous health, global indigenous health. And
7 as well as another publication that I was involved
8 in entitled "Eliminating Health Disparities:
9 Conversations with American Indian and Alaska
10 Natives," which was a way of attempting to give
11 people a story. Because one of the problems again
12 in this country and not just in IHS. IHS, it's a
13 very small fish in a much larger pool. It is
14 important to Indian people when you look at funding
15 for a CDC, you look at the funding for HRSA, you
16 look at the funding for all these other entities,
17 it's Indian people who are really invisible.
18 There's a tendency to go towards where the larger
19 populations, African American, Latino, urban based
20 populations. There's a natural sort of movement in
21 that direction so when it comes to dealing with
22 Indian populations, my experience has been three
23 things. You get three responses when you're an
24 Indian dealing with another non-IHS entity.
25 One is you explain what the issues are

1 for American Indian populations and people
2 acknowledge it, recognize it and want to do
3 something and will work with you. That's about a
4 third.
5 The second third got reinvented by Al
6 Gore and the downsizing of all government, and they
7 kind of go, oh, you know, I've got too much. I
8 can't deal with this. I'm dealing with everything
9 else. And IHS employees feel that way, too, I'm
10 sure.
11 The third population goes oh, my God, we
12 had to deal with African Americans, Hispanics and
13 everybody else, now we've got to deal with the
14 Indians. And they're not as open or as ready or as
15 willing to work at addressing the needs of our
16 communities. And that is a very real issue.
17 It is extremely frustrating, having been
18 in government, and now in the non-profit sector for
19 three years. When you talk about faith-based
20 initiatives, if you're in the non-profit arena, how
21 do you get by? A lot of faith.
22 CHAIRPERSON BERRY: Let me just say that
23 we're going to close this particular session. But
24 let me just say that the problems, they are a subset
25 of the overall problem of access to medical

1 resources of the 44 million folks you talked about
2 that don't have health insurance, and we don't seem
3 to be doing anything about either. And then we do
4 have some of this, let the groups go fight each
5 other kind of stuff; the urban Indians as opposed to
6 the people on the reservations and under-resourcing
7 the urbans whose numbers are increasing enormously.
8 And we do have the IHS in some sense feeling
9 embattled and the people who operate it and run it
10 being constrained by bureaucracy so that they don't
11 scream, I suppose, the people at the top who are
12 aware of these problems as we are.
13 And so we're going to continue this.
14 This has been a very interesting discussion, very
15 enlightening. We're going to take a break here.
16 And then we're going to continue this discussion.
17 But we've changed the time. We're going to start
18 again at 12:15 so that we have more time. We're
19 just going to break here for about half an hour.
20 So I want to thank you very much. I
21 thank the panels.
22 And if there are members of the media
23 who would like me to answer some questions, you can
24 come up now over in this corner, and I'll be pleased
25 to answer any questions now for a few minutes.

1 (Whereupon, at 11:45 a.m. the briefing
2 was adjourned, to reconvene this same day at 12:25
3 p.m.)
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1 A-F-T-E-R--N-O-O-N S-E-S-S-I-O-N

2 12:25 p.m.

3 CHAIRPERSON BERRY: The U.S. Commission

4 on Civil Rights will reconvene.

5 PANEL THREE: CAUSES OF DISPARITIES -

6 QUALITY OF HEALTH CARE PROVIDED

7 CHAIRPERSON BERRY: And our

8 panelists are Mr. Charles Mowll, who is the

9 Executive Vice President for Business Development,

10 Government and External Relations at the Joint

11 Commission on Accreditation of Health Care

12 Organizations. Yes, I've been looking forward to

13 seeing you.

14 He's called upon to provide testimony on

15 patient safety and quality of care issues. The

16 Commission, their job is to maintain and improve

17 patient safety and quality of care in hospitals and

18 other health care settings.

19 Mr. Mowll was educated at the University

20 of Delaware and Widener University. And at the

21 Robert Wood Johnson Medical School, Rutgers

22 University. And he is a fellow in the Healthcare

23 Financial Management Association, and the American

24 College of Healthcare Executives.

25 And I have also somewhere, I don't see

1 anything on Dr. Olson. And I know Dr. Olson is
2 here, because I'm looking right at him. Here it is.
3 Dr. Richard Olson, who has been here all
4 morning, if I'm not mistaken, has been the Director
5 of the Office of Clinical and Preventive Services at
6 IHS headquarters for the past 20 months. As the
7 Director, he oversees budgets and policy development
8 and program implementation for IHS health programs,
9 including Contract Health Services.
10 He was educated in medicine at
11 Vanderbilt University in Nashville, Tennessee, where
12 I'm from. And completed his internship and one year
13 residency at Parkland Memorial Hospital in Dallas,
14 Texas. He is board certified in internal medicine
15 and also has an MPH with an emphasis in health care
16 administration.
17 He has spent 29 years with the Indian
18 Health Service. He's been at a lot of places and is
19 very knowledgeable, of course, about all the issues
20 that relate to this subject.
21 I want to begin this with Dr. Olson, if
22 you would please, and you have -- the time will be
23 kept by this clock that I have up here, and you have
24 15 minutes for your presentation and then we will
25 have representations and questions.

1 So could you please proceed, Dr. Olson?

2 DR. OLSON: I was watching your clock

3 for other folks.

4 Good afternoon. I'll discuss this

5 afternoon the quality of health care provided to

6 American Indian and Alaska Natives. We've had a

7 fair amount of discussion this morning about

8 available resources or maybe lack thereof, but

9 within available resources we feel that the Indian

10 health system, which includes IHS, Tribal and Urban

11 programs does provide high quality health care

12 services.

13 One of the main reasons for this is that

14 the IHS organizes health care differently from other

15 providers of care. IHS is really the only system of

16 care in the United States, which integrates both

17 individual health care and community health services

18 to any large degree.

19 In addition, the IHS strives to provide

20 a full array of ambulatory care services at one

21 location, a one-stop shopping concept.

22 At our hospitals and health centers the

23 IHS or tribes provide dental, medical, optometric,

24 mental health, audiology, physical therapy and in

25 some locations, podiatric care in addition to a full

1 array of ancillary services including pharmacy,
2 laboratory and x-ray.
3 As Dr. Grim mentioned this morning,
4 besides providing for these usual acute and chronic
5 individual health care services, the IHS also
6 provides a full array of community health, public
7 health services. These include sanitation facilities
8 construction of water systems and sewer systems, and
9 a little bit of solid waste, community or public
10 health nursing, community health representatives,
11 public health nutrition, health education, medical
12 social services, alcohol and substance abuse
13 services, emergency medical services and
14 epidemiology.
15 Most of these services are integrated at
16 the local level because of co-location and because
17 of an integrated currently paper based patient
18 medical record and an electronic data system which
19 contains patient clinical information which is
20 gathered from most of these providers and available
21 to these array of providers.
22 In addition, slightly over one half of
23 the IHS program, is administered directly by the
24 tribes which allows an even greater degree of
25 integration at the community level, particularly

1 with non-health related social services programs.

2 The end result is almost a complete

3 array of integrated individual and community health

4 services. So from an individual's viewpoint, the

5 IHS and tribal programs strive to provide one-stop

6 shopping for health services. As I think was

7 pointed out this morning, there are economies of

8 scale issues. Obviously, with very small populations

9 this full array of services may not be available

10 locally, but at the larger locations, what we call

11 health centers which are 40 hour a week or greater

12 and the 49 hospitals this array of services is

13 generally available.

14 As we talked about this morning some,

15 there are limitations because of capacity, the

16 demand for services at the local level, naturally,

17 relates to emergency and other acute care.

18 Decisions are made frequently in favor of providing

19 acute care, trauma, heart attacks, cancer, things

20 like that at the expense of prevention and community

21 focus services. And this is unfortunate.

22 I was the clinical director or medical

23 director at a hospital in eastern Oklahoma for 10

24 years. And there was always discussion about

25 needing more emergency room services, more acute

1 care services, but nobody ever demands prevention
2 services unless a problem arises. And I think
3 everybody's aware that there's a real need for
4 prevention services.
5 Another specific organizational or
6 structural component of Indian health programs that
7 greatly improves the quality of care and patient
8 safety in the Indian Health system is the pharmacy
9 system. And this is one of the systems that I've
10 been most vocally proud of ever since I came into
11 the Indian Health Service, over 29 years ago.
12 Except for the very smallest clinics, pharmacy
13 services are provided on site in our hospitals and
14 health centers. Pharmacists have access to the
15 patient's entire medical record, including
16 laboratory results, problem list, immunization
17 status, past medical history, drug allergies,
18 etcetera, so that they can provide appropriate drug
19 therapy to the individual patient that they are
20 seeing. This situation is in contrast to what's
21 seen in most pharmacy services in the United States
22 where pharmacists have almost no information on the
23 patients that they're seeing and are filling
24 prescriptions from a small piece of paper which they
25 may have difficulty in reading.

1 Problems are resolved between the
2 pharmacists and the Indian Health Service or Tribal
3 providers on site, because they know each other,
4 they're just down the hall from each other. They
5 have the same information and issues can be easily
6 resolved, which is not necessarily the case in the
7 rest of the United States.
8 Also, one of the things that we do, and
9 particularly in all of our new facilities, we have
10 counseling rooms for the pharmacists to take the
11 patient into to be able to explain things concerning
12 their medications, possible side effects, things to
13 look for, etc. And the patient is free and able to
14 ask questions. Once again, this is very different
15 from most of the United States.
16 I get my medication down at the Navy,
17 and it's a standup counter with 70 or 80 people
18 right behind me. There's no instructions. I don't
19 talk to a pharmacist at all. I talk to a pharmacy
20 tech and I get my little bottle of pills. And that's
21 the state in most of the United States. But that's
22 not the case in Indian health. So this greatly
23 improves the quality of patient care as well as
24 patient safety.
25 Another area that we're moving towards

1 now is electronic medical record. I understand that
2 you all saw the record room at Gallup Indian Medical
3 Center yesterday, which is probably fairly similar
4 to most medical record departments in the United
5 States. A huge number of charts, very small space.
6 But we are moving towards developing electronic
7 medical records.
8 There's been a pilot project for the
9 last year or year and a half that Crow Indian
10 Hospital in Montana using components of the Veterans
11 Administration computerized patient record system
12 with a GUI or graphical user interface screen. And
13 over the past several months we've been working on
14 developing programs so that this now can be beta
15 tested in about five locations. We'll start in late
16 winter or early spring. So we are moving forward.
17 The IHS and the VA clinical applications
18 are very similar. The IHS system basically was
19 adopted from the VA many, many years ago. So we have
20 the same basic platform. We utilized a lot of the
21 VA's software originally and then modified it for
22 our use. The VA has used some of our software.
23 Obviously, we have a lot more interest in women's
24 health and MCH issues than the VA has traditionally.
25 So they utilized some of our software development

1 as well.

2 So we're working very closely with the
3 VA to implement an electronic health record. They,
4 obviously, have a lot of resources and have put a
5 lot of resources into developing and electronic
6 health record.

7 Dr. Grim talked some about cultural
8 competence, and I just wanted to touch on that,
9 because that obviously is another aspect of quality
10 of care. It is the policy of IHS to facilitate the
11 access to traditional American Indian and Alaska
12 Native medicine practice in all of its service
13 delivery locations. We work hard to protect the
14 rights of American Indian and Alaska Native people
15 in their beliefs and their health practices as
16 defined by their own tribal or village traditional
17 culture.

18 As it was mentioned earlier when we
19 design new facilities now, particularly for the
20 hospitals, we have spiritual -- we have meditation
21 type rooms or spiritual rooms and use the local
22 traditional healers to help design these so that
23 they are meaningful and correct for that individual
24 location.

25 As Dr. Grim I think mentioned also, the

1 issue of English, dealing with patients with limited
2 English proficiency since many of our providers are
3 non-natives, physicians and dentists in particular.
4 At most of our locations, as he talked about, most
5 of the staff is native. I worked in Oklahoma, for
6 11 years and we dealt mainly with the Cherokees and
7 Creeks. And we had many, many nurses in particular
8 who were bilingual, very bilingual and they could
9 interpret if a patient's family was not available to
10 help. So even though interpretation is not
11 necessarily the best, we certainly work on that all
12 the time. Because of our staff capabilities at the
13 local level, things work very well in that arena.
14 Accreditation by nationally recognized
15 organizations is another measure of quality of
16 services. All of IHS and Tribal hospital are Joint
17 Commission accredited except for one, which decided
18 to undergo certification by the Centers for Medicare
19 and Medicaid Services.
20 In addition, all of the IHS and some of
21 the tribal health centers, which are large enough to
22 be accredited are accredited either by the Joint
23 Commission or by the Accreditation Association for
24 Ambulatory Health Care, the AAAHC.
25 We've had a policy in place for over 20

1 years that all of our facilities must be accredited.
2 That's normal business for large and urban
3 facilities, but is not necessarily the case for
4 small, rural locations, like ours are. And so it's
5 a higher standard.
6 Also, many small medical group practices
7 in the United States don't have an accreditation
8 process. Because we require a formal medical staff
9 at all of our health centers, we have systems in
10 place that are higher standard than is usual in the
11 United States as well. Our laboratories at all of
12 our facilities are accredited either by the Joint
13 Commission, by the College of American Pathologists,
14 CAP, or by COLA, all recognized lab accreditation
15 organizations.
16 There are, obviously, challenges as
17 we've talked about this morning. One is the high
18 vacancy rate, particularly in dentistry. Dr. Grim
19 gave a range of vacancy in dentistry, it's 22 to 24
20 percent range. So it's by far the highest vacancy
21 rate for a profession.
22 To deal with this, as he talked about
23 some, we do have loan repayment programs; we have
24 scholarship programs. We also hire temporary
25 providers to help meet the acute health care needs.

1 Temporary providers, even if their skills are
2 outstanding, obviously don't know the patients, they
3 don't know the culture, they don't know our system
4 of care and they're usually not available for follow
5 up for patient care. So that, unfortunately, causes
6 difficulty.
7 I guess the one good news is that
8 longevity of our providers has been increasing
9 significantly. When I came in, in the '70s, right at
10 the tail end of the Vietnam era, almost everybody
11 was there for a 2-year rotation and then left, which
12 meant we had almost a 50 percent turnover every
13 year. And the average longevity was 2 or 2½ years
14 for physicians, at least. The average longevity now
15 is in about the 9-year range for physicians. So
16 things are better as far as turnover. But we still
17 have high vacancy rates and we still have turnover,
18 particularly the folks who have been here 2 or 3
19 years and then leave. So there may be a steady pool
20 of leadership at a lot of locations who may have
21 been there for a long time, but there are other
22 providers that come and go fairly frequently.
23 So I'll stop there. And that concludes
24 my comments.
25 CHAIRPERSON BERRY: All right. Thank you

1 very much.

2 Mr. Mowll, please.

3 MR. MOWLL: Thank you. Madam Chair,

4 members of the Commission, good afternoon. I hope

5 you have copies of my testimony. I brought it with

6 me and you should have that by now.

7 My name is Chuck Mowll, Executive Vice

8 President of the Joint Commission on Accreditation

9 of HealthCare Organizations. Maybe one of the

10 organizations with the longest names in the United

11 States. It has 18 syllables. It can beat anything

12 that the Indian Health Service can put up in lights.

13 We are pleased to have the opportunity

14 to describe the Joint Commission's accreditation

15 process and our experience in accrediting the Indian

16 Health Service health care organizations.

17 The Joint Commission is the nation's

18 oldest and largest health care accrediting body. We

19 currently accredit 17,000 organizations, including

20 83 percent of the nation's hospitals.

21 The Joint Commission was established

22 about 50 years ago. It is a private sector

23 501(c)(3) not for profit organization. We're often

24 confused as a governmental agency. We're not. We

25 are a private sector voluntary organization. And

1 organizations, like the facilities in the Indian
2 Health Service, elect to go through Joint Commission
3 accreditation voluntarily. They do have options.
4 The Joint Commission's mission is to
5 continuously improve the quality and safety of care
6 provided to the public through the provision of
7 health care accreditation and related services that
8 support performance improvement in health care
9 organizations. And the member organizations are the
10 American Medical Association, the American Hospital
11 Association, American College of Surgeons, the
12 American College of Physicians and the American
13 Dental Association.
14 In addition to hospital, the Joint
15 Commission accredits ambulatory, behavioral, home
16 care, long term care and laboratory organizations.
17 That includes 49 hospitals in the IHS system, 540
18 health clinics, 43 residential treatment centers, a
19 few critical access hospitals and some of their
20 clinical laboratories.
21 The Joint Commission's two principle
22 activities are to maintain national state-of-the-art
23 standards for health care quality and safety and to
24 evaluate health care organization compliance with
25 those standards through the administration of an

1 accreditation process. It is our accreditation or
2 independent evaluation, if you will, of Indian
3 Health Service facilities that is, obviously, of
4 interest to this Commission.
5 It is important to understand the scope
6 and focus of our standards because I'll in a moment
7 talk about Indian Health Service facility compliance
8 with those standards, and in a number of areas.
9 The Joint Commission standards were
10 developed through an open process of public comment,
11 are continuously being updated to represent the
12 things that health care organizations must do to
13 provide safe and high quality care.
14 The Joint Commission develops new
15 standards in response to stresses on the health care
16 system that threaten the provision of high quality
17 care. Most recently, obviously, the shortage of
18 nurses and in patient safety in emergency
19 preparedness, restraint and seclusion, pain
20 management and how you care, making sure that the
21 patients experiencing the health care system is pain
22 free.
23 We're currently developing and enhancing
24 standards to address infection control. We know
25 from the Center of Disease Control that infection

1 control is needlessly -- injury in health care
2 organizations is needlessly harming and killing
3 thousands of patients each year.
4 And the management of patient flow.
5 That's a disguised word for making sure that our
6 emergency rooms and access to care is efficient and
7 is assured to reduce waiting times, to assure the
8 timely transfer to needed services and to reduce
9 delays in treatment which we know from our
10 experience of reviewing adverse or sentinel events,
11 is a major cause of adverse events. And that is
12 delay of treatment.
13 Joint Commission standards were recently
14 subjected to a thorough and comprehensive review to
15 ensure their continued relevance and contribution to
16 safe high quality care. The Joint Commission
17 utilizes groups of health care experts to develop
18 new standards, and all new proposed standards are
19 submitted to the health care field for field review
20 and issued for public comment before they're finally
21 adopted.
22 Hospital standards cover important
23 issues such as the competency and credentialing of
24 staff. This is important when you employ 900
25 physicians and 2600 nurses in the system that

1 they're constantly monitoring the competency and
2 credentialing and privileging of those staff, our
3 standards require that.

4 Utilization of performance improvement
5 strategies to examine variation in patient care
6 processes using such techniques as failure mode and
7 effects analysis and root cause analysis to
8 understand why there are variations in care, to have
9 a systematic performance improvement strategy to
10 eliminate those negative variations and to improve
11 the care provided to the Native American population.

12 The standards cover important issues
13 such as patient rights, employing ethical practices,
14 involving patients in the decisions about their care
15 and ensuring that the environment of care is safe.
16 Special emphasis is placed in the standards on
17 maintaining a safe medication management system, and
18 we know from our data at the Joint Commission
19 reported from hospitals around the country that it
20 is the administration of pharmaceuticals that is
21 often a major source of error and sentinel events.

22 In providing access and equitable care
23 to all patients requiring care, we have a standard
24 that requires that the same standard of care be
25 given to all patients seeking care. And that there

1 not be discrimination for any reason.

2 And the standards require that the

3 organizations that we accredit must thoroughly

4 access the patient's medical needs upon entry into

5 the system and assure that the appropriate care and

6 services are provided to that patient.

7 The accreditation process is then

8 carried out to analyze the organization's compliance

9 with these rigorous standards. We conduct those on

10 site reviews with a team of surveyors that are

11 usually comprised of a physician, a nurse, and a

12 hospital administrator. And these surveys can vary

13 in length from, depending on the size of the

14 organization or complexity of its services, anywhere

15 from 2 to 3 days to 4 or 5 or 6 days.

16 The Joint Commission also requires that

17 the hospital measure on a monthly basis and report

18 to the Joint Commission quarterly a core set of

19 performance measures. This is moving the evaluation

20 process from just looking at the ability or the

21 structure and process of providing care, to the

22 actual performance of care and the outcomes of care.

23 And the Joint Commission is the first in the world

24 to do that.

25 We call our system the Oryx reporting

1 system. It doesn't mean anything other than, I
2 understand an oryx is a fleeting gazelle, and there
3 happens to be one in the San Diego Zoo. But that
4 name for no other reason than it's a creative, new
5 evolution of the accreditation process about 3 years
6 ago.
7 Performance measurement is an integral
8 part of our oversight of the Indian Health Service
9 and their reporting of outcomes to us.
10 Hospitals choose measures from four
11 measure sets. Those include acute myocardial
12 infarction, heart failure, community acquired
13 pneumonia, and pregnancy and related conditions.
14 Accredited organizations must also comply with the
15 Joint Commission's National Patient Safety Goals and
16 associated requirements. Again, we're the first to
17 do this. We have studied our data, the data that's
18 been reported to us. We've issued lessons learned
19 to the field, much like the aviation industry has
20 done for many years, to help all hospitals and all
21 primary care givers to understand the things that
22 lead to error, to learn from other organizations
23 success stories and best practices to prevent error
24 and adverse events from occurring in the future. And
25 we've had some very good success in that, but a long

1 way to go.

2 As a health care system, National

3 Patient Safety Goals address things as simple as

4 making sure that you have the right patient in front

5 of you. Amazingly patient identification is a huge

6 challenge in the health care system.

7 Communication among the care giving team.

8 Wrong site, wrong procedure, or wrong person surgery

9 is one of our highest recorded sentinel events in

10 this country and should never occur. It does occur

11 at all too frequent levels. We've just issued or

12 going to require all hospitals we accredit to follow

13 universal protocols to make sure they have the right

14 patient in front of them and that they take a time

15 out, and that they are performing the right

16 procedure in the future. Again, something you would

17 think would be fundamental in the health care

18 system, it does not exist today.

19 VICE CHAIRMAN REYNOSO: It seems pretty

20 fundamental to be operating on the right person.

21 MR. MOWLL: You would think. Be

22 careful.

23 Those procedures require the marking of

24 the site, for instance. All too often the wrong

25 site is operated on for laterality issues.

1 The Joint Commission has announced it
2 will also be conducting all on site surveys on an
3 unannounced basis beginning in 2006. One of the
4 criticisms of our process is that organizations know
5 when we're coming and prepare for the Joint
6 Commission survey. Although we do conduct 5 percent
7 of all our surveys on a random unannounced survey
8 basis today, we are going to be conducting all
9 surveys on an unannounced basis in 2 years. And
10 hospitals may volunteer for unannounced surveys over
11 the next 2 years to get used to the process.
12 The Joint Commission also has a strong
13 commitment to public accountability in providing
14 meaningful information to the public about its
15 accreditation of health care organizations.
16 Detailed information about the results of Joint
17 Commission accreditation of health care
18 organizations can be found on the Joint Commission's
19 website at jcaho.org under Quality Check.
20 Organization's specific performance reports provide
21 detailed information about the organization's
22 compliance with the Joint Commission's now 250
23 standards for the hospital program. Beginning in
24 2004 revised performance reports called Quality
25 Reports will be substantially modified and enhanced

1 to contain information about the organization's
2 compliance with these National Patient Safety Goals,
3 National Quality Improvement Goals; those are the
4 measures I talked about earlier, performance measure
5 outcomes, as well as the organization's overall
6 accreditation status.

7 The Joint Commission also maintains, and
8 I was particularly concerned about Mr. Jack's
9 comments this morning about inadequacies of the
10 system. We also provide and maintain an active
11 complaint hotline. It's 1-800-994-6610. 1-800-994-
12 6610. And that is posted on every accreditation
13 certificate that we issue and hanging on the walls
14 in the organizations we accredit. We actively
15 promote that complaint hotline on our website and we
16 require every health care organization we accredit
17 to notify its community of an impending onsite
18 survey so that they have the opportunity to either
19 call us or talk to our surveyors in person.

20 Now, about the IHS system, very quickly.
21 The IHS has had a longstanding commitment to
22 requiring its hospitals and other health care
23 organizations to seek and maintain Joint Commission
24 accreditation. The Joint Commission accredits
25 hospitals, as I mentioned earlier, ambulatory

1 facilities, laboratories and residential treatment
2 centers in the system.
3 In the most recent full year of
4 accreditation activity, that's last year 2002, the
5 Joint Commission accredited 32 Indian Health Service
6 facilities. The names of these facilities, their
7 addresses and their accreditation scores are
8 provided as Attachment A to this testimony.
9 Indian Health Service facilities have
10 over time demonstrated a high degree of compliance
11 with Joint Commission standards. The average score
12 for the 32 organizations accredited last year is
13 94.4 percent; that's on a range of zero to 100
14 percent. The scores range from a low of 82 percent
15 to a high of 100 percent in 3 organizations.
16 The average score of the Indian Health
17 Service organizations compare favorably with the
18 average score of all Joint Commission accredited
19 health care organizations around the world, which is
20 92.4 percent. So it's two full percentage points
21 higher than the hospitals in Boston, Philadelphia,
22 Chicago, and Los Angeles.
23 Joint Commission surveyors approach
24 Indian Health Service facilities with an
25 understanding and sensitivity to the culture

1 differences of the facilities and the patients they
2 serve. Of particular note is the surveyor's
3 assessment of the organization's approach to end of
4 life care, the advance directives, and the conduct
5 of post-mortem examinations. It is the Joint
6 Commission's observation of Indian Health Service
7 facilities generally have identified and are
8 attempting to address within budgetary restraints
9 the health needs of the Native Americans served.
10 These programs include maternal and child health,
11 the immunization programs, cancer prevention and
12 women's health care.
13 The Indian Health Service also seems to
14 have a strong commitment to community outreach,
15 working with the tribal councils and tribal
16 communities to identify their health needs and
17 populations served and to design their programs
18 around those needs. And our standards require that
19 as well.
20 I'll just conclude by saying that we
21 have those detailed performance reports on any of
22 the Indian Health Service facilities that we
23 accredit available on our website if you want to see
24 the details. And I'll be pleased to address any of
25 the questions you might have.

1 Thank you.

2 CHAIRPERSON BERRY: Thank you very much.

3 Let me welcome you, Mr. Anslem
4 Roanhorse, Jr., who is a member of the Navajo
5 Nation, and he's the Executive Director of the
6 Navajo Division of Health where he oversees the
7 tribal health divisions. He has about 1,000 people
8 working there, serving a population of 210,000 and
9 an annual budget of more than $65 million. He has
10 also worked for third party providers in various
11 other jobs.

12 He has received his education at the
13 University of Arizona, where he got his bachelor's
14 degree in sociology and a master's degree in social
15 work from Arizona State University.

16 Welcome to you, Mr. Roanhorse. And the
17 clock will time your presentation, but please
18 proceed. You get about 10 to 15 minutes

19 MR. ROANHORSE: Madam Chairperson,
20 members of the Commission, thank you for allowing me
21 to speak before you and give my presentation.

22 My name is Anslem Roanhorse. I'm the
23 Executive Director for Navajo Nation Division of
24 Health. And I'm honored to present on behalf of
25 Navajo Nation.

1 I would like to just give you some
2 background information about the Navajo Nation. The
3 Navajo Nation is the largest land-based American
4 Indian tribe covering an area of 26,649 square
5 miles, which is equal to the state of West Virginia.
6 The Navajo boundary expanding into three states,
7 covering the state of Arizona, New Mexico and Utah
8 and it also covers 13 counties and three different
9 federal regions, including region 6, region 8 and
10 region 9. And then because the location of Navajo
11 Nation, this presents several issues for us when we
12 start dealing with federal funds and state funds.
13 And some of the information that I would
14 like to share with you is that conditions on the
15 Navajo Nation include 56 percent of the people live
16 below the poverty level. The per capita income is
17 $7,269. The unemployment rate is 43 percent. And
18 over 50 percent of the households rely on wood
19 burning for heating fuel. Thirty-two percent of the
20 homes lack complete plumbing. Sixty percent of the
21 homes lack telephone service. Seventy-eight percent
22 of the public roads are unpaved. And then 75
23 percent of the Navajo people speak the language at
24 home.
25 So I think this is very important

1 information that I would like to use this as the
2 basis for my presentation. And then I should also
3 add that the Navajo Nation has a rich culture and
4 many continue to carry on the traditional lifestyle.
5 The Navajo Division of Health, we
6 provide many different health care related services
7 from infants, adolescents, children, and adults to
8 the elderly and their families and all throughout
9 the 110 chapters.
10 The Indian Health Service is the primary
11 health care provider of the Navajo Nation. The
12 Navajo Indian Health Service is responsible for
13 providing health care services to more than 200,000
14 patients. In fiscal year 2003 the Navajo area
15 budget amounted to over $500 million, the majority
16 of which was appropriation totaling 391,000 from the
17 Congress and the remaining $143 million came from
18 third party including Medicare, Medicaid and
19 Children's Health Insurance and also private
20 insurance.
21 The Navajos and the Native Americans
22 that are served by the Navajo Nation Health Services
23 have experienced disparities in Indian health care
24 with funding and other resources for many decades.
25 This condition is contrary to the federal

1 government's trust responsibility to deliver and
2 fund health care services to the American Indian and
3 Alaska Natives based on treaties and subsequent
4 legislations and the goal of eliminating the racial
5 disparities in health care. Although the IHS is
6 severely under funded, the Navajo Indian Health
7 Services has made strides in improving the health
8 care conditions in certain areas.
9 Some of the information I would just
10 quickly highlight for you versus the general U.S.
11 population. For all death for Navajo, it's 628.9,
12 while the U.S. rate is 479.1. For diabetes death the
13 rate on Navajo is 35.9, while the U.S. rate is at
14 13.5. The cervical cancer death for Navajo is 4.6,
15 while the U.S. rate is at 2.5. The alcohol related
16 death for Navajo is 49.8, while the U.S. rate is at
17 6.3. Suicide deaths for Navajo is 16.8, while the
18 U.S. rate is 10.6.
19 So that's the information. I think it's
20 also very key in understanding my presentation.
21 The Navajo area IHS is funded at around
22 55 percent at the projected total need. And this
23 translates to the fact that only half of what the
24 Navajo area IHS needs for health care services are
25 funded. We think this is unacceptable and it

1 demonstrates a gross inequity of funding for the
2 Navajo health care.
3 Overall, the federal funding for the
4 Indian Health Service has not kept pace with factors
5 such as medical and escalating inflation.
6 Two, the rising costs of health care.
7 The third one is increasing costs of
8 pharmaceuticals.
9 Has not also kept pace with the offering
10 of competitive salaries in the recruitment and
11 retention of qualified health care professionals.
12 These data includes personal medical
13 services and does not include critical areas such as
14 community health and prevention oriented services,
15 which are integral parts of the programs in the
16 health care system. We wonder how can tribes and
17 other partners in health care intervene effectively
18 if the total fund it needs is not considered.
19 With the high rates of alcoholism,
20 homicides, accidents primarily due to alcohol
21 factors, funding must be appropriated to
22 comprehensively address the treatment aspects as
23 well the prevention components. To truly have
24 excellent quality of care, additional funding is
25 much needed on all fronts.

1 Now I would like to just mention some of
2 the -- highlight some of the areas where we see as
3 concerns.
4 The first one, staff recruitment and
5 retention issues. The Navajo health care delivery
6 system is fortunate to have many dedicated doctors,
7 nurses, and other staff who have worked on the
8 reservation for 15 to 20 years, or even more. And
9 these individuals are hard to find. So this means
10 that recruitment and retention of additional health
11 professionals is an area of great concern for the
12 Navajo Nation.
13 Currently the Navajo area is
14 experiencing a nursing shortage with a 25 percent
15 vacancy rate.
16 Another area I would like to mention is
17 behavioral health. Alcoholism is a tremendous
18 problem on the Navajo people, both as a -- and
19 contributed to other problems, such as accidents,
20 mental diseases, problems of pregnancy, homicides,
21 suicides and cirrhosis of the liver. It is
22 estimated that about 9 out of 10 or about 1434
23 Navajo individuals of all ages are affected by
24 alcohol, substance abuse and other related health --
25 that deal with health problems.

1 The Navajo Department of Behavioral
2 Health Services, we provide treatment services,
3 counseling services to about 19,000 patients every
4 year. Information and education on alcohol and
5 substance abuse is provided to about 20,000
6 individuals and families every year, and another
7 14,000 individuals receive prevention, education and
8 treatment, and after care services through contracts
9 with other providers.
10 I'd like to also mention some concerns
11 regarding health care facilities. Currently the
12 Navajo Department of Behavioral Health Service
13 operates two adolescent residential treatment
14 centers. One has 20 beds; the other one has 24
15 beds. We also provide -- operate two adult
16 residential treatment centers and we feel that this
17 is not enough.
18 The Tribal Behavioral Health Services
19 purchased modular buildings with unused prior year
20 service funds. But what we've been told by the
21 federal officials is that this is not permitted, the
22 use of carryover funds for a conventional site,
23 field construction. But we can use these funds to
24 purchase modular buildings.
25 The primary issue we have with the

1 modular units is that they tend to separate and the
2 roofs leak, the walls crack, the doors and the
3 windows jam due to poor foundation systems. And so
4 these are just some of the problems that we feel are
5 associated with the use of modular buildings.
6 Also, the Navajo Nation has accepted
7 several buildings considered access to either the
8 in-house services. These buildings are generally in
9 acceptable conditions, but are very old. And this
10 results in us having to put up some resources in
11 order to make the necessary corrections.
12 Another area that I would like to also
13 mention is the sexually transmitted disease,
14 HIV/AIDS. The Navajo Nation is now challenged with
15 a significant increase in syphilis transmission over
16 the past 2 years. The greatest need for the Navajo
17 Nation right now is funding, getting some funding
18 for dealing with the prevention program. And
19 looking at the past data, this year there has been a
20 high rate of syphilis outbreak that we have to deal
21 with.
22 Also would like to mention the
23 traditional healing. With respect to the sovereignty
24 of the Navajo Nation, discussion of the Navajo
25 health care issues must always include the use of

1 traditional healers as well as conventional
2 medicine. A 1998 study conducted on the Navajo
3 Nation confirms the use of dependence on traditional
4 healers as a continued common occurrence. A cross
5 section of Navajo people were interviewed, about 300
6 patients, and then the results indicated that 69
7 percent had used traditional healers with 39 percent
8 using traditional healers on a regular basis.
9 The use of traditional healers is
10 significant to the Indian Health Service and other
11 health care providers. We feel that we need to
12 always incorporate the use of traditional healers in
13 every segment of our health care delivery system.
14 Further, the Navajo Behavioral Health
15 Services continued to see a steady increase of
16 referrals over the last 5 years. This is partly due
17 to the Navajo traditional treatment expansion
18 project. Part of which was initiated through a 5
19 year grant from the Center for Substance Abuse
20 Treatment. This has helped the tribal behavioral
21 health program establish positions for traditional
22 practitioners at each of our treatment sites and to
23 implement and significantly enhance the expansion of
24 Navajo traditional treatment services.
25 Another area I would like to mention is

1 the trauma system development. Recently the Navajo
2 Nation has begun working on the development of a
3 trauma system development. Presently, after initial
4 care is provided by local hospitals, the majority of
5 critical care patients are transferred to other
6 reservation trauma centers, hospitals located
7 throughout the states of Arizona, New Mexico and
8 Utah. The purpose of the Navajo Nation's initiative
9 is to establish and coordinate within the agencies
10 the capability of identifying facilities on the
11 Navajo Nation that would serve as a level 2 or level
12 3 trauma center.
13 Another area I would like to just
14 briefly mention is the veterans. There are
15 approximately over 11,000 veterans that are now
16 mixed with the Navajo Nation. This means over 200
17 young people from the Navajo Nation are on active
18 status. The Navajo Nation continues to advocate for
19 quality health care for Navajo and all Native
20 American veterans. The nearest veteran hospitals
21 are located in Prescott, Arizona, Albuquerque and
22 Phoenix metropolitan areas. The major problem is
23 transportation to these off reservation hospitals.
24 Due to great distances between the Navajo nation and
25 these health care facilities, there is a definite

1 need to form closer partnerships with the Veterans
2 Administration, state to make these entitlement
3 services accessible to all the Native American
4 veterans.

5 In closing, I would like to say that I
6 really appreciate you allowing me to present this
7 statement before the U.S. Commission on Civil
8 Rights. The Navajo Nation requests that all findings
9 and recommendations from this hearing be included in
10 the report to the United States President and the
11 U.S. Congress. It is very important that the
12 existing health care experience in this country be
13 resolved.

14 Thank you very much.

15 CHAIRPERSON BERRY: Thank you very much,
16 Mr. Roanhorse.

17 Do you have any questions, Vice Chair?
18 You want to start?

19 VICE CHAIRMAN REYNOSO: Oh, my goodness.
20 Let me just ask one or two questions.

21 CHAIRPERSON BERRY: If you want, I can
22 ask a question. Are you ready, do you have a
23 question?

24 VICE CHAIRMAN REYNOSO: I asked the
25 questions last time,

1 CHAIRPERSON BERRY: Okay. Go ahead.
2 COMMISSIONER MEEKS: This is for Dr.
3 Olson. You and Dr. Grim talked about focusing on
4 preventative services or preventative programs. I
5 don't know if that's the same thing. I guess that's
6 your venue.
7 What will this look like at the
8 community level? I mean, what will we start to see
9 in the community that shows that there's more focus
10 on prevention?
11 DR. OLSON: Well, one of the things that
12 we're trying to do is to coordinate and to teach
13 methods at the community level. Last fall we
14 launched, Dr. Grim launched, a new prevention focus,
15 which you know has always been in the Indian Health
16 Service but there hadn't been a whole lot of
17 attention paid to it, at least in a focused way.
18 We've developed a prevention task force,
19 which is a group of experts from around Indian
20 Country dealing with mainly community based
21 prevention type efforts.
22 The other arena is the clinical or
23 hospital based prevention efforts, which we haven't
24 focused quite as much on yet, but will.
25 And then in addition, we have a tribal

1 leaders policy advisory committee that was formed
2 about the beginning of this summer to provide
3 leadership to take the message of prevention to
4 tribal leaders and to help us develop linkages and
5 relationships with other organizations to look for
6 outside resources that we can pour into this.
7 Because, as we've talked about, the demand for acute
8 care services is so large that it's very difficult
9 to shift resources into prevention even though
10 everybody realizes that that's an important area to
11 do. So some of the activities that we're developing
12 is that we're going to have regional forums where we
13 will be inviting community based leaders in
14 prevention. Because there's a lot of folks out
15 there already doing things, but they may be doing
16 things in isolation. They may not know other ideas
17 or issues that other folks are successfully dealing
18 with. And bring folks together to try to build some
19 momentum there. We're going to be developing
20 prevention fellowships over a year period of time
21 where folks will come in for a week or two at a time
22 in an academic setting, and then go back and have a
23 real live project that they're working on during
24 this year fellowship. And then will come back and
25 have experts help them formulate how they're going

1 to market this, how they're going to implement it, 2 how they're going to measure it and this sort of 3 thing.

4 So most of our focus is, as I said, at 5 the grassroots level. The other area is prevention 6 in the clinic and in the hospitals. Because there 7 are a lot of preventive measures that providers can 8 do and already are doing, but what we want to do is 9 get the massage out and have indicators, counting 10 systems to emphasize that so that we can measure: 11 are we doing a good job for colon cancer screening, 12 are we doing a good job with breast cancer 13 screening? So that we can measure these and then 14 systematically improve.

15 Folks who deal with measurement systems 16 frequently say "what gets measured, gets done." And 17 that's what our approach will be at the clinical 18 level.

19 What we hope is that what we see at the 20 clinical level will improve as efforts in the 21 community are ongoing. Because, hopefully, things 22 will get better from a community based approach so 23 that, for example people with cancer are identified 24 earlier in their course.

25 One of the difficulties that we see in

1 cancer here in Indian Country is that the people are
2 diagnosed late in the disease. Part of that may be
3 that folks come in late. And that was mentioned a
4 couple of times this morning. Or providers aren't
5 screening for certain types of preventable diseases
6 early enough.

7 COMMISSIONER MEEKS: And the folks that
8 you'll bring in for the fellowships, who are those
9 folks?

10 DR. OLSON: They being community based
11 folks. This is probably going to start this next
12 spring. We're moving forward with getting these
13 things developed. I'm just about to hire a health
14 promotion disease prevention coordinator at
15 headquarters because we've really not had that
16 function embodied in an office as such. My office
17 is clinical and preventive services, but we don't
18 have a prevention specialist as such. We also don't
19 have a patient safety specialist either. We want to
20 move into patient safety issues as well.

21 COMMISSIONER MEEKS: So at this point it
22 doesn't really look like the funding will go out to
23 start new programs, necessarily, but to strengthen
24 health care that's provided?

25 DR. OLSON: It's to try to foster

1 thinking on prevention and getting the word out at
2 the local level. There are health fairs and those
3 sorts of things that are already are occurring at
4 the community level. And to piggyback on existing
5 efforts to get more prevention efforts going.
6 Getting people into screening for cholesterol, for
7 diabetes. Diabetes is rampant. And what's been said
8 is about a third or a fourth of the people with
9 diabetes don't know they have it. We now have very
10 good clinical evidence that if you start treating
11 diabetes early, you can at least prolong the time
12 before people get complications, possibly prevent
13 certain complications. So it's very important to
14 identify early, just like with high blood pressure.
15 It's important. And if people aren't being seen in
16 the health care system or aren't being screened for
17 those types of things, we see greater morbidity and
18 mortality as a result of that.
19 COMMISSIONER MEEKS: Mr. Mowll, in your
20 testimony you said that your observation of the
21 Indian Health Service facilities are generally --
22 generally have identified and are attempting to
23 address within budgetary constraints the health
24 needs of Native Americans served. Are you seeing --
25 I mean, is there a pretty stark difference between

1 the other hospitals that you accredit and the Indian
2 Health Service as far as the budgetary issues? Are
3 you seeing a lot of constraints? I mean, is it
4 pretty noticeable?
5 MR. MOWLL: I would say they do very
6 well with the budgets that they have been allotted
7 and that, as I have grown to understand, that they
8 have -- our standards really require you cannot
9 perform the service as the facility itself, you must
10 still meet the needs of the patients that are coming
11 to your door. And as I understand it, they're
12 providing that through contractual relations with
13 tertiary care facilities.
14 For instance, in the Phoenix area I
15 believe it's with the University of Arizona so that
16 they can quickly stabilize the patient, access the
17 patient's needs and transfer that patient to the
18 appropriate care setting.
19 So what I think is very impressive to me
20 is that the system has recognized its weaknesses, if
21 you will, and contracted for those services which
22 they can't perform within the rural setting or the
23 settings that they're providing care with those who
24 do have the competency and abilities to provide
25 those more intensive services.

1 I think that, you know, on for instance
2 the preventive care, I'm impressed again in the
3 Phoenix area, the area that I'm most familiar with,
4 that their immunization rates I think far exceed the
5 immunization rates that we're seeing in the rest of
6 the country and the rest of the health care system.
7 In the 80 to 90 percent range.
8 So, there are some pretty impressive
9 efforts to take care of the patients' needs,
10 contrary I think to some of the anecdotal reports
11 that we've heard here this morning.
12 COMMISSIONER MEEKS: So are you focusing
13 your focus on the health care facilities, not just
14 the hospitals?
15 MR. MOWLL: That's correct.
16 COMMISSIONER MEEKS: So the clinics,
17 too? And so, I mean, for instance when we're at
18 Gallup Indian Health Service yesterday, the waiting
19 room was jammed packed. And, I mean, how do you
20 rate that sort of thing?
21 MR. MOWLL: It's an access issue. And as
22 I mentioned before, we're really comprehensively
23 looking at the patient flow problem. This is not a -
24 - I guess an anomaly in the health care system. This
25 is a critical stress on the entire nation's health

1 care system. You can go into emergency rooms in the
2 fanciest hospitals in Los Angeles, for instance.
3 There are specialists working on this issue of
4 overcrowding, particularly in the urgent and
5 emergency settings because the primary -- it's
6 either access, affordability, they can't get primary
7 care. So they're ending up in those clinics. And
8 it's a black eye on the entire health care system.

9 We're trying to work on it in a new set
10 of standards that require organizations; they can't
11 solve the nation's problems on the shortage we
12 heard, 25 percent shortage of nurses in the Navajo
13 Health Care system. But that is a critical issue for
14 all of us to deal with. So we're trying to address
15 the root causes of the problem of getting enough
16 health care workers into the system, and we're just
17 supporting on Capitol Hill the Nurse Reinvestment
18 Act and trying to get more funding into that act.
19 As I understand it, the Senator Mikulski amendment
20 will add $50 more million to try to get more nurses
21 into this health care system and the entire nation's
22 health care system.

23 So we've got to deal with the real root
24 causes of the problem. And then we've got to deal
25 with what the organization can control. And they can

1 control and manage at reducing those waiting lines
2 and delays in treatment by making sure that they
3 have throughput management. In other words, it's
4 engineering science that the health care system has
5 to learn better. How to manage patient flow. If
6 you have a backlog of patients in any one of your
7 entry points, how are you going to resolve that
8 moving forward in your health care system or getting
9 them into a contracted health care system. And then
10 we've got to deal collectively; we've got to deal
11 with some of the root causes of the problem.
12 COMMISSIONER MEEKS: Thank you.
13 CHAIRPERSON BERRY: I have a number of
14 questions.
15 First of all, Dr. Olson, could you tell
16 me, and this addresses some of the points that were
17 made by Mr. Roanhorse, first of all the issue he
18 raised about buildings and the modular buildings and
19 the other facilities. Did you hear that part of his
20 testimony?
21 DR. OLSON: Yes.
22 CHAIRPERSON BERRY: What part of the
23 public health -- I mean the Indian Health Service
24 has responsibility for being able to answer those
25 questions about that?

1 DR. OLSON: Well, we build hospitals and
2 clinics. And as was stated earlier I think in Dr.
3 Perez' opening statement the first thing this
4 morning, is that the average age of our facilities
5 is around 32 years. The oldest facility that we
6 currently have is over 100 years old. It's being
7 replaced right now, a new facility is being built.
8 So how we frequently deal with it is
9 that we put modular buildings in, or bring in
10 trailers because our population continues to grow,
11 and the scope of services continues to grow. We
12 construct hospitals and clinics as Congress
13 appropriates money for us to do so.
14 We currently have a backlog. In 1991 we
15 did a health facilities construction priority
16 listing. And what we did was go out to all of the
17 areas and rank all of the facility needs in the
18 agency, and then took the top 10 or 15 percent, and
19 put them on a list. We're still working on that
20 list from 1991, and currently there's about a
21 billion dollars of yet to be constructed hospitals,
22 clinics or quarters or youth regional treatment
23 centers from that 1991 list.
24 The average appropriation that we
25 receive is probably about $75 to $85 million per

1 year for construction of new facilities.

2 CHAIRPERSON BERRY: So the answer is

3 that they get the modulars because there's no money

4 to do anything else. And if these are not problems

5 that are easily solvable because you don't have the

6 money to solve them? Is that basically it?

7 DR. OLSON: Right. Yes. I was the

8 chief medical officer for the Phoenix area up until

9 about a year and a half or so. And if folks go down

10 to Phoenix, it probably is like Gallup. There must

11 be 30 buildings on that campus. There's the main

12 hospital building that was built about 30, 35 years

13 ago and then modular buildings and trailers in order

14 to accommodate the need.

15 The dental department is 3 trailers that

16 are strung together. Surgery services or ambulatory

17 surgery services are in a very nice modular building

18 that's right adjacent to the hospital. There's

19 primary care modular building for internal medicine

20 and family practice just off the parking lot. And

21 that's way we deal with it because our population

22 and workload continues to grow and we need to meet

23 the need.

24 Frequently the way we fund these now,

25 though, at the local level is through Medicare and

1 Medicaid collections. And so a sizeable amount of
2 our collections go towards expanding temporary type
3 space, temporary in the form of modular buildings.
4 CHAIRPERSON BERRY: The point he raised
5 about HIV and syphilis and prevention, the need for
6 prevention programs. Whose is responsibility is
7 that?
8 DR. OLSON: It seems it's our
9 responsibility. I mean, we've got HIV STD programs
10 available and do within the available resources that
11 we have what we can.
12 CHAIRPERSON BERRY: So if he's
13 complaining that he doesn't have enough resources
14 available and he needs educational programs on sex
15 education programs, then where is he supposed to
16 complain or what's the mechanism for dealing with
17 that?
18 DR. OLSON: Well, the money basically
19 that we have is at the service unit level. It's at
20 the local level, that's what we call service units.
21 And that's where the treatment dollars are. There's
22 no cache of money sitting at IHS headquarters to
23 deal with HIV/AIDS or STDs.
24 CHAIRPERSON BERRY: And do you have a
25 joint initiative with CDC to deal with these

1 problems in the Indian populations?

2 DR. PEREZ: Yes. We work with CDC, we

3 work with HRSA, we work with a variety of the other

4 public health services agencies that have expertise

5 in those areas.

6 CHAIRPERSON BERRY: But there's no

7 allocation of funding to deal with AIDS or STD

8 prevention?

9 DR. OLSON: Well, in our budget the

10 money has been dispersed down to the service unit

11 levels. So it's already there at the service unit

12 level.

13 CHAIRPERSON BERRY: You mean Mr.

14 Roanhorse already has the money?

15 DR. OLSON: Well, he works in the tribe

16 now, so I don't know that the tribe has it.

17 CHAIRPERSON BERRY: You mean the clinics

18 and the hospitals?

19 DR. OLSON: Right. Right.

20 CHAIRPERSON BERRY: So the problem is

21 with the clinics and the hospitals if he's got a

22 problem?

23 DR. OLSON: Well, it's the same issue

24 that we've been talking about all day is where you

25 make your choices and where the stresses are, that's

1 where you put the money.

2 CHAIRPERSON BERRY: Mr. Roanhorse, is
3 that an acceptable answer to your question or could
4 you shed some more light on -- I understand your
5 problem is not with IHS headquarters, it's with the
6 service unit, is that right?

7 MR. ROANHORSE: The problem that we run
8 into is that we're getting lots of cases and what we
9 have been doing, is that the Navajo Nation
10 government, the Navajo Nation Council has
11 appropriated its own funds to fund some of these
12 things.

13 Just recently we have begun to work
14 closer with Indian Health Service, and then have
15 also brought in the county health department
16 personnel along with the state departments, and also
17 have been working closer with the CDC. So we're
18 hoping that we can be able to pull some of these
19 resources together.

20 And then we actually also note that we
21 have just completed the memorandum of agreement with
22 CDC. And then we hope to get 2 physicians that
23 would be given to the Navajo Nation so that we can
24 get some assistance in setting up some protocols and
25 procedures, some policies in dealing with responding

1 to sexual transmitted disease with HIV to syphilis
2 outbreak, and that sort of thing.
3 Another position we hope to get in order
4 to get this position down to the service area, to
5 the front lines, and then also provide some PA in
6 terms of giving our staff and the techniques and
7 then the expertise in how we should be able to
8 address some of these problems.
9 What we are aware of is that the funds
10 are lacking everywhere. And then I also pointed out
11 that we see the need, but Indian Health Service, the
12 appropriation is only less than what we should be
13 getting. And I think we just -- the big picture
14 really is to try to get some real need, which is to
15 get additional appropriation at the highest level.
16 So what results is that if you have X
17 number of funds available to the Indian Health
18 Service and they're doing their best to -- I guess
19 it really comes down to rationing health care. And
20 that's something where you have to set your
21 priorities. Once you decide to fund certain
22 services, then that leaves some other areas
23 unprotected.
24 So in this case I think the Navajo
25 Nation Council has been generous enough to give us

1 some additional funding so where we take
2 responsibility for these services.
3 CHAIRPERSON BERRY: Let me ask you about
4 traditional healing, Dr. Olson. Mr. Roanhorse made
5 a point about, and some of the other witnesses have
6 too, the use of traditional healing and where that
7 fits in to addressing the disease problem.
8 Does the IHS interface with the
9 alternative medicine program in HHS, which is
10 somewhere over there in HHS. There's a new -- well,
11 it's reasonably new, the last few years, program in
12 alternative medicine, which affirmed the viability
13 of looking at an alternative medicine, which was a
14 new departure for the federal health program some
15 years ago, as I recall. And there's an office of
16 alternative medicine.
17 DR. OLSON: I think that's at the NIH.
18 CHAIRPERSON BERRY: Which would have
19 traditional healing under alternative medicine. And
20 I talked to some people over about other issues.
21 And I know that that's what they do.
22 How do the programs that the Indian
23 Health Service is responsible for, the Indian
24 programs, interface on the issue of traditional
25 healing and remedies and approaches and so on with

1 the alternative medicine? Are there opportunities
2 for interface for affirmation or is there some
3 engagement, or do you know?
4 DR. OLSON: Well, I don't know that I
5 can specifically answer that. I am not aware that
6 there is a whole lot of interaction between the IHS
7 and the NIH center.
8 The NIH mainly funds research, and I
9 think a lot of your emphasis is on looking at
10 alternative medicine practices and is there validity
11 from a scientific perspective or not.
12 CHAIRPERSON BERRY: Right. Right.
13 DR. OLSON: And so I think that's what
14 the major issue is.
15 Traditional healing and Indian health
16 system basically is a local issue. And so the
17 interactions there are very local. Anslem could
18 probably talk a lot more eloquently than I can about
19 it.
20 Winslow, an IHS facility, was one of the
21 first places in the Indian health a number of years
22 ago that had a traditional healer on staff on the
23 facility. And he may want to talk a little bit about
24 the specifics of that and other interactions at the
25 local level. But that's where it takes place.

1 CHAIRPERSON BERRY: My major concern is
2 that through the Office of Alternative Medicine, as
3 I understand it, there has been developed some
4 positive affirmation of the use of certain practices
5 which has resulted in not only recognition of them,
6 but funding. And so my point is if in the -- I
7 mean, I've heard about traditional healing practices
8 before. Obviously, I'm not an expert about any of
9 this stuff, but I have heard it. So I'm not asking
10 people to give me testimony about traditional
11 healing.
12 What I'm saying is would it make sense
13 for there to be some opportunity for discussion or
14 interaction to see whether there's something
15 positive that could come out of such discussions,
16 either for funding or for other kinds of things?
17 Because that office, I mean NIH has a lot of money.
18 I know that. So I'm just leaving that as a
19 suggestion that people might want to take up.
20 I know it's not your area of responsibility.
21 Another thing I wanted to ask you is I
22 was quite impressed with the discussion about how
23 you're trying to move toward electronic use of
24 medical records and computerization and all that.
25 And with the facility that we saw yesterday and the

1 jamming and all the rest of it. How long is this
2 project going to take? Because in most major
3 medical centers now they already have medical
4 records computerized. I mean in the private sector.
5 And people are able to transmit information about
6 people's medical condition from one site to the
7 other rather easily and do things like having
8 consultations among physicians. And it seems to me
9 that your health service would be particularly
10 benefited by the ability to use all of this new
11 technology in ways. Do you agree with that?

12 DR. OLSON: Absolutely. Absolutely.

13 CHAIRPERSON BERRY: So how long is it
14 going to take? What's your timetable?

15 DR. OLSON: I can't tell you a
16 timetable. We're going to start beta testing, which
17 is the final testing before you launch new software.
18 And that will be occurring starting either late
19 winter or early spring or so, and probably go on for
20 six months, nine months depending on what issues are
21 discovered.

22 Part of the issue is that going to this,
23 obviously, takes intensive training. The whole
24 engineering of health care has to change because
25 things are done very, very differently in that

1 environment versus our current paper based
2 environment. And so that'll take a lot of gearing
3 up.
4 We're not completely without electronic
5 health record information now. But it started out
6 as a paper based and then is inputted by data entry
7 folks. So we've got a huge amount of information on
8 patient care right now. We get printouts when the
9 patients comes with the patient problems, with
10 medications they're on and allergies. That's
11 already in our database. But what we don't have is
12 where the providers enter data themselves and where
13 there's automatic coding that can occur and where
14 there are drop down menus or helps, and this sort of
15 thing. So we're part way there.
16 One area that we are very interested in
17 getting into is provider order entry. Because one
18 of the safety issues in medicine is that there's
19 translation. The physician writes down and it goes
20 to a clerk who interprets the handwriting and fills
21 out a form. And then it goes to x-ray or lab, or
22 whatever, and with the provider putting it in
23 electronically then it's automatically routed.
24 There isn't any interpretation. There could be
25 software that catches errors immediately, like in

1 medications. That the dosage is way out of range,
2 it doesn't compute and you get an error message
3 immediately. Or there's a message that you're on
4 two different medications that have a bad
5 interaction and you automatically get this.
6 In our system as I was describing with
7 pharmacy, we catch an awful lot of those because we
8 have pharmacist that have the complete record of the
9 patients and spend the time to be really involved in
10 the patient care, not just dishing out pills. So we
11 catch a lot of that right now in our current system.
12 But if it's done electronically, then you don't
13 have a human element that might fail or miss
14 something.
15 CHAIRPERSON BERRY: Right. I
16 understand. I have another couple of
17 points, then I'll get to you, Mr. Mowll.
18 If we know -- I know that physicians are
19 taught in their training because a friend of mine
20 who is a doc told me this. That when you're
21 diagnosing patients, don't always immediately jump
22 to the conclusion that he see zebras out the window,
23 because zebras are not -- you don't see them very
24 often.
25 DR. OLSON: Right.

1 CHAIRPERSON BERRY: So don't immediately
2 come up with the simplest thing first before the
3 most complex. But given that there've been studies,
4 and Commissioner Meeks cites one, that shows that a
5 high percentage of Native American Indians end up
6 with advanced cancer stage, whatever the last stage
7 is, when it's diagnosed. And if we know that, and
8 if we accept that data, wouldn't it make sense for
9 health care providers to immediately when they see
10 something that might possibly be cancer, to jump to
11 the conclusion that that ought to be ruled out
12 rather than jumping to the simplest conclusion that
13 that might be bursitis or it might be arthritis, or
14 it might be stomach ache, or whatever. And to rule
15 it out, given that they know. As in the Asian
16 American community has a high incidence of certain
17 kinds of cancer, or especially among women, so
18 providers in that area immediately always are on the
19 alert to try to look out for that.
20 So that wouldn't it make sense for
21 people to be looking for zebras if they know that
22 their studies all show that the likelihood of these
23 people ending up with stage -- well, the end stage
24 cancer before we have to chance, if there's any
25 inkling? That's one question. And the second one

1 is added to that. Are there opportunities for the
2 physician assistants, I guess are which PAs are --
3 people who are out in the clinics and on the ground
4 to consult easily with health care providers who are
5 more expert as they interface with patients so that
6 they can do a better job of diagnosing, either using
7 electronic means or whatever they could use to do
8 that on a easy basis that happens naturally to try
9 to help them and reinforcing -- I'm just adding
10 those two together.

11 DR. OLSON: Well, your first question is
12 difficult to answer. Obviously, zebras are not
13 common and someone comes in with a cough it's
14 usually bronchitis or something minor. It's usually
15 not lung cancer, but it could be. And, obviously,
16 that's a lot of the art of medicine. There is no
17 one size fits all in medicine. That's what makes
18 medicine so difficult.

19 There've been a lot of comparisons on
20 the safety issues between medicine and airline
21 industry. But the airline industry basically does
22 one thing, whereas in medicine every patient is a
23 unique product. Every single patient is a unique
24 product if you look at it from an industrial
25 standpoint, which makes it very difficult. If you

1 standardize everything, then you don't look for
2 zebras.
3 And someone who comes in with a cough
4 who is 55 years old and has been smoking for 40
5 years, obviously you think of lung cancer much more
6 than a 20 year old whose never smoked and just came
7 in. Because of their age and smoking and things
8 like that. That's a lot of the art of medicine.
9 I was talking earlier about prevention.
10 There are a lot of prevention protocols out there
11 now, and one way an electronic health record helps
12 is to bring that information to the provider
13 automatically. You've got this age person, male or
14 female. Then there've these types of screening
15 activities that need to occur. Electronically you
16 can say it hasn't occurred in the last 12 months or
17 18 months or whatever is considered the normal
18 screening time and they'll alert the provider to go
19 ahead and screen.
20 That's different than when somebody
21 coming in with symptoms, because many are somewhat
22 in a different arena.
23 As far as the issue with physician
24 assistants, it depends on the local medical staff.
25 We have a lot of nurse practitioners, probably more

1 nurse practitioners than physician assistants. Most
2 work on site with other providers, but we have small
3 locations that are very isolated where we may have a
4 nurse practitioner or a PA without an on-site
5 provider. They've got someone who they relate to
6 from a medical standpoint at the base facility.
7 And, hopefully, those relationships are close so
8 that folks can call.
9 I'll give you specific example. We have
10 a program in Alaska called Community Health Aide
11 Program, the CHAPs program. Community health aides
12 are local folks from Alaska villages that are
13 trained. The level of training is less than a PA,
14 but they work in very isolated locations in a
15 village of 500, 300, 200, 100 people, 75 people.
16 And the system we have in place there is that they
17 have what they call radio traffic. And that's
18 because in the past that communication needed to be
19 by shortwave radio. Now, it's done by satellite
20 phones, and hopefully in the future it will be done
21 with telemedicine links.
22 But in those situations the CHAs can
23 call the base facility and get guidance. And
24 particularly in Alaska we're developing an
25 extensive, or not we, the tribes up there are

1 developing an extensive telemedicine network along
2 the VA and the Air Force for the whole state and are
3 getting telemedicine capabilities down to the
4 village level.
5 In the instance of a PA at a health
6 station 50 or 100 miles from the nearest other
7 facility, that's the ideal and that's obviously the
8 direction we're going in.
9 CHAIRPERSON BERRY: Okay. And Mr.
10 Mowll, finally, I've been sitting here trying to get
11 my brain around your testimony. Because Commissioner
12 Meeks or someone asked you about the -- well, maybe
13 no one did -- yes you did. The rating system and
14 how these Indian health facilities could be rated so
15 high. And as I understand it, they're rated much
16 higher than the average of all the other facilities.
17 Now, given everything we know about them
18 being understaffed, about the lack of resources like
19 ICUs that can't open because there's no staff, all
20 the stuff that we've heard, are you comparing them
21 with -- and then one of your answers was that you
22 see the same problems in Baltimore. You named some
23 cities. Philadelphia. You named some other cities.
24 And so I was sitting here trying to think did you
25 mean Johns Hopkins in Baltimore? Did you mean the

1 University of Pennsylvania Health Center in
2 Philadelphia? Or did you mean that the Indian
3 Health hospitals and clinics are compared to the
4 worst public hospitals and the most under-funded
5 ones in the big cities where some of them are having
6 to close because they don't have any resources?
7 So is it that compared to them the
8 Indian Health and is that what we're supposed to
9 use, is that what your committee uses as a standard
10 or is it the worst one somewhere in some third world
11 country that has all these problems or what is it?
12 Are you comparing it with Johns Hopkins or Huff or
13 what are you comparing it with?
14 MR. MOWLL: Yes, absolutely, those
15 hospitals are accredited by the Joint Commission.
16 They are in the base of scores that I shared with
17 the Commissioner earlier. And I think the point is
18 comparability. While these problems that you've
19 heard about the Indian Health Service in the Native
20 American health care system here today and yesterday
21 seem startling, they are really endemic of the
22 entire nation's health care system.
23 We have a severe nurse, pharmacy, lab,
24 laboratory tech or radiation tech shortage in
25 American hospitals with vacancy rates of 5 to 20

1 percent. That has an implication in Johns Hopkins
2 as well as it does in, you know, the Phoenix area
3 hospitals.
4 So some of these, you know, we talked
5 about the flow in the emergency rooms. We have
6 emergency room over-crowding; it is an epidemic
7 throughout the country in the best of the nation's
8 hospitals and those that you wouldn't consider the
9 best of America's hospitals.
10 So the ratings I share with you are with
11 all hospitals and all the organizations that are
12 accredited. They are problems that some are
13 solvable within the system, some are not solvable
14 within the system. We think that there are shared
15 responsibilities. For instance, we talked about the
16 overcrowding in the clinic that you observed I
17 believe, they have a responsibility to control that,
18 to understand and monitor how many patients are
19 coming in and tracking the number of patients that
20 are coming in at peak times and monitor peak flow.
21 That is the organization's responsibility.
22 However, there are environmental
23 problems that contribute to that that are broader
24 responsibilities.
25 So I don't know if I am answering your

1 question exactly.

2 CHAIRPERSON BERRY: Well, actually

3 you're not because it's like in the field of

4 education, for example, everybody knows that there

5 is a national teacher shortage in certain fields.

6 This is a national problem. Everybody knows that

7 there are 44 million people or so who don't have

8 health insurance in the nation. That there are

9 certain kinds of specialties, whether it be

10 radiology technicians or whatever, certain

11 specialties in medicine where there are shortages

12 everywhere. Everybody knows this. This is true.

13 MR. MOWLL: Right.

14 CHAIRPERSON BERRY: But we also know

15 that in the case of teachers that better financed

16 school districts have more of the kind of teacher of

17 which there is a shortage than school districts that

18 are not better financed and that school districts

19 that are located in geographically desirable areas

20 have more of that kind of teacher.

21 MR. MOWLL: Sure.

22 CHAIRPERSON BERRY: And we also know

23 that school districts that pay a lot more have more

24 of those kinds of teachers. So it just boggles my

25 mind that there is not some kind of analysis that

1 while it accounts for the overall picture, which is
2 dire in some cases, would not also pay attention to
3 the public hospital in the worst neighborhood in
4 Baltimore, say. Just make that up. As compared to
5 Johns Hopkins or D.C. General as compared to
6 Washington Hospital Center. Or, you know, how all
7 these things play out. And that the Indian programs
8 would not be understood, in part, because of where
9 they are, who the folks are and so on, to have more
10 of these kinds of problems. And if they would come
11 with numbers that are better than all of these other
12 places, it just -- anyway, I just leave it at that.
13 I find it mind boggling.
14 I'll go to your website and read the
15 numbers there to see if I can figure it.
16 Yes, Commissioner Meeks?
17 COMMISSIONER MEEKS: I have just one
18 follow up question that I forgot to ask. That
19 patient hotline that you talked about, now what's
20 the purpose of that? And if someone calls that,
21 what do they get?
22 MR. MOWLL: The purpose of the hotline
23 is to allow the public and employees within the
24 health care system, anyone who has a concern about
25 the quality and safety of an organization that the

1 Joint Commission has accredited, to be able to speak
2 to us directly in a confidential way, in an
3 anonymous way to share their concerns about the
4 facility.
5 We get over 5,000 complaints either in
6 writing or phone calls a year. We manage that in a
7 staff of about 8 people in our office of quality
8 monitoring. And we facilitate those calls either,
9 as I say, in writing or by phone.
10 It's to give the public a chance or
11 those within the health care system that don't feel
12 like they have a chance during our review of the
13 organization to raise red flags, to say you know
14 Joint Commission you were in there but you missed
15 this. You know, you didn't see the overcrowded
16 clinic while you were here, you know, they
17 controlled their patient flow that day or those two
18 days you were here.
19 So, you know, one of our restrictions is
20 that we're not in the organization everyday. It's a
21 real challenge for us to understand the day-to-day
22 operations of each of the organizations we accredit.
23 So this is a big help to us because it allows the
24 public to contact us and so I offered that up as a
25 potential remedy to the entire system and those who

1 are involved and concerned about the quality of
2 care. Because they can communicate with us directly
3 in a confidential way and bring quality issues to
4 us. We will inspect those issues. We will
5 investigate them, and often we go back on site to
6 review whether the allegation of the complaint is
7 valid.
8 COMMISSIONER MEEKS: It doesn't bring
9 remedy to that particular person, though? It does?
10 MR. MOWLL: Yes. We get back to the
11 complainant, let them know what we did and the
12 action we took.
13 CHAIRPERSON BERRY: Okay. Vice Chairman?
14 VICE CHAIRMAN REYNOSO: Dr. Olson, I
15 just wanted to comment on one aspect of your
16 testimony. You mentioned the way in which you use
17 interpreters, which I think was very good. On the
18 other hand, I'm a law professor and lawyer and
19 retired judge. And in the legal system we have
20 found that interpreters who are lay interpreters
21 very often can do very well interpreting from the
22 layperson to the professional. But then
23 interpreting from the professional to the layperson
24 becomes a more difficult task because it's not the
25 common language the person uses.

1 And so in the legal system we have found
2 that educational programs for them are very helpful.
3 And I'm just suggesting that you might think about.
4 I know you have difficulties because you
5 are dealing with 100 languages, not just in
6 California -- well, I guess we have like 100
7 languages in California. But we have found that it
8 is very helpful to have special training for those
9 interpretations. And you might consider that.
10 CHAIRPERSON BERRY: All right. Well, I
11 want to thank this panel. Thank you very much. It's
12 been very informative. Thank you for coming.
13
14 MR. BIRD: PANEL FOUR: CAUSES OF
15 DISPARITIES -
16 STRUCTURE, DISTRIBUTION, AND ADEQUACY OF FUNDING
17 CHAIRPERSON BERRY: And I want to call
18 the next panel.
19 Meanwhile, if anyone wants to testify at
20 the open session, which is for anyone who has a
21 comment that they want to make, you should check in
22 with the staff outside the room and tell them that
23 you want to make a comment so that your name can be
24 put on the list.
25 All right. This panel is on the causes

1 of disparities - structure, distribution and
2 adequacy of funding. And they're going to explain
3 the funding structure so that everyone can
4 understand it, and the sources, and tell us about
5 qualifying, the inadequacy. And look at the sources
6 of funding.
7 And the panelists are Ed Fox, who is
8 Executive Director of the Northwest Portland Area
9 Indian Health Board, Portland, Oregon. He has 14
10 years of experience with health care issues.
11 He was educated and a Ph.D. at the
12 University of Washington. He has written a lot of
13 articles on the subject of federal health care
14 policies. He's worked for the state of Washington
15 Department of Health, and also worked as a community
16 analyst at Fred Hutchinson Cancer Research Center in
17 Seattle.
18 His main experience before he became
19 Executive Director was he worked as a policy analyst
20 with the Northwest Portland Area Indian Health
21 Board.
22 The next panelist will be Duane
23 Jeanotte, who is Acting Director of Headquarters
24 Operations, Indian Health Service, Rockville,
25 Maryland.

1 Mr. Jeanotte is member of the Turtle
2 Mountain Band of Chippewa. Where is Turtle
3 Mountain?
4 MR. JEANOTTE: Close to Canada.
5 CHAIRPERSON BERRY: Oh. And native of
6 Belcourt, North Dakota. And he was appointed as
7 Acting Director of Headquarter Operations for the
8 Indian Health Service in November of 2001.
9 He was educated at Mayville State
10 College in Mayville, North Dakota in accounting and
11 education. And also at the University of Colorado,
12 where he got a master's in science degree in health
13 administration.
14 He began with IHS in 1974 and has long
15 experienced in headquarters and out in the country.
16 Has been at Box Elder, Montana, and Crow Agency and
17 so on.
18 In the position he's in, he is
19 responsible for administering management and support
20 operations of the IHS. And so he will know
21 everything about these particular issues.
22 Ms. Dorothy Dupree, Senior Policy
23 Advisor, American Indian and Alaska Native Programs,
24 Centers for Medicare and Medicaid Services in
25 Baltimore.

1 Ms. Dupree is an Assiniboine and Sioux
2 Tribal member from Montana on the Fort Peck
3 Reservation.
4 She has a bachelor of science in
5 education from the University of North Dakota and a
6 master's degree in business administration from the
7 University of Arizona.
8 She began her work as Senior Policy
9 Analyst to the Health Care Financing Administration,
10 which name has changed to the Centers for Medicare
11 and Medicaid Services. It used to be HCFA and now
12 it's -- how do you say it now? What do you say?
13 MS. DUPREE: CMS.
14 CHAIRPERSON BERRY: CMS. In January of
15 1999. She is responsible for addressing all Native
16 American health issues related to Medicare and
17 Medicaid and State Child Health Insurance programs.
18 She has extensive administrative background in
19 Indian health. She began working at IHS in 1989 in
20 the Albuquerque office of Tribal Activities. And
21 then she went on from there.
22 I am going to have to leave, and I'm
23 going to turn this over to the Vice Chair. So I'm
24 going to indulge myself by asking you a question
25 even before you do your testimony, if that's all

1 right with everybody. Is that all right, Vice
2 Chair?
3 VICE CHAIRMAN REYNOSO: Sure.
4 CHAIRPERSON BERRY: Because I'm dying to
5 have an answer this question all day long.
6 If Indians are supposed to have their
7 health care taken care by the federal government
8 because of the trust relationship that we've heard a
9 lot about, and the treaty obligations, why would
10 Indians have to file for Medicaid or rely on
11 Medicaid or Medicare or some private insurance and
12 does the idea of an entitlement, which is the
13 proposal before the Congress now, I guess, to make
14 it an entitlement, the IHS programs an entitlement -
15 - Dr. Grim referred to that -- would proposal
16 undermine the trust relationship and the trust
17 obligations that the Indians talk about? Not that's
18 it been kept or anything, but I think conceptually?
19 I'm just trying to get my arms around the conceptual
20 issue. How does it make logical sense if Indians,
21 the federal government has responsibility for them,
22 to have them in the same programs where there is no
23 trust relationship, number one? And to require that
24 they do that, and to give the principle source of
25 funding or one of the major sources of funding to

1 IHS comes from these providers and these programs
2 that you're all going to explain in detail, which I
3 won't ever understand? But how does that
4 conceptually make any sense? And how does this
5 whole idea fit in with the trust relationship, and
6 how does the further idea of making IHS part of the
7 entitlement and be treated like Medicaid, how does
8 that fit in with the trust relationship?
9 Could somebody explain that to me before
10 I go? Does anybody know the answer to that?
11 Yes, Mr. Fox knows. Good.
12 MR. FOX: I'm sure our elected leaders
13 stand behind, probably, just dying to stand up and
14 answer this question. And it's a pretty question is
15 easy to answer, the question you raised. That is
16 they do object to having their people means tested
17 for a Medicaid program when health care is an
18 entitlement to Indian people.
19 When I speak before our tribes in the
20 Northwest encouraging them to seek out third party
21 revenues, to seek out alternative resources, I have
22 to talk about 5 minutes before I get to that. I have
23 to say that I do understand that our number one
24 objective at the Health Board is getting the Indian
25 Health Service budget sufficiently funded to provide

1 all the health care of American Indian and Alaska
2 Natives. Then I tell the story about, well there are
3 these Medicaid services out there. We've worked hard
4 with CMS to make them less onerous to sign up.
5 You know, people are getting used to it,
6 they're not that mad at you. You might not get
7 voted out of office when they do get mad and resent
8 the fact that they have to sign up for means tested
9 program.
10 And then sometimes we're lucky and the
11 tribal leaders will say, okay, go ahead, encourage
12 our people to sign up for Medicaid. Encourage our
13 people to sign up for Medicaid and pay that 20
14 percent premium even though they have the right to
15 health care services that they've already paid for
16 with the exchange of lands.
17 So, the answer really is they highly
18 object to it and they see it as an obligation of the
19 responsibility of the federal government. Having
20 said all that, in the Northwest we go forward and
21 work hard to seek out those alternative resources
22 and often travel to other parts of the country to
23 tell people how we do it.
24 And I got ripped pretty hard here in New
25 Mexico once standing up and talking about what we're

1 doing, and someone -- I didn't do enough of a
2 preface to it. And someone said who are you to come
3 down to New Mexico and tell us that we need to sign
4 up for Medicaid. And I learned my lesson there, so
5 I'm not going to say that today.
6 CHAIRPERSON BERRY: Is that basically
7 it, or is there anything that you could add that
8 would explain it further?
9 MR. JEANOTTE: I think he's spoken very
10 well of the issue. It's a matter of not enough
11 resources to improve the health status of the
12 population.
13 CHAIRPERSON BERRY: Okay.
14 MS. DUPREE: I agree. I hear it all the
15 time, given that I work at CMS, that tribes do
16 object to having to apply and fill out these
17 cumbersome applications when the federal government
18 owes through treaty obligations health care to
19 Native Americans. I do believe that if Indian
20 health service were an entitlement, it would smooth
21 the path to a number of issues that we continue to
22 address day, after day, after day, month after month
23 after month, year after year after year that never
24 seem to get resolved.
25 CHAIRPERSON BERRY: Okay. Well, thank

1 you. And I will read with interest the rest of the
2 testimony.
3 Thank you, Vice Chair.
4 VICE CHAIRMAN REYNOSO: Yes. Thank you.
5 I'll call the folk in the order that the
6 Chair called them.
7 Mr. Fox, why don't you go first.
8 MR. FOX: Good afternoon. I'm Ed Fox,
9 the Executive Director of the Northwest Portland
10 Area Indian Health Board. I'm pleased to be invited
11 to lend our voice to others here today.
12 I was invited to speak on the structure,
13 distribution and adequacy of funding for health care
14 services to American Indian and Alaska Natives. In
15 order to do this, I'll describe that structure but
16 also give my views on some of the history behind the
17 provision of health care services to Indian peoples.
18 The points I will try to make today are
19 several. Number one, there is a funding crisis in
20 Indian health, yet our programs are doing a fine job
21 with inadequate resources. I'll briefly restate
22 what others have noted.
23 The Indian Health Service budget has
24 lost well over a billion dollars to inflation over
25 the past ten years.

1 Number two, the funding crisis is caused
2 by an on again, off again commitment by the federal
3 government for Indian health.
4 Three, this vacillating commitment is
5 explained, in part, by a deep seated ambivalence
6 about Indian people and Indian tribes. Assimilation
7 is the ugly goal of many reforms that like the
8 groundhog on Groundhog Day, reoccurs on a regular
9 basis. It's seldom spoken, but it's often behind
10 many reforms.
11 Four, the United States Government needs
12 to recognize its obligations to tribes and Indian
13 people with sustained financing of health care
14 services.
15 Five, tribes have responded to the
16 funding crisis by providing own source revenue, the
17 tribe's own money, that was intended for other
18 purposes and by assessing third party revenue, most
19 importantly Medicaid and Medicare.
20 Six, these attempts to backfill for
21 inadequate funding of the Indian Health Service
22 threatens to assist assimilation by forcing tribes
23 and Indian people to access mainstream health care
24 systems.
25 Seven, attempts by this Commission to

1 understand and perhaps act to improve Indian health
2 may be quite different from past actions of the
3 Commission due to the political status of tribes and
4 the federal obligation to tribes for health care
5 services. Analogies to your past successes may not
6 be valid.
7 Eight, a final caution the tribes are
8 always stating. Be wary of federal agencies who are
9 here to help. Having said that, there are instances
10 when they have.
11 I might skip through some of our
12 advertising about the Health Board. The Northwest
13 Portland Area Indian Health Board is a tribal
14 organization. We represent all the tribes of the
15 Northwest, 43 tribes in Washington, Oregon and
16 Idaho.
17 Our tribes insist that we help tribes
18 nationally whenever we can with our resources and
19 policy analysis. We do an annual budget analysis of
20 the President's budget. We participate in other
21 national meetings.
22 We've also established a fund for legal
23 lobbying for increases to the Indian Health Service
24 budget and other health legislation. This year we
25 have again provided leadership in meeting support

1 for the Indian Health Care Improvement Act
2 reauthorization effort. We have provided staffing
3 support and advocacy for the establishment of the
4 new Tribal Technical Advisory Group within the
5 Centers for Medicaid and Medicare Services. It is
6 in that role today as contributor to national
7 efforts to improving Indian health that we're here
8 today.

9 I do want to state that I understand I'm
10 a visitor here in the Albuquerque area and I am
11 often in this wonderful part of Indian Country, and
12 glad to be here. Our staff includes a member of the
13 Jemez Pueblo, Francine Romero, one of the nation's
14 two Indian geneticists, a Ph.D. from the University
15 of Washington, and Sandra Bennell who is from the
16 Sandia. They will both be here next month to visit
17 with family and their communities.

18 The hospitality of the tribes and
19 pueblos of this area are renowned and often marked
20 by a bag containing a loaf of bread for departing
21 visitors lucky enough to be here for a feast day.
22 And I've carried a few bags away.

23 I'm happy to be here and appreciate the
24 opportunity to raise awareness of financing issues
25 that contribute to the low health status of Indian

1 people.

2 I think you've heard our view that the

3 federal government has signed treaties. Many of our

4 tribes in the Northwest actually do have treaties.

5 As a matter of fact, though, I would like to point

6 out that some of our tribes that don't have treaties

7 are proud of that fact, too. The Spokane Tribe told

8 the U.S. Government "Kill us in place. We will not

9 move." And that tribe still exists, much reduced,

10 and Hangman's Creek is named after that event in

11 Spokane, Washington.

12 So when we say there are treaty tribes

13 and non-treaty tribes, be aware that we believe that

14 the obligations of the federal government extend to

15 all tribes.

16 President Lyndon Baines Johnson, the

17 President that signed the Civil Rights Act, was not

18 one of the champions of Indian sovereignty. His

19 successor, Richard M. Nixon was. This state's two

20 Senators, Pete Domenici and Jeff Bingaman are as

21 well. I note the names to highlight something about

22 Indian health. Tribes are not partisan in their

23 champions in the White House or the Congress. The

24 media have difficulty with this, and most recently

25 in California have tried to pin a specific party

1 affiliation to all tribes and all Indian people.
2 History shows that it is understanding of Indian
3 issues, not party that earns the allegiance and
4 votes of Indian people.
5 Our Indian health programs are a success
6 story. Death rates are down since 1955. We've
7 improved greatly life expectancy; maternal death
8 rates have declined over 65 percent since 1973. And
9 in Washington State the life expectancy of an Indian
10 person exceeds 70 years. So clearly there has been
11 progress over the years.
12 A view since the 1950s will reveal
13 however, a very uneven history of funding Indian
14 health. There are some very good years and some
15 very, very bad years. I think this ambivalence is
16 explained by the larger philosophical ambivalence
17 the United States and Americans generally have shown
18 towards tribes and Indian people.
19 This month in Portland, Oregon an
20 authentic handwritten copy of the Declaration of
21 Independence was on display. I mentioned to some of
22 our staff that in that document's list of crimes of
23 King George was the fact that the King had aligned
24 himself with the Indian savages. This is in our
25 Declaration of Independence. Few knew that reference

1 in the document.

2 Most American Indians do know that the

3 Constitution, written 13 years later, refers to the

4 authority of Congress to regulate trade between the

5 United States and the various Indian nations. It's

6 mentioned in the Constitution.

7 The first image of Indians as savages is

8 contained in a document that is a call to arms in

9 revolt against the mother country. The second

10 reference to Indian nations is in a document that is

11 seeking to secure the future of a fragile and

12 fledgling new nation, the United States, seeking

13 allies among other nations, Indian included.

14 The first document was written by the

15 sometimes radical, at least in his writing, third

16 President Thomas Jefferson. The second, by the more

17 practical minds of James Madison and John Adams.

18 They, and other founding fathers including George

19 Washington and Benjamin Franklin, had firsthand

20 experience with Indian nations and had no doubt that

21 they were a force to be reckoned with. A young

22 George Washington surveyed lands that were sold by

23 tribes to settlers. A youthful publisher Ben

24 Franklin published hundreds of contracts and

25 treaties between British America and the Indian

1 nations. There was no doubt in 1789 that there were
2 Indian nations.
3 The Constitution was actually written in
4 1787 but ratified in 1789.
5 Nor was there any doubt that these
6 tribes' territories stretched across the continent
7 in 1805, as the reports from Jefferson's Lewis and
8 Clark expedition of discovery came back to
9 Washington, D.C.
10 It turns out that nearly all of these
11 men eventually came to believe that tribes could not
12 have a future in the United States. They believed
13 that Indians, as savages, could and should be
14 assimilated. Some may have felt it was a sad
15 reality, but a reality nonetheless. I believe
16 assimilation is the predominant motivating force
17 behind most of the United States Indian policy.
18 This goal of assimilation of distinct ethnic groups,
19 inhabiting their traditional territory has gained
20 another name since World War II. It is called
21 genocide.
22 The goal of assimilation is
23 diametrically opposed to the goal of Indian tribes
24 to preserve and foster their own cultures. For
25 Indian people the concept of tribes as sovereign

1 nations is about their survival as a people.
2 Survival is the number one priority of tribes, and
3 health care is a secondary goal that clearly
4 contributes to that preeminent goal.
5 I think it is important for this
6 Commission to consider the unit -- sorry the
7 analysis -- I am a Ph.D. in political science -- of
8 your research into health disparities. I say that,
9 I wish I weren't.
10 But are you studying the rights of
11 individuals? And my assumption is that you are. Or
12 are you studying rights of Indian tribes? I expect
13 you will often be reasoning by analogy to other work
14 you have done. The advances and the life changes of
15 African-Americans or women are two of your great
16 successes, in my view. But I caution you to be
17 aware when your analogical reasoning is inadequate
18 to the challenge of understanding why Indian people
19 suffer from poor health status.
20 I do know something about the history of
21 civil rights, the work of great advocates like
22 Morris Dees of the Southern Poverty Law Center, who
23 takes the case of an individual to advance the cause
24 of an entire race is a proven success. It is
25 possible to help a people, a race, an ethnic group

1 through the vehicle of advocacy for an individual.
2 I am weary, however, of how this is possible for
3 Indian tribes and Indian people whose survival is
4 absolutely tied to the survival of Indian tribes.
5 It may be sad to say but it is true that there is no
6 useful analogy today between African-Americans and
7 their traditional African cultures and communities
8 and the American Indian and their tribes. In this
9 respect, tribes are perhaps more fortunate. There
10 is hope, and I believe optimism, that the great
11 Navajo Nation, for example, will survive. And,
12 hopefully, the nearly annual extinction of yet
13 another Indian language will cease.
14 For tribes health care, much like public
15 safety, is an essential government function. Again,
16 this concept is not directly related to the rights
17 of individuals, but to the community in which they
18 live. Tribes have the right to exercise their
19 police powers relating to health, public safety and
20 education. Again, I'm not sure how this Commission
21 will integrate this reality into your traditional
22 way of examining cases of discrimination.
23 I see a red light.
24 I am advising that you take the view
25 that you are embarking on a fairly new subset of

1 your work and one that will often be new territory
2 that may take longer to understand, for example,
3 than exploring the civil rights of recent immigrants
4 of people who belong to ethnic groups that do not
5 have a political status as governments as tribes do.
6 I'm usually pretty good at timing.
7 Okay. Let me just take a quick look at
8 what I would like to say before I wrap up.
9 VICE CHAIRMAN REYNOSO: Why don't you
10 just summarize the rest that you have.
11 MR. FOX: Okay.
12 VICE CHAIRMAN REYNOSO: And we'll have
13 questions where you'll be able to expand on it.
14 MR. FOX: Okay.
15 VICE CHAIRMAN REYNOSO: Incidentally, I
16 noticed the red light came on when you still had a
17 few seconds to go. So, apparently, this light is
18 done a little bit differently than a traffic light.
19 MR. FOX: Okay. Well, I'll do the
20 California red light here. No, I'll finish up here
21 in a minute.
22 I do believe that there are some dangers
23 ahead for Indian health. I'm weary of reforms. I
24 just mentioned that, you know, allotments,
25 relocation, boarding schools were all considered

1 reforms. So your recommendations should be
2 cautionary and be cautious of what you recommend.
3 I do have some description here of
4 Indian finance and health. Most of our funds come
5 from the Indian Health Service. Second to that would
6 be Medicaid and Medicare. Third would be own source
7 revenues of tribes. Increasingly, though, we are
8 trying to spend money on health care prevention
9 activities that have recently received some
10 increases in funding with the hope that it will
11 reduce long-term costs to our programs. So the money
12 for prevention will be well spent. I do think it's
13 significant that the United States now recognizes
14 that.
15 And finally, I'd just restate my two
16 main points. Tribes are always glad to have an
17 honest appraisal of their health programs. Secondly,
18 if the Commission is mindful of the central role of
19 tribes, their work can result in recommendations
20 that will help, not hurt the survival of Indian
21 people.
22 Thank you.
23 VICE CHAIRMAN REYNOSO: Thank you very
24 much.
25 Mr. Jeanotte?

1 MR. JEANOTTE: Thank you. Good
2 afternoon.
3 VICE CHAIRMAN REYNOSO: Good afternoon.
4 MR. JEANOTTE: My name is Duane
5 Jeanotte, and I'm the Acting Director of
6 Headquarters Operations. And I'd like to speak to
7 you this afternoon about the structure and funding
8 of the Indian health care program. And I'd like to
9 abridge my statement a little bit so I can spend a
10 little time maybe going over and walking you all
11 through a few charts that will graphically display
12 some of this information.
13 VICE CHAIRMAN REYNOSO: Good.
14 MR. JEANOTTE: So if I can, I'll quickly
15 go through my written statement and try to preserve
16 a little time to show you these graphics.
17 The Indian health care system available
18 to American Indian and Alaska Natives is a
19 combination of federal and non-federal health
20 services resources. Actively depicting the adequacy
21 of these resources is made difficult as a result of
22 data shortcomings. Almost no data is available on
23 the population that does not access the IHS Tribal
24 Health Care System and there have been no studies to
25 isolate the total public expenditures on this

1 population.

2 Substantial amounts of financial and

3 health status data are available for the portion of

4 the population served by IHS and tribal programs,

5 while very little information is available on the

6 estimated 40 to 60 percent of the American Indian

7 population that is not served by IHS or tribal

8 programs.

9 The availability of insurance in the

10 total Indian health population is not known, but

11 anecdotal information suggests that it's less than

12 other groups.

13 The health care system for American

14 Indian and Alaska Natives is funded primarily

15 through appropriations. However, substantial

16 amounts of third party resources are available to

17 supplement the annual federal appropriation.

18 At the community level the health

19 services provided by IHS and tribes are made up of

20 appropriated and non-appropriated resources, the

21 amount of which varies by location. The current IHS

22 appropriation of approximately of $3 billion is

23 supplemented by over $500 million in revenue

24 collected from Medicare, Medicaid, and private

25 insurance.

1 The distribution of IHS and other health
2 resources is a function of historic funding
3 patterns, formulas, special funding direction from
4 Congress, and unique community circumstances which
5 bear on the eligibility and availability of private
6 insurance and Medicaid services.
7 Efforts to balance the funding in IHS
8 are an ongoing activity with congressional
9 appropriations in recent years targeting annual
10 increases at local operating units with the lowest
11 level of funding. The IHS federal disparity index
12 study benchmarked resource availability to the
13 Federal Employees Health Benefit Plan and to other
14 federal health programs, and is used by the agency
15 and the Congress as a guide in closing the funding
16 gap between programs.
17 The IHS was first authorized to bill
18 Medicare and Medicaid and private insurance through
19 the Indian Health Care Improvement Act of 1976. The
20 legislation mandated the use of these funds for
21 improving the quality of care and directed the
22 revenue be used to seek and maintain accreditation.
23 During the initial years limited
24 investment in the IHS third party billing system
25 resulted in low charge rates and incomplete and

1 episodic actual billing. In recent years the agency
2 has devoted substantial attention to increasing
3 rates and improving billing processes and
4 procedures. This effort has resulted in early '90s
5 revenue going from approximately $100 million to now
6 nearly $460 million in '03. Unreported in this
7 increase is the revenue collected by tribal
8 programs.

9 The third party revenue available in IHS
10 and tribal programs results from the rate setting
11 process for services rendered to Medicare and
12 Medicaid beneficiaries by the system. Since the
13 inception of the program in 1976 the IHS has
14 negotiated outpatient encounter and inpatient day
15 rates with the CMS, Centers for Medicare and
16 Medicaid Services. The process for changing rates
17 involves the IHS completion of hospital cost
18 reports, which are summarized and averaged to reach
19 a new annual rate agreement that is published in the
20 *Federal Register*. After significant catch up
21 increases in the late 1990s, the recent experience
22 with the rates has been a more gradual increase
23 nationwide.

24 IHS and tribal programs collect Medicare
25 and Medicaid under a simplified all-inclusive rate

1 system. This system has allowed the program to
2 receive Medicare and Medicaid reimbursement without
3 making substantial investments in health insurance
4 billing infrastructure. As a result, the cost
5 information systems in IHS facilities are not as
6 sophisticated as those seen in private sector
7 facilities.
8 In the IHS and tribal user population
9 approximately 60 percent has some type of third
10 party coverage. The 40 percent of the population
11 that has no coverage is entirely dependent on the
12 IHS and tribal health care system for care.
13 In FY 2003 IHS provided $31 million to
14 urban programs around the country, some 41 different
15 cities, to supplement local health services for a
16 portion of the native population that do not reside
17 near tribal or IHS systems. These programs have
18 become increasingly important as points of access to
19 the care for the highly mobile, young and
20 increasingly elder population in Indian Country.
21 As the age of the population of American
22 Indian and Alaska Natives increases, it is likely
23 the general U.S. rural population tendency to move
24 to urban communities will be replicated in Indian
25 communities. And it is certainly a policy

1 consideration for the future.

2 A number of programs both federally and
3 tribally operated have witnessed substantial revenue
4 increases as a result of out-stationing Medicaid
5 eligibility technicians in tribal communities.
6 Clearly, this activity should be promoted in every
7 state and community.

8 The IHS has conducted preliminary
9 studies of the utility of purchasing Part B
10 insurance for Medicare eligible beneficiaries with
11 indications of a positive cost benefit in many
12 communities. A number of tribes have increased
13 tribal member access by using IHS resources to
14 supplement employer-sponsored health insurance. And
15 this experience needs to be evaluated for
16 applicability in other communities.

17 The CMS study that is currently ongoing
18 is a qualitative study of the barriers to access to
19 Medicaid services in a number of states. This study
20 will isolate many reasons why individuals do not
21 access state administered Medicaid programs and
22 could be the basis for a larger study that would
23 quantify the number of Indians potentially eligible
24 for the program in particular states.

25 The increasing Indian population and the

1 demand associated with it, coupled with inflation
2 poses an important challenge to IHS and tribal
3 program officials as they address other knotty
4 problems of health, manpower and chronic diseases.
5 The estimated 42 to 44 million uninsured in the
6 United States include an unknown number of American
7 Indian and Alaska Natives. Increasing health
8 coverage to this population is an important policy
9 consideration.
10 And with that, I'd like to now go
11 through a few charts that I brought along to further
12 explain this issue.
13 This first chart is, obviously, a map of
14 the United States. But what our programmer did was
15 develop a way of mapping our population where we
16 have programs and provide services so that you see
17 in the Arizona/New Mexico area a lot of green,
18 basically coinciding with the large user population
19 that we have in this area of the country.
20 And, again, if you look in the South
21 Dakota area, you see the Sioux country and a large
22 number of green spots there. Alaska has a large
23 spot as you can see. But then if you look at the
24 scattered nature of it, you see something in Florida
25 and Maine, and all over California, and so on.

1 It provides you a graphic of where, if
2 you were an Indian person living not near one of
3 these spots, where you might be able to go or need
4 to go if you need health care.
5 For example, there are a large number of
6 Indian people in Denver. And they have to go home to
7 South Dakota or to Wyoming, or down here to the
8 Southwest to receive care because there's nothing
9 there. Salt Lake City is very similar.
10 The BIA relocation programs of the '50s
11 and '60s moved a large number of people to Chicago
12 and Seattle, to LA and San Francisco and so on. And
13 so you see very small activities that we have in
14 those areas. In some communities we have much better
15 services. The issue is, in my mind, is access for
16 the population that is not near an IHS facility.
17 This chart with three different tables
18 on it, basically is addressing two issues. One is
19 the federal disparity index issue that I talked to
20 earlier and has been spoken to already today. It
21 shows the per capita expenditures that IHS incurs
22 versus a Federal Employee's Health Benefit Plan, the
23 VA benefits, and other groups who have health care
24 coverage.
25 The other graph basically addresses the

1 access issue and the population that has no health
2 care access. In the Civil Rights Commission report
3 it shows a variation in population. IHS uses a
4 number of 2.6 million as a potential user
5 population, and the Census uses 4.1 million as the
6 Indian population. IHS estimates it provides
7 services to about 1.4 of the 2.6 million eligible
8 Indian people.
9 The bottom graph compares U.S. all
10 races, poor people and American Indian and Alaska
11 Natives relative to health insurance coverage. As
12 you can see in the first graph on the left there's
13 about 7 percent of the American Indian and Alaska
14 Natives that have Medicare. As life expectancies
15 grow, the 7 percent will increase.
16 The Medicaid number shows poor people in
17 this country, in fact, access Medicaid at a higher
18 rate than American Indian and Alaska Natives,
19 supporting what I said earlier in terms the need for
20 eligibility technicians in reservation communities.
21 The private insurance shows that
22 approximately 70 percent of the people in this
23 country have private insurance, while only
24 approximately 22 percent of the Indian population
25 has private insurance coverage.

1 The final column demonstrates that 42
2 percent of the Indian Health Service population has
3 no health insurance or no coverage other than the
4 Indian Health Service resources. This also means
5 they are entirely dependent on Contract Health
6 Service funds for services beyond what IHS can
7 provide. The amount of Contract Health Services
8 that IHS receives is less than $500 million a year
9 and results in rationing of services, resulting in
10 Indian patients not receiving what other people in
11 this country take for granted in health care
12 services.
13 With that, thank you.
14 VICE CHAIRMAN REYNOSO: Yes. Thank you
15 very much.
16 Ms. Dupree?
17 MS. DUPREE: Well, thank you for
18 inviting me here today.
19 I wanted to begin the discussion of
20 structure to talk briefly about the Indian Health
21 Care Improvement Act, Medicare and Medicaid and
22 CHIP.
23 The Indian Health Care Improvement Act,
24 when passed in 1976, extended Medicare and Medicaid
25 payment to facilities of the Indian Health Service.

1 And the purpose of doing this was to increase
2 access to entitlement programs for those
3 beneficiaries entitled to them who received their
4 services through the Indian Health Service
5 facilities.

6 This is the only relationship in which
7 CMS, HCFA at that time, but CMS today makes payments
8 to another federal agency.

9 IHS is also considered the payer of last
10 resort. In other words, Medicare and Medicaid pay
11 before IHS. For all other provider relationships,
12 Medicare and Medicaid are considered themselves the
13 payer of last resort.

14 As the Indian Health Service improved
15 its billing capability over time, it's reported that
16 30 to 60 percent of their base operating budget is
17 income from Medicare and Medicaid and CHIP. And so
18 we realized the significance of these programs to
19 the sustainability of their programs, both IHS and
20 tribes.

21 Medicare payment to IHS was originally
22 limited to only Part A inpatient services and
23 services provided through hospital based clinics.
24 The Benefits Improvement Protection Act Section 432,
25 otherwise known as BIPA 432, extended Part B payment

1 but only the professional component to the Indian
2 Health Service effective July 1, 2001.
3 Payments for Medicare are made through
4 fiscal intermediaries for Part A and through
5 regional carriers for Part B. And in discussions
6 when we implemented BIPA 432, the Medicare Part B
7 for Indian Health Service, in discussions with the
8 Indian Health Service we had agreed that we would
9 keep both the fiscal intermediary relationship or
10 contract with the same -- excuse me -- The Part B
11 contract with the fiscal intermediary contract, who
12 was Trailblazers.
13 We decided it was reasonable in that the
14 program is unique and how we treat the Indian Health
15 Service is so unique, we felt that the Trailblazers
16 had an understanding of the issues that Indian
17 Health Service and tribes were dealing with so that
18 they could best implement the Part B benefit.
19 Under Medicaid, I've included in the
20 handouts this foldout that describes Medicaid at a
21 glance. It's called "Medicaid At A Glance, 2002."
22 And under Medicaid this handout will describe that
23 it's a federal/state partnership. And in this
24 federal/state partnership, IHS programs and tribal
25 programs have to seek reimbursement from their

1 respective state Medicaid programs.
2 CMS reimburses states at 100 percent of
3 FMAP. If you'll look on this section of the
4 foldout, the far left hand column shows what their
5 usual FMAP is for states. And it ranges anywhere
6 from 50 percent to 75 percent in 2003. For the
7 Indian Health Service CMS will pay states 100
8 percent FMAP for payments made for services provided
9 through facilities of the Indian Health Service.
10 States, however, are not allowed to
11 treat Indian beneficiaries any differently than they
12 would any other beneficiary, even though they
13 receive 100 percent FMAP from the federal
14 government.
15 The other point I wanted to make, when
16 Indians access services at non-IHS and tribal
17 facilities, they are not identified as Native
18 American. Only if they volunteer, however, because
19 they're not required to submit supporting
20 documentation, it's not validated that they are in
21 fact Native American coming through the doors when
22 they receive services. So there is an impact in
23 that regard on data.
24 The 100 percent FMAP from Medicaid is
25 part of the federal trust responsibility.

1 Legislative history reflects that Congress intended
2 100 percent FMAP to reimburse states for Medicaid
3 payments made to facilities of the Indian Health
4 Service in order to not burden states with costs
5 traditionally born by the federal government as part
6 of their federal trust responsibility.
7 One hundred percent FMAP is paid to
8 states for payments made through IHS facilities.
9 Additionally, 100 percent FMAP is not available to
10 states for tribal programs operating outside self-
11 determination authorities. This may create barriers
12 to tribes wanting to establish much needed services
13 like long term care, particularly during times of
14 economic downturn when states are reducing their
15 services. In other words, states are not getting
16 the reimbursement. So, if there is a need that they
17 have to come up with their share of FMAP at a higher
18 level, then there is hesitancy in many of the states
19 to do so.
20 In 1976, CMS entered into a memorandum
21 of agreement with the Indian Health Service
22 extending the 100 percent FMAP to facilities
23 operated by tribes under the authorities of self-
24 determination. The MOU, which you have also a copy
25 of as one of your handouts, was established to

1 provide roles and responsibilities and guidance in
2 the implementation of this change in payment policy.
3 The State Children's Health Insurance
4 Program was authorized in 1976. Legislation
5 requires CMS, well HCFA at that time, to remove
6 barriers to Indian children in order to access CHIP
7 services. And one of the barriers that was
8 identified immediately was that of cost sharing. So
9 when the regulations were developed in '99, we
10 waived cost sharing for Indian children in order to
11 participate in CHIP.
12 Adequacy. I wanted to talk next about
13 the adequacy of collections. First of all,
14 beginning over back again with Medicare and Medicaid
15 and then I want to talk briefly about the payment
16 methodology.
17 Medicare, as referenced earlier, CMS
18 agreed to keep the Medicare FI and regional carrier
19 responsibilities with one contractor, Trailblazer,
20 due to their working knowledge of the Indian Health
21 Service and tribal programs. Some of the problems
22 cited by Trailblazers that hinder the collection
23 efforts of the IHS and tribes are as follows:
24 They have a high turnover rate in
25 billing staff;

1 They have a high submission of
2 incomplete claims or improper billing coding;
3 They have difficulty in obtaining the
4 right mix of staff at training workshops that are
5 provided by Trailblazers;
6 There is little follow up on pended
7 claims; and
8 Providers enroll in Medicare but do not
9 submit claims.
10 There are also problematic barriers that
11 need to be identified as well. I spoke to one
12 briefly earlier, and that is related to the fact
13 that Part B only provides reimbursement for the
14 professional component. Services provided by a
15 physician, nurse practitioners, clinical nurse
16 specialists and so forth, they do not allow
17 reimbursement for clinical lab services, pap tests,
18 pelvic exams, those preventive health services that
19 normally other providers would seek reimbursement
20 for.
21 And another barrier is the dual eligible
22 population, those who are eligible for both Medicare
23 and Medicaid. The Medicaid payment was legislated
24 to be implemented at the fee for service. However,
25 the Medicaid payment is an all-inclusive rate and is

1 a higher rate of payment than is the fee for service
2 payment. So if you have a dual eligible, more than
3 likely they will not bill Medicare for the services
4 provided to that beneficiary. They will, instead,
5 bill Medicaid at the higher rate, which makes
6 perfect sense when you're trying to get the income.
7 Another handout that I provided to you
8 is this summary here of the options that are put
9 together for what tribes have available to them when
10 electing to participate in the Medicare program. We
11 found early that it was difficult to understand how
12 you bill and what your options are under BIPA 432
13 versus that of a regular physician clinic versus
14 that of a rural health clinic versus that of a
15 federally qualified health center. And now what
16 needs to be added to this is that of a critical
17 access hospital. So we're trying to put more
18 educational materials together so that tribes
19 understand their choices.
20 IHS doesn't have the same breadth of
21 choices that tribes do under 638. They still have
22 the restrictions as a federal provider.
23 Next I want to talk briefly about
24 payment methodology.
25 The current methodology that we pay is

1 the all-inclusive rate. This is generated based on
2 Medicare, hospital cost reports that are called
3 Method E Hospital Cost Reports. It's a truncated
4 cost report. IHS puts together these on behalf of
5 CMS and submits them to CMS. Adjustments for
6 Medicaid services are provided within the Method E
7 Cost Reports so we're able to identify an average
8 rate for both Medicare and Medicaid through this
9 Hospital Cost Report rate setting process.
10 The rate is actually negotiated between
11 CMS and IHS, however, it is approved by OMB.
12 They are averaged rates. And, as you
13 know, with averaged rates you have winners and you
14 have losers. For those facilities with higher levels
15 of care, surgery, deliveries, etcetera, they
16 continue to have to bill the same as any other
17 provider or any other service at an inpatient rate -
18 - for the lower 48, because we separate -- we do
19 establish a separate for Alaska. But in the lower
20 48, for example, for inpatient regardless of the
21 service, it's $1,526 that would be paid for that
22 one-day visit. And then outpatients, it's $206.
23 Also another problem that relates to
24 data regarding the all-inclusive rate. In order to
25 receive payment of the all-inclusive rate, the only

1 thing that needs to be provided is the name, date of
2 service and then we take for granted that because
3 the patient is being seen by IHS or the tribal
4 facility, that that individual is Native American.
5 So very little data is gathered by CMS through the
6 payment of the all-inclusive rate. Consequently,
7 when you come to the CMS database we have no data on
8 the American Indian population.
9 I have two summaries. You heard Mr.
10 Jeanotte mention this study that is going on right
11 now on the eligibility and enrollment. The
12 preliminary findings, we have identified what we've
13 been hearing all along of what some of the barriers
14 to enrollment are. On your handout they are divided
15 up into the barriers as seen by individuals,
16 barriers as identified by the tribal leaders,
17 barriers as identified by IHS and urbans, barriers
18 identified by Medicaid and CHIP, and those barriers
19 identified by the programs.
20 The prominent barrier is that of federal
21 trust responsibility because of the expressed belief
22 that the federal government is to provide health
23 care to Indians and that American Indian and Alaska
24 Natives have no need to apply or enroll in other
25 public programs. Tribal leaders are concerned that

1 if they encourage enrollment, that it will diminish
2 the federal trust responsibility to provide health
3 care to the tribal members. However, at Section 404
4 of the Indian Health Care Improvement Act it does
5 authorize grants or contracts for tribal
6 organizations to establish programs to assist with
7 Medicare enrollment, pay premiums and to apply for
8 Medicaid. However, it was never funded. And as
9 you'll see, quite a few of the barriers that are
10 cited on this first one relate to the lack of
11 knowledge and awareness of the programs offered by
12 Medicare and Medicaid and CHIP.
13 The next page gives a different layout
14 of the identified barriers. They identify it by
15 tribal, state and urban. I'm not going to read what
16 those are, as you have them in front of you on the
17 chart.
18 CMS is involved in collaboration with
19 IHS. We have a joint steering committee. You have
20 the charter as a handout to the joint steering
21 committee. It was formed in 1999 and it was for the
22 purpose of addressing issues that were in common to
23 both Medicare and Medicaid and the Indian Health
24 Service programs.
25 We also have a number of interagency

1 agreements. Currently there are five that are in
2 existence involving the Indian Health Service. One
3 deals with the issue of outreach and education.
4 It's in the process for 3 years. It's a combined
5 effort of CMS, IHS and SSA.
6 We also have a 2-year, we're in our
7 second year, of Cost Report Assistance to the Indian
8 Health Service. And I won't read what that is,
9 because I do have the handout that describes each of
10 what we do under the Cost Report Assistance effort.
11 We also have a satellite, training
12 network that extends to 57 sites within the Indian
13 Health Service and some tribes. And the purpose of
14 this one is to extend educational programs out to
15 the very rural areas.
16 We also have one to eliminate barriers
17 on data. We're working with the Indian Health
18 Service, this is the second year, to begin matching
19 the Indian Health Service data with state data so
20 that we can begin to see fuller Indian data coming
21 from state programs.
22 And then under the in-house working
23 relationship interagency agreement we've asked IHS
24 to do a comparison, and it's in the Billings Area
25 Office where this is being conducted, where they are

1 aligning what services are being provided, what
2 Medicaid services are being provided by the
3 facilities and comparing that to what services in
4 Medicaid are being offered by the state and looking
5 for what gaps exist. The purpose is to look for
6 opportunities to enhance their services into those
7 areas and create additional income streams.
8 In tribal consultation, there are two
9 handouts that I've provided. One is the
10 Presidential Executive Order. With that I wanted to
11 mention that the Presidential Executive Order
12 parallels that on the Presidential Executive Order
13 on federalism, that federalism describes the federal
14 government's relationship and responsiveness to
15 states.
16 The Presidential Executive Order in
17 consultation with tribes parallels that. We have the
18 same authorities to be treated the same way --
19 treating tribes the same way in which we treat
20 states. However, under Medicaid it's very difficult
21 because of the Medicaid state federal partnership in
22 the administration of that program.
23 Additionally, I wanted to comment that
24 we're well aware of the fact that most tribal
25 leaders feel strongly that they should not have to

1 work through states to access Medicaid services.

2 You may have heard earlier, Mr. Fox

3 mention that we have a tribal technical advisory

4 group established. That was most recently

5 established last month on the 26th. It was approved

6 and we're in the process now of representatives

7 being identified and we're funding 3 meetings per

8 year.

9 We're in the midst of Medicare reform,

10 as you know. Tribes are trying to be involved in

11 that. It's moving quite fast. It's very closed.

12 Medicaid reform is something that's still on the

13 horizon, but it's not a dead issue. It is still

14 being talked about. And we continue to encourage

15 tribes to proceed.

16 In summary, I want to mention that the

17 top four items that I think are most important to us

18 and our concerns, is that of the federal trust

19 responsibility and the confusion that exists between

20 who's responsible in providing that care; the

21 government to government -- federal government to

22 tribal government relationship, inadequate or

23 adequate payment, the adequacy of the payment -- not

24 knowing whether or not when you have losers and when

25 you have winners -- whether or not they actually are

1 winning and losing if you don't have the data, which
2 is the last item, to really back it up.
3 Thank you for this opportunity.
4 VICE CHAIRMAN REYNOSO: Thank you very
5 much. We appreciate that comprehensive outline of
6 the not uncomplicated systems of reimbursement and
7 so on.
8 Elsie, would you like to start?
9 COMMISSIONER MEEKS: Yes. I have
10 questions.
11 First of all, I want to respond to Mr.
12 Fox's caution to us. And I think we're all pretty
13 aware that treaty rights are not the same as civil
14 rights. And we try to tread carefully around that
15 issue. And I think it's our intent to -- I mean,
16 since there is no U.S. Commission on Treaty Rights
17 and there is a U.S. Commission on Civil Rights, we
18 just want to provide a voice, another voice I guess,
19 to strengthen the voices that are already out there
20 in Indian Country. And since I am from Pine Ridge,
21 you know, these issues are near and dear to my heart
22 and things we deal with everyday.
23 Dorothy, South Dakota just sued the
24 federal government on Medicare and Medicaid
25 payments. Do you know about that suit?

1 MS. DUPREE: I'm not allowed to speak.
2 COMMISSIONER MEEKS: Really?
3 MS. DUPREE: Actually, it has to do with
4 contract care. The law as it was written referenced
5 that 100 percent FMAP would be available for
6 services provided through a facility of the Indian
7 Health Service. There's been a narrow definition
8 over time that has been used at the Centers for
9 Medicare and Medicaid Services that would really
10 mean within the four walls of an Indian Health
11 Service facility. And states --
12 VICE CHAIRMAN REYNOSO: Sort of like the
13 early Constitution counting slaves as part human
14 beings, right?
15 MS. DUPREE: Right. What the states
16 have been claiming for services that are referred
17 services from the Indian Health Service or Tribal
18 638 provider to a contracted provider in the private
19 sector and using that, they would like to see a more
20 liberal definition of what "through" means.
21 We've denied several states the 100
22 percent FMAP for those services. South Dakota and
23 North Dakota appealed to the department appeals
24 board. And the department appeals board upheld the
25 CMS denial of payment. And the next step then was to

1 go to court, which they did, on October 30th and
2 late September they both, two separate Judges found
3 in favor of the states.
4 We have yet to decide what our position
5 is as whether we're going to appeal or not.
6 COMMISSIONER MEEKS: One other question.
7 On South Dakota Indian reservations, at least, and
8 I'm sure this is true for others, there's a great
9 need for nursing homes. And at least in South
10 Dakota, in order for a nursing home to qualify for
11 Medicaid payments, it must be certified by the
12 state. And except for one pilot project in South
13 Dakota, South Dakota refuses to certify any more
14 nursing homes because there is space available in
15 the homes off reservation. And, you know, the
16 problem with that is that people would rather stay
17 at home than go to some other town.
18 Why does the federal government require
19 state certification for nursing home Medicaid
20 patients or payments?
21 MS. DUPREE: Because it's a
22 federal/state partnership. And it's up to the state
23 to determine how they operate and what the
24 requirements are within the state in any service,
25 including that of long term care.

1 The problem that exists with states like
2 South Dakota and the issue of long term care, we've
3 looked closely at the issue with regard to the
4 nursing home desires in Pine Ridge; I think the last
5 time we looked there were 40 patients that were
6 residing elsewhere other than the reservation and
7 far away from home; Looking at 40 patients coming
8 back to a nursing home or an assisted living type of
9 arrangement would require that the state, because
10 IHS doesn't operate long term care services, tribes
11 cannot take them over under the authorities of 638;
12 So if it's not IHS and it's not a tribal 638
13 program, the state will not receive 100 percent FMAP
14 and they do have to come up with an FMAP share. So
15 that does get into a funding issue for the state.
16 COMMISSIONER MEEKS: And so is there
17 discussion of how to get around that?
18 MS. DUPREE: It is in the Indian Health
19 Care Improvement Act.
20 MR. FOX: The authority of nursing
21 homes?
22 MS. DUPREE: Pardon?
23 MR. FOX: The authority to have nursing
24 homes is in the proposed Indian Health Care
25 Improvement Act. So we would have that authority

1 and then tribes could contract that program, then
2 the state would be eligible for 100 FMAP, they'd
3 probably certify the nursing homes.

4 MS. DUPREE: Yes. IHS already has
5 authority under 1880 to receive payment for skilled
6 nursing facilities. It's a resource issue in that
7 they haven't opened up any skilled nursing
8 facilities.

9 It still comes down to a payment issue,
10 though, with regard to what the payment would be.
11 If a tribe could connect it to a 638 effort, perhaps
12 under something like the redesign authority of 638,
13 they could take some funding and attach it to a
14 facility, a nursing home or whatever, and call it a
15 638 which would qualify for 100 percent FMAP.

16 COMMISSIONER MEEKS: You know, this
17 issue of IHS becoming an entitlement program. What
18 are the arguments out there? I talked to Dr. Grim
19 briefly after the session and he said that there
20 were some political issues with that, which I'm just
21 not familiar enough with it to know what those are,
22 I guess.

23 MR. JEANOTTE: I think one of the
24 political issues would be the actual funding stream.
25 At this point in time, as you know, entitlements

1 flow through a trust fund. There is controversy as
2 to what is charged to the trust funds.
3 One other issue is that if it's
4 entitlement, what does it cost? As you may have
5 read in this week's papers, Part B Medicare
6 coinsurance is rising to $66 per month this year.
7 COMMISSIONER MEEKS: What's the IHS
8 budget overall?
9 MR. JEANOTTE: About $3 billion.
10 COMMISSIONER MEEKS: Three.
11 MR. JEANOTTE: And about another half
12 billion in revenue. So, about 3.5 billion dollars.
13 COMMISSIONER MEEKS: And VA I heard
14 yesterday was funded at about $26 billion?
15 MR. JEANOTTE: Yes.
16 COMMISSIONER MEEKS: And what's the
17 difference per capita?
18 MR. JEANOTTE: I think it might be shown
19 there. The column to the far left, the $5,214
20 number versus the column to the far right.
21 COMMISSIONER MEEKS: Is VA an
22 entitlement program or is it a discretionary --
23 MR. JEANOTTE: I'm not certain that it's
24 called an entitlement program. I believe it is an
25 entitlement for certain kinds of veterans, those

1 wounded in war and so on. I'm actually not a
2 veteran so I'm way out of my league here.
3 VICE CHAIRMAN REYNOSO: I'm a veteran
4 and I don't know.
5 MR. JEANOTTE: I suppose it's not an
6 entitlement of that sort.
7 Where their costs are, I believe is in
8 intensive medical care services. VA hospitals are
9 often near medical schools, and provide intensive
10 Medicare care. IHS does more primary care and buys
11 the more intense care.
12 COMMISSIONER MEEKS: But does the IHS
13 budget also include the cost of construction of
14 infrastructure, water and sewer?
15 MR. JEANOTTE: Yes.
16 COMMISSIONER MEEKS: It's a small
17 budget?
18 MR. JEANOTTE: Right. Right.
19 MR. FOX: An even better comparison in
20 terms of inflationary costs that is an entitlement
21 is the people that are in the service or get paid,
22 you know, the families of servicemen. There was a
23 report last month that showed their costs basically
24 tripling per capita over the last 5 or 7 years.
25 Well, that would have been nice if we had tripled

1 per capita standardized by person. And we weren't
2 able to maintain that kind of inflationary growth at
3 all.

4 And the VA isn't quite an entitlement.
5 Yes, a veteran is entitled to something. What he's
6 entitled to changes if he or she changes every year.
7 That's because it's a discretionary appropriation.

8 MR. JEANOTTE: Right. These are clearly
9 different populations.

10 VICE CHAIRMAN REYNOSO: Yes. Thank you
11 very much.

12 I have some questions also. Mr. Fox,
13 with respect to the issue of individual rights
14 versus tribal or collective rights, I just want to
15 mention to you that we've had hearings in Alaska and
16 in Hawaii. And I guess my conclusion would be that
17 we of the Civil Rights Commission have taken a
18 different view than the U.S. Supreme Court.
19 Unfortunately, they rule on cases. We just make
20 recommendations. Because, you know, Alaska for
21 example right now there's a great debate as to the
22 right of Northern Alaskans to do gathering and
23 hunting exclusively, because that's what they've
24 done for thousands of years. And if you allow every
25 Alaskan to do gathering and hunting in those

1 particular areas, it'll destroy their culture, their
2 economy, etcetera. The Governor has taken a
3 position in favor of protecting those rights, for
4 example.
5 My own personal view is that those
6 collective rights are, in fact, individual rights.
7 In Hawaii we see the contrast where the Hawaiian
8 legislature had passed a piece of legislation saying
9 that only native Hawaiians could be elected to a
10 board that controls a trust account for specifically
11 for native Hawaiians. That was challenged and the
12 U.S. Supreme ruled that to be unconstitutional, that
13 anybody ought to be able to serve on that board.
14 I think our view is; and certainly my
15 own personal view is, that the Supreme Court is
16 wrong. That it makes a lot of sense when you have a
17 fund for the benefit of native Hawaiians, that
18 native Hawaiians ought to be able to serve on the
19 board exclusively.
20 So you're right that as the U.S. Supreme
21 Court has seen it, somewhat a conflict sometimes
22 between collective rights and individual rights. To
23 me there's no conflict. It seems to me that the
24 individual right of those native Alaskans in the
25 northern part of Alaska, that their own individual

1 rights coincide with those collective rights. And
2 that's what we've seen with Indian rights and Indian
3 issues here in the 48 states, which explains why
4 many Indian tribes are quite disturbed about the
5 Hawaiian decision by the U.S. Supreme Court. Because
6 that implicates them on the collective rights that
7 folk have under treaties, and sometimes not, even
8 beyond treaties as part of the due process of
9 respecting each person's individuality, which means
10 belonging to a group.
11 You mentioned, for example and I want to
12 ask you, what the approach should be, what we should
13 recommend with respect to non-treaty tribes?
14 In California, and I'm from California,
15 we have a series of perhaps about 30 tribes that are
16 trying to get federal recognition. And we have some
17 small tribes that are so poor that even though they
18 have lived in the geographic area and are recognized
19 as a tribe, are so poor that they can't afford to
20 hire the experts to delineate for the BIA their
21 history and geography and so on. I understand it's
22 gotten very complicated to be recognized. And so
23 they'll probably go on for the next few hundred
24 years not being recognized, even though we all know
25 they are a tribe, they live in a certain area,

1 etcetera. It's a difficult practical issue.
2 What should we recommend? What should
3 we do about that aspect of it?
4 MR. FOX: The tribes that are not
5 federally recognized?
6 VICE CHAIRMAN REYNOSO: Yes.
7 MR. FOX: Of course, you don't have to
8 have a treaty to be federally recognized.
9 VICE CHAIRMAN REYNOSO: Oh, of course.
10 MR. FOX: And yet the process is
11 somewhat complicated. But I think it's the process
12 that we have to use, and we shouldn't tinker. You
13 can maybe reform it, but you should follow the
14 process that's in place for federal recognition.
15 Now, if there's a California tribe that
16 wants a consultant in how to get federally
17 recognized, I'll help them. I think there's enough
18 opportunities in California that -- I'm not sure I
19 believe that you couldn't find someone to help you
20 do your research.
21 VICE CHAIRMAN REYNOSO: I've been
22 meeting with many tribes because I'm a negotiator
23 for the gaming tribes. And they tell me that many
24 of them, the smaller tribes, are having great
25 difficulty along those lines.

1 I assume that from a sort of
2 philosophical point of view, which is what I think
3 you have raised, whether a tribe is recognized or
4 not if it's a tribe, that ought to be from a civil
5 rights point of view have the same rights, if you
6 will, as a tribe that has a treaty. If it's a
7 people?
8 MR. FOX: Well, our tribes believe that
9 you have to go through the federal recognition
10 process. You have to be a federally recognized
11 tribe.
12 COMMISSIONER MEEKS: Yes. Because you
13 were talking about treaty or non-treaty, not whether
14 they're federally recognized or not?
15 VICE CHAIRMAN REYNOSO: Yes. Those are
16 also different matters, as you indicated. Yes.
17 Well, let me ask you a different sort of
18 question. Again, I guess it's still sort of a
19 philological ground.
20 You mentioned the history of our country
21 and the efforts to assimilate the Indians into the
22 greater North American culture, including religion.
23 And manifestly, your statements are historically
24 correct.
25 In your view is that still going on or

1 have we changed our public policy in our country to
2 recognize more the autonomy of the Indian peoples?
3 MR. FOX: Well, there's some great
4 historical landmark legislation in the last -- you
5 know, Indian Self-Determination Act, Indian Health
6 Care Improvement Act, the consultation policies that
7 we see now in federal agencies, President Clinton's
8 -- what do we call it?
9 MS. DUPREE: Executive Order.
10 MR. FOX: Executive Order. Those are
11 good. But I think it's a bit like racism. No one is
12 a racist openly anymore. And no one is an
13 integrationist or an assimilationist vis-à-vis
14 Indian people anymore. You don't openly state that.
15 So it's harder to ferret out. But I think the
16 average American wishes Indian people would become
17 Americans.
18 COMMISSIONER MEEKS: Yes.
19 VICE CHAIRMAN REYNOSO: As Anglo-
20 Americans in the Americas is Anglo-Americans.
21 Presumably they're Americans already.
22 MR. FOX: They state it, that's probably
23 what they mean. They mean Anglo-Americans, European
24 Americans.
25 VICE CHAIRMAN REYNOSO: My final

1 question for you still goes somewhat along those
2 lines. You mentioned that health care is a
3 government function. And, of course, that's being
4 debated throughout the country now as to whether
5 it's a government function or an employer function.
6 And I take it you meant that particularly with
7 respect to Native Americans, not just generally for
8 the population?
9 MR. FOX: Well, no. I think more
10 generally, actually. I mean, to me the police powers
11 of the state are public safety, health, education,
12 and often roads. I mean, you can see variations
13 across countries. Of course, we're the only
14 civilized country in the world that also has
15 resources that doesn't have universal health care,
16 so that's different.
17 But Indian people are like most
18 civilized nations. They believe that health care is
19 essential to their people. So they, typically, want
20 and fight to provide it. Different than the United
21 States.
22 VICE CHAIRMAN REYNOSO: That interest is
23 so high in terms of the interest of the people of
24 this nation, and particularly with Native Americans.
25 But generally that you're saying it really ought to

1 be a government function?

2 MR. FOX: Well, that is my personal

3 view.

4 VICE CHAIRMAN REYNOSO: Okay. Good.

5 MR. FOX: I do think it just one of the

6 police powers of a state of the sovereign.

7 VICE CHAIRMAN REYNOSO: Mr. Jeanotte,

8 why do we still have data shortcomings? You

9 mentioned that several times. And, actually, Ms.

10 Dupree also mentioned it near the end of her

11 presentation. You'd think that by now, particularly

12 with the long involvement of government agencies in

13 providing health services that we'd have pretty good

14 data.

15 MR. JEANOTTE: There are a number of

16 reasons. A major reason is that the IHS does not

17 see the total Indian population in this country. If

18 they are on Medicaid living here in Albuquerque and

19 are Indian and go to Presbyterian Hospital here in

20 Albuquerque, the bill that goes to CMS for that

21 patient does not necessarily indicate that the

22 service was provided to an Indian. We don't really

23 know what is going on with the entire Indian

24 population.

25 The same lack of information results

1 when patients have private insurance and do not use
2 IHS services.
3 So on the entire Indian population data
4 is in many cases is nonexistent.
5 VICE CHAIRMAN REYNOSO: Well, we had the
6 testimony earlier today just talking about
7 Albuquerque and the great number of Native Americans
8 that are in the general area of Albuquerque because
9 they've left their homes because they couldn't find
10 jobs and so on. And at least the testimony was that
11 those Native Americans don't receive sometimes even
12 the same level of service as those in tribal lands.
13 Is there a way, in your view, of gathering that
14 data?
15 MR. JEANOTTE: Yes. And I touched on it
16 in my comments about the very important study that
17 Ms. Dupree just spoke to. In my mind, it's a
18 foundation for a larger study that could be done to
19 look at the total potential Medicaid population of
20 American Indians and could determine the level of
21 insurance access in the population.
22 If we could expand that project, we may
23 be able to get a better feel for the actual coverage
24 level in the American Indian population.
25 Our sense in IHS is that Indians who

1 live away from IHS facilities and travel to IHS
2 facilities have a lesser amount of insurance
3 coverage than U.S. all races. The American Indian
4 population is a young and migratory population,
5 often moving to jobs that do not provide health
6 insurance or they are reasonably healthy and that do
7 not access Medicaid services.
8 We think there is a lesser amount of
9 insurance in the population that we do not serve.
10 And clearly there is a lesser amount in the
11 population we do serve when compared to all U.S.
12 races.
13 VICE CHAIRMAN REYNOSO: Ms. Dupree, near
14 the end of your discussion you came back to the
15 trust responsibility. And apparently many of these
16 problems come up because the federal government, in
17 effect, has never quite recognized that or perhaps
18 lived up to an obligation to provide medical
19 service, as testimony earlier indicated, as part of
20 the agreement, the treaty that the federal
21 government had with certain Indian tribes. And you
22 described in great detail the various programs.
23 Would there be a way? I know it
24 includes legislation and all that. But in your view
25 would there be a way of simplifying the legislative

1 and administrative processes that now control the
2 system into a similar system whereby the federal
3 government could meet that obligation and make data
4 gathering a little bit easier? I see you're taking
5 a deep breath.
6 MS. DUPREE: Well, I could answer that in
7 two different directions really.
8 VICE CHAIRMAN REYNOSO: Yes.
9 MS. DUPREE: It's dependent on whether
10 we keep the programs as they are relative to how we
11 change the payment methodology and the collection of
12 data through how we pay for services, could be one
13 way.
14 Another way that I think is more
15 conducive to federal trust responsibility is to
16 allow tribes to directly operate these programs so
17 that they, who have a better working knowledge of
18 their communities and who are eligible and so forth,
19 and would have a greater chance of accessing the
20 information they need to enroll these individuals, I
21 think it would be simpler. They're difficult
22 programs to operate, especially the Medicaid
23 program, but within Medicaid and CHIP the tribes
24 could operate them. Again that would require
25 legislative change.

1 VICE CHAIRMAN REYNOSO: So if you had
2 more of a uniform system, then it would be easier to
3 come up with the statistics and so on that Mr.
4 Jeanotte had commented upon? Presumably it would be
5 easier to then analyze a little bit easier whether
6 or not that trust obligation is being met or not?
7 MS. DUPREE: Yes.
8 VICE CHAIRMAN REYNOSO: Mr. Fox?
9 MR. FOX: I was going to add that we do
10 something for our epidemiology programs at the
11 Health Board. We take, as given, anyone gets to one
12 of our programs and gets health care, INS funded
13 health care, is an Indian. We then take the tape --
14 we have permission from the tribes. We take the
15 tape and then we match that to disease registries
16 for cancer or other diseases. And some other
17 registries, too. And then we have a probablistic
18 software that pops up the names and decides is it
19 Edward John Fox with this Social Security number, is
20 it Edward J. Fox, is it Ed Fox. And we decide, we
21 match those people up and then we get accurate
22 disease rates.
23 So, if we can do that for disease rates,
24 I think you could find out better information if
25 some money would be invested in this.

1 I mean, CMS doesn't mind, although they
2 say they mind, spending $147 billion on Medicaid.
3 But for us to get $100,000 out of them, it would be
4 just-- that would never happen. That's impossible.
5 It hasn't happened yet, anyway.
6 VICE CHAIRMAN REYNOSO: I hate to end
7 the discussion on that impossibility, but I think
8 it's being realistic.
9 Any more?
10 Well, thank you very, very much. You've
11 been very informative and very helpful.
12 I'm told that we need to take a short
13 break, maybe 5 or 10 minutes, then I'll call our
14 last panel up.
15 Thank you again very much.
16 (Whereupon, at 3:08 p.m. a recess until
17 3:18 p.m.)
18 VICE CHAIRMAN REYNOSO: I'd like to call
19 the meeting to order.
20 I was a judge for many years, and I
21 never got a chance to use a gavel, so now I'll use
22 it.
23 PANEL FIVE: PROPOSED LEGISLATIVE AND STRUCTURAL
24 CHANGES AFFECTING DISPARITY
25 VICE CHAIRMAN REYNOSO: This is our

1 last panel dealing with proposed legislative and
2 structural changes affecting the disparities we've
3 been hearing about yesterday and today. So we're
4 very glad to get some answers to our questions.
5 We have Ms. Myra Munson, a lawyer, with
6 the law firm in Juneau, Alaska. I'm told that her
7 joining a firm in 1990 followed four years of
8 distinguished service, not just service but
9 distinguished service, as a Commissioner of the
10 Alaska Department of Health and Social Services.
11 And prior to that she was an Assistant Attorney
12 General specializing in matters pertaining to these
13 same issues.
14 She graduated from the University of
15 Denver School of Law, but then went all the way up
16 to Juneau. Simultaneously got a degree, a master's
17 degree in Social Work. So a person of many talents.
18 My notes that her specialty is, and then
19 it lists about 20 or 30 things. So I don't know how
20 she can be a specialist in all these things, but
21 this is what it says. Health law, lobbying,
22 regulatory practice, Medicare and Medicaid, Title IV
23 "self-governance" issues, representing non-profits,
24 nursing homes, mental health centers. We're going to
25 get a lot of answers to all these problems today.

1 Hospitals and other health care providers, Indian
2 child care, Child Welfare Act matters,
3 reapportionment law. We need you in California.
4 General representation of the firm's clients.
5 And she's in charge, as I understand it,
6 of the Juneau office of your law firm.
7 And Ms. Kay Culbertson, who is the
8 Executive Director of the Denver Indian Health and
9 Family Services in Denver, Colorado where Ms. Munson
10 left. And I think that you're still at Denver,
11 right?
12 MS. CULBERTSON: Yes.
13 VICE CHAIRMAN REYNOSO: And Ms.
14 Culbertson there is particularly involved with the
15 Indian Health and Family Services. She's an enrolled
16 member of the Fort Peck Assiniboine-Sioux.
17 MS. CULBERTSON: Assininboine.
18 VICE CHAIRMAN REYNOSO: Yes. From
19 Poplar, Montana. She traveled a ways.
20 She holds a bachelor of science degree
21 in human services. She serves on the National
22 Council of Urban Indian Health Board of Directors,
23 where she completed two terms as president and one
24 terms as vice president.
25 She has more, despite her youth, 20

1 years of experience working on behalf of Indian
2 communities in Denver and has testified before
3 Congress on health, financial and other matters.
4 She's participated as a member of the
5 Indian Health Care Improvement Act National Steering
6 Committee, the Indian Health Service Business Plan
7 Workgroup, and the Indian Health National Budget
8 Formulation Team. So she's had a lot of experience
9 in thinking about these issues and thinking about
10 answers to the problems we've been hearing.
11 So we'll start with Ms. Munson
12 MS. MUNSON: Thank you very much. It
13 really is an honor for me to have an opportunity to
14 testify before the Commission on Civil Rights on
15 these matters. I've had the privilege for the last
16 10 years of being a partner in a law firm that does
17 almost exclusively Indian work. We represent tribes
18 and tribal organizations all over the United States.
19 I have the smallest office -- this maybe not quite
20 the smallest office anymore -- in Juneau. We have
21 offices in four other locations, principally in
22 Washington, D.C. as well as one in Albuquerque.
23 I should start with an apology. I
24 apologize for not having gotten you a written
25 statement in advance. I had hoped to and other

1 commitments and a little bit of a head cold got in
2 the way of doing that. I will be submitting a
3 written statement.
4 VICE CHAIRMAN REYNOSO: Thank you.
5 MS. MUNSON: I had an opportunity a few
6 weeks ago to meet with two of your staff. And we had
7 about 3 hours with one of my colleagues, Carol
8 Barbero, who also specializes in Indian law. And I
9 found all of their questions thoughtful and thought
10 provoking, as I found the questions that have been
11 asked here. But one in particular really struck the
12 heart of my practice, and of the work that I feel
13 like I've done both as a lawyer and a social
14 workers. And it really triggered my thinking about
15 this.
16 They asked whether there were any
17 strategies that could reduce health disparities that
18 were not dependent on eliminating the funding
19 disparity. And that really does go to the heart of
20 this problem.
21 The level of under-funding is so
22 pervasive, as your report found, across all programs
23 of the federal and state governments, across all
24 programs that are intended to benefit Indians that
25 in response to what someone asked another panel,

1 will the funding disparity ever be eliminated?
2 Certainly. Will it be eliminated before the 2010?
3 We all know the answer to that and we shouldn't
4 dance around it. No, that funding disparity isn't
5 going to be eliminated.
6 One of the gentleman spoke pretty
7 harshly about if the United States will ever live up
8 to its moral, and in my view, legal obligations
9 financially, the deficit or the balance -- we had a
10 balance not all that long ago, a surplus in the
11 budget, we now have a deficit, but both are being
12 achieved by maintaining the health disparity of
13 Indian people by not fulfilling that responsibility
14 to provide the necessary funds and other things it
15 takes to eliminate health disparities.
16 The level of under-funding, as pervasive
17 as it is, is not however the only factor. It
18 exacerbates the conditions that affect Indians
19 derived from the forced resettlement, deliberate
20 government policies that were intended to eradicate
21 Indians.
22 First, literally, but then over time
23 more subtly, to eliminate family relations, to
24 eliminate language, to eliminate ties to the
25 community, to eliminate the powers of government.

1 Some of those tribes that have to seek to be
2 recognized were tribes that were, undoubtedly, were
3 terminated at one point. That certainly has been the
4 history around the country.
5 When you eliminate the identity of
6 people, when you eliminate the family relationships,
7 when you eliminate the community you create such
8 profound problems described early by your Chairwoman
9 in the most compelling ways. You create such
10 profound outcomes that there will be health problems
11 is an absolute given. There's insurmountable
12 evidence about the correlation between poverty and
13 health problems. There's equally, I think, profound
14 evidence about the correlation between dispossession
15 or discrimination about loss and the effect that it
16 has on one's health.
17 Those issues must also be addressed in
18 order for health disparities to be addressed, no
19 matter how much money there is. And that is not to
20 suggest, I ran a department, it all comes down to
21 the budget. The ultimate policy document is always
22 the budget document. It's always the appropriations
23 document. That's where you choose what you really
24 care about.
25 Executive Orders are nice. I've helped

1 write a whole bunch of policy papers and write
2 charters and statements and so on to get public
3 officials to sign, and I signed a few of them. And
4 they're all fine and well, and they make great
5 footnotes. But in the end, it's the budget document.
6 And you've heard lots of testimony about the
7 budgets. Those reflect our real policies.
8 In the statement I submit, I'm going to
9 elaborate on some these points, but I want to focus
10 on some principles that I think are essential to
11 addressing this combined catastrophe of a disparity
12 in funding and the status of Indians in the United
13 States, a status which is created by deliberate
14 policy and by subtle policy and subtly ignoring.
15 And sometimes worse, pretending -- pretending we
16 care about Indians as a matter of policy, writing
17 Executive Orders but not paying attention to them,
18 making public statements about how important the
19 funding is but not funding.
20 The system of care established by the
21 Indian Health Service, in my view, must be supported
22 and sustained. I spent nine hours yesterday in
23 Anchorage negotiating with IHS on the other side of
24 the table, and it was a very heated and contentious
25 negotiation on behalf of self-governance tribes in

1 Alaska over what might seem a very small point, but
2 which had very substantial meaning both in terms of
3 the relationship and the process as well as the
4 substance of the issue being negotiated. So, I'm
5 used to being on the other side of the table with
6 IHS. But I've been responsible for health services
7 for a state. As much as anyone can claim to be
8 responsible for health services in the United
9 States.
10 I think Dr. Grim, some other witnesses
11 have said, the Indian Health Service, the Indian
12 health system, is the only true system -- system of
13 health care that exists in the United States. A
14 system constituting something which starts with
15 prevention or has an element of prevention that
16 recognizes that if you don't have safe water and
17 sewer, that you don't have a decent health care
18 system. If you don't have housing for your health
19 care employees, you don't have a health care system.
20 One which also tries to provide direct health
21 services, one which buys health services when
22 they're not available directly. And no system -- no
23 health care provider provides every bit of health
24 care. Every health care provider refers someplace
25 else or buys the service someplace else in part.

1 This question of entitlement that's been
2 woven throughout the discussion here has been very
3 interesting, because there is, at the beginning of
4 the Clinton Health Reform Initiative I participated
5 with tribal leaders in huge meetings in which tribal
6 leaders were trying to come to terms with their view
7 of health care reform. And they were asked pointedly
8 by the leadership of that reform effort, and I think
9 in one meeting perhaps directly by then the First
10 Lady Hillary Clinton, well if we all get a health
11 card, if every Indian has a health card, then why do
12 you need the Indian Health system? Because that
13 health card does not get you culturally competent
14 care. That system doesn't buy you the reinforcement
15 of the tribal government. It doesn't ensure that
16 your provider will be an American Indian or Alaska
17 Native, that there will be role models in your
18 system who teach young people that there are
19 opportunities to participate in those fields. It
20 doesn't buy you relief from the discrimination that
21 occurs and from the biases and prejudices that occur
22 when you walk into other settings.
23 And, truthfully, it doesn't get you what
24 in the best systems, and listening to the stories
25 from Pine Ridge and listening to stories that others

1 tell, and I've listened to lots of them at meetings
2 from some of my clients and from others about the
3 catastrophes that can happen, you can't defend
4 those. But you can defend the system. The
5 improvements in Indian health that have resulted
6 from there being a system of care are truly
7 remarkable, notwithstanding the enormous challenges
8 that remain.

9 The opportunity for self-determination
10 and self-governance must also be sustained. It
11 cannot be underestimated how absolutely fundamental
12 to relieving the disparities that result from the
13 dispossession and from poverty, how tied they are to
14 the other parts of your report, your last report,
15 that weren't about health care under-funding but
16 about education under-funding, about housing under-
17 funding, about roads under-funding, about justice
18 under-funding, about the conditions in which Indian
19 people live. If you take away all the things that
20 allow people to be responsible for themselves and
21 have a sense of hope, to have an opportunity, then
22 health will suffer as well. And so fundamental in
23 self-governance, in self-determination, is the right
24 to also carry out your health program.

25 Tribes have assumed control, as you've

1 heard and I'm not going to try to give you any
2 numbers because I couldn't, sleep deprived as I am,
3 even if I wanted to. And you've heard them already
4 today. I'll put some in my written material.
5 But as tribes have taken over their
6 problems, some things are absolutely clear. Quality
7 and quantity of services go up.
8 Native hire or Indian hire goes up. It
9 increases. Even over the extremely good numbers that
10 Indian Health Service has, but even more
11 professionals get into the system, even more
12 American Indian and Alaska Natives have
13 opportunities to be encouraged to participate. And
14 that goes up.
15 Professional training, a commitment to
16 finding ways to do professional training. I work
17 with clients who've have done collaborations with
18 local colleges to run nursing programs, to train
19 their own business office staff to bill. This
20 hasn't been easy, it hasn't been a straight line,
21 but there's pride in meeting the standards. There's
22 pride in making the attempt.
23 These arise from the Indian Self-
24 Determination Act. They arise from the Indian
25 Health Care Improvement Act. They arise from the

1 Self-Governance Act. Each of these things plays a
2 part.
3 The initiatives that are underway, the
4 statutory initiatives, the strategies that tribes
5 will continue to pursue or one, the reauthorization
6 of the Indian Health Care Improvement Act. That
7 reauthorization is, in my view, represented in some
8 ways, I see change among Indian people. In the
9 past, the Indian Health Care Improvement Act was
10 written with some consultation with Indians, but it
11 was written by congressional staff and IHS
12 employees. This reauthorization bill, the two that
13 are pending in the Congress, were written by Indian
14 people, sometimes directing non-Indian lawyers, like
15 myself, or consultants to write paragraphs. But
16 they directed the policy. And those policies really
17 are intended to assure that there will be control by
18 Indian people, that the new law reflects the fact
19 that tribes have taken responsibility for their own
20 health care in substantial measure.
21 And I must say for those tribes, and
22 many in this region, have made the decision as a
23 self-determination, a self-governance decision to
24 continue to rely on IHS. That is as legitimate a
25 self-governance decision as that of a tribe that

1 chooses to operate the program themselves. They
2 carry a banner as well for Indian people in trying
3 to force that system to meet its obligations, and
4 they bring a voice that's important. And they devote
5 their own limited resources to the other priorities
6 they have and make IHS do these things. Other tribes
7 make a different choice.

8 So the Health Care Improvement Act does
9 that. It creates flexibility for funding, for
10 facilities. Lots of new flexibility. It also does
11 one more fundamental thing I want to mention, and
12 that it eliminates to large measure reference to
13 demonstration projects and instead makes reference
14 to a full continuum of care.

15 The Indian Health Care Improvement Act
16 in the past, like the Medicare and Medicaid billing
17 language, talks about facilities. Facility based
18 care is quite antiquated in the notion of care. It's
19 sort of out the window ten years ago. If you think
20 about it, how many inpatient beds have closed, how
21 many outpatient clinic examine rooms have had to
22 open? The model of care has changed. The Health
23 Care Improvement Act needs to catch up.

24 It also eliminates demonstrations
25 because demonstrations assume there'll be money for

1 them, there'll be a report and there'll be some new
2 money to actually do something with it. That really
3 hasn't been the way it's proceeded. So what we're
4 really looking for is giving tribes and the IHS the
5 broad authority and letting them on a local basis
6 find the resources they can.
7 We've applied those same principles to
8 the Medicare and Medicaid provisions. I said money
9 won't solve this problem, but money improves
10 everything. It helps a lot. The principles behind
11 the Medicare and Medicaid provisions of the draft
12 Indian Health Care Improvement Act and the other
13 advocacy and lobbying that's going on in the
14 Prescription Drug Bill in every meeting with CMS and
15 every other forum, is that there should be no
16 beneficial payment provision to any kind of entity
17 that isn't equally made available or better to
18 tribes. That administration should be simplified,
19 that you should not be devoting resources to more
20 and more complex billing activity, and that the
21 priority setting should be driven by the health
22 needs, not by chasing which little box the Medicare
23 and Medicaid program has chosen. We say rather than
24 conform the Indian health program to Medicaid, let
25 the Medicaid conform to the Indian health program.

1 It would be better, I suspect, for the Medicaid
2 program generally if they tried that and, in fact,
3 learn from it and made those options available in
4 other settings.
5 Cautionary notes from me. Finally, I
6 apologize. I'm way over time.
7 Reform is really should be watched out
8 for. We heard about 1-HHS -- someone asked a
9 question earlier. 1-HHS if it's a way of achieving
10 efficiencies in the Department is terrific. If it
11 results in fewer Indian people controlling Indian
12 programs, which I guarantee you it will result in if
13 it is not dramatically changed, notwithstanding the
14 assurances we heard this morning, that will be a net
15 loss in every level. Spending money on new
16 administrative initiatives without new
17 appropriations will take dollars away from health
18 care. That's a mistake.
19 Reform that drives toward an insurance-
20 like model in which care is fragmented is not a
21 reform that improves health status. It may improve
22 access to certain kinds of care, but it will not
23 improve health status.
24 Finally, with regard to entitlements.
25 Two things about entitlements. The first is if you

1 establish an entitlement, you have to determine the
2 basis of the entitlement? Is it an entitlement to
3 tribes to provide health services or the Indian
4 health system? My preference, the Indian Health
5 Service, the urban Indian programs and tribes
6 entitled organizations. Or is it an entitlement to
7 individuals? If it's an entitlement to individuals--
8 which individuals?
9 When folks were saying they couldn't
10 tell you numbers, you can't count how many Indians
11 there are because there's no common definition of
12 what an Indian is. Being an Indian fundamentally
13 for the tribes I represent is that you're a member
14 of a federally recognized tribe or that they
15 recognize you as an Indian. But for certain Indian
16 health service programs, as it should be, it's a
17 different definition. For the Census it's you said
18 so. For CMS it's you said so. That's not something
19 upon which one can base an entitlement. And those
20 extraordinarily complex issues must be decided
21 before there can be. And that's why the Health Care
22 Improvement Bill in the Senate has a commission to
23 study these things and not a conclusion about what's
24 right.
25 And the second reason is entitlements

1 are intended to create floors, but frequently create
2 ceilings. And Indian people are so small in number
3 and so quiet a voice, no matter how loudly they may
4 try to speak, and we saw in the Medicare
5 Prescription Drug Bill. One last example. We took
6 lots of provisions around saying look how badly we
7 need this. You can't get into those meetings.
8 When the bill's first draft came, when
9 the first bills came out, we found lots of
10 provisions in there that we've been wanting to get
11 but other voices were heard louder. There were more
12 of them. And they got their provision in and we went
13 and said, "Please add us, too." And that's in
14 conference. When we asked, the last email I sent out
15 to the folks I had been meeting with to say what's
16 going on, are they talking about our provisions?
17 The answer was yes. One word. Well, do you need any
18 more information; are there any more questions? The
19 answer was no. Those rooms are closed to us. I
20 don't know who else is getting into them. I suspect
21 there are some folks who are, but it's not Indians.
22 Thank you.
23 VICE CHAIRMAN REYNOSO: Thank you very
24 much.
25 Ms. Culbertson?

1 MS. CULBERTSON: Well, my focus will
2 really be on the urban issue.
3 And I'd like to start out by saying
4 thank you very much for inviting me to participate
5 in this testimony.
6 I had created a Power Point
7 presentation, so that's what you have. And I'm
8 really disappointed because my pictures were fade in
9 and fade out, and so I don't want to have to read
10 everything to you.
11 But I'd like to start out by saying that
12 I am an enrolled member of a federally recognized
13 tribe, the Assiniboine-Sioux from Fort Peck,
14 Montana. And I'm not an urban Indian. I'm a member
15 of a federally recognized tribe who happens to live
16 off the reservation, who happens to live in the
17 city. My children are enrolled; my grandchildren
18 will be enrolled. And I imagine that they will live
19 off reservation also. It's just opportunities for
20 Indian people living on reservation are so limited.
21 And that brings me to how urban programs
22 were created and urban communities were created. It
23 was a lack of housing, obviously. If urban Indians
24 are now making up 63 percent of the population of
25 the total Indian population, could you imagine if we

1 all moved home? Then how would they meet that
2 federal trust responsibility for the Indian people
3 that are living off reservation?
4 A lack of employment. Education
5 opportunities and federal relocation policies. They
6 have stopped, but still people are still continuing
7 to move to the cities. Off reservation adoption and
8 to escape racism, cultural pressure, poverty. And
9 that's the main reason why my parents moved off our
10 reservation.
11 Off reservation Indians today comprise
12 nearly 60 percent of the total Indian population.
13 We continue to have ties to our homelands, to our
14 reservations. I know I go home on a regular basis. I
15 know. I go home, people know who I am. Because I
16 had the opportunity to go to high school there. A
17 lot of people still remember my father from when he
18 was young and lived there. But we've become
19 invisible to not only federal policies, but also in
20 the cities in which we live in we're considered
21 "other." That's why there aren't any statistics on
22 Indian people that live off reservations, because
23 we're often times lumped into the "other" category.
24 Regardless, though, Indian people that
25 come into my clinic I can tell you are 100 percent

1 members of federally recognized tribes. We're one
2 of the few clinics that have that distinction of the
3 Urban Health Care providers. And when they come
4 into our clinic, our little tiny clinic, they expect
5 that they are covered with full Indian health
6 benefits and can't understand why we can't pay for
7 their prescriptions. Can't understand why we can't
8 send them to cardiologists. Can't understand why
9 they have diabetes now and they have to go on
10 dialysis, why do they have to go home for care? Why
11 can't they stay here? They have families in Denver.
12 They continue to suffer many of the same
13 social and health ills as those on the reservations.
14 Society perceives us as casino rich; the government
15 takes care of us and we're just another minority
16 group. Indian people are not just another minority
17 group. We exist as a political entity also, and
18 therefore we are a little bit different and should
19 be treated differently than the other minority
20 groups.
21 And we're definitely not casino rich,
22 not all of us. I do know my tribe; I don't think
23 it's making any money off of our casino. And that
24 was evident in now Governor-Elect Schwarzenegger's
25 statements about Indians needing to pull their full

1 share now in California.

2 You'll see a picture of two little boys.
3 They're at a celebration and they're dressed in
4 their traditional outfits, grass dancers. Both of
5 these boys are members of the same federally
6 recognized tribe. Both love to grass dance. Both
7 love sports and the Broncos. Both participate in
8 traditional ceremonies. And both don't have health
9 insurance. Can you find the difference in one of
10 those boys? One of those boys has a different zip
11 code and lives off reservation.

12 The boy living off the reservation
13 cannot access contract health care. Oh, no, wait.
14 I'm sorry. The boy living on the reservation can
15 access contract health care. Has access to
16 comprehensive dental services. Has access to
17 specialty care. And I'm not saying one of the boys
18 is in psychiatric care, but that's an example of the
19 things that we don't have in Denver or in many of
20 the urban programs. And respiratory services.

21 Community health representative support
22 and provide home visits to that child's family. They
23 have comprehensive medical services from cradle to
24 grave. They have prenatal care, and then they're
25 taken until their end of life, almost. They have

1 full prescription coverage, granted there's
2 formularies and limitations, but they still have
3 prescription coverage.
4 If that child should have cancer, he
5 would be covered under the Catastrophic Health
6 Emergency Fund. And he can receive services
7 regardless of his family income.
8 The boy who lives off reservation has
9 limited access to health care. Has a family who
10 must income guide limits for any state or federal
11 health plans. Does not have comprehensive health
12 care if he lives in Denver. Does not have emergency
13 or urgent care services unless the family is willing
14 to go without to be able to pay for those emergency
15 care. Does have access to basic health dental care.
16 Many providers in Colorado are not accepting
17 Medicaid patients for dental care. And has a family
18 who hopes he never has to go to the emergency room.
19 I'm going to talk about some bills that
20 have been placed that really will affect urban
21 Indians or urban Indian health care. And one was the
22 Urban Indian Health Bill that Senator Bingaman put
23 forth. It extended federal Medicaid match, the FMAP,
24 to urban Indian health programs. That's not
25 extended to us.

1 It would provide incentives for states
2 to work with their urban Indian populations to
3 increase state revenue received for Indian Medicaid
4 patients. We saw in Denver, in Colorado, the state
5 legislature was trying to pass a bill for substance
6 abuse treatment that would get the 100 percent FMAP,
7 and then start up a special fund for Indian people
8 that have substance abuse issues and needs, and
9 unfortunately they needed to come with $40,000 to be
10 able to actually write the legislation. And no
11 program could actually come up with that much money
12 to pay that person to come with that legislation.
13 And, apparently it had to go through their state
14 office and such.
15 FMAP increases our bargaining leverage
16 for urban Indian clinics when we're working in a fee
17 for service setting or an HMO setting. It was
18 introduced in the 107th Congress, but will need to
19 be reintroduced in the current session. It died for
20 lack of cosponsors.
21 Now we get into the Indian Health Care
22 Improvement Act. This is the one that is proposed.
23 Myra was one of the attorneys that helped us
24 formulate a lot of it. And one of the things that
25 actually I was quite excited about was the qualified

1 Indian Health programs where it really set us up as
2 an Indian health system, and urban programs could
3 work with tribes for referrals and the hospitals,
4 and we would really share. We would have a good
5 data package. Unfortunately, it came out too
6 expensive and it was dropped from the Indian Health
7 Care Improvement Act. But as far as the proposed
8 legislation, it extends scholarship eligibility to
9 members of state recognizes tribes.
10 It also authorizes urban Indian programs
11 to receive payment from private health insurance,
12 state and federal health programs as out of network
13 providers. That means we don't have to have
14 contracts with all these providers.
15 It allows urban Indian health programs
16 to operate satellite clinics.
17 Importantly, it authorizes Federal Torts
18 Claims Act coverage for urban Indian health
19 programs. Right now malpractice insurance is, you
20 know, on a national level very expensive. It
21 prohibits us from being able to provide certain
22 types of services.
23 And it also makes permanent the Oklahoma
24 City and Tulsa Demonstration Projects as urban
25 Indian health programs. We feel that this is very

1 important because they see so many different tribes.
2 And as we have seen in the Oklahoma area, as tribes
3 start to 638 the health care away from the Indian
4 Health Service, they have limited services to their
5 tribal members, which means that 100 and some other
6 tribal members that live in those areas would be out
7 of services.
8 And the construction of two adolescent
9 treatment centers for urban Indian youth.
10 I see I'm yellow.
11 The Balanced Budget Act also was
12 something that was really great for urban Indian
13 health programs. This is the first time that the
14 tribes in the urban programs have really worked
15 together to look at some funding issues. And there
16 was a set aside for urban Indian programs of five
17 percent. And because of that set aside, we were
18 able to really focus on diabetes prevention and
19 treatment. We've been able to create fitness
20 programs in communities where none existed before.
21 And it allows off reservation Indian people
22 consistent monitoring of their glucose levels. And
23 it created education and support groups for urban
24 Indians, something that really did not exist up
25 until this funding was available.

1 I want to talk about the Indian Child
2 Protection and Family Violence Act. You have it in
3 front of you. You see what it provides. It does
4 not include urban Indian communities and Indian
5 children are placed in foster homes in a high rate
6 in urban communities also.
7 I think my recommendations for this
8 group are that they recognize the needs of Indian
9 people who live off reservation. Their needs are
10 often as great or worse than those who reside on
11 their homelands.
12 The survival of all Indian people
13 requires holistic health initiatives that include
14 physical, mental, spiritual and social program
15 development.
16 And funding at local, state and federal
17 levels should not be limited to tribal and tribal
18 organizations, but should include off reservation
19 Indian communities. A lot of times it's only limited
20 to tribes and tribal organizations.
21 This is not urban Indians versus tribes.
22 I just want to be very clear in that. This is the
23 federal government has failed to meet its trust
24 responsibility and treaty obligations to Indian
25 people. And because I'm an Indian in Denver, I

1 should still have access to those services.
2 Luckily, I have health insurance, but there are a
3 great majority of people that do not that are Indian
4 people who are living off reservation.
5 The health conditions for Indian people
6 are alarming and the funding levels for addressing
7 health concerns, I think, verges on criminal. I
8 think it is appalling, and I think that somebody
9 needs to look at it and do something about it.
10 As you can see, I have included some per
11 capita spending disparities. You can read those.
12 But FEHP is the Federal Employee Health Plan, and
13 the USBP is the prison population's health insurance
14 or what is spent on them.
15 And then, of course, there's the IHS,
16 which is 1,914 versus 3,803 for somebody who is in
17 prison.
18 Indian Health Service spends $359 on the
19 user population for urban Indian people who live off
20 reservation.
21 And in closing, I'd like to thank you.
22 And I hope that this will make a difference.
23 And thank you for saying that I was
24 young.
25 VICE CHAIRMAN REYNOSO: Thank you very,

1 very much.

2 COMMISSIONER MEEKS: I never did hear

3 what percent of Indian Health Service budget is

4 spent on urban programs. Doesn't anyone know?

5 MS. CULBERTSON: It's between 1 and 2

6 percent.

7 COMMISSIONER MEEKS: And your numbers of

8 60 percent of Indian --

9 MS. CULBERTSON: The U.S. Census says

10 that we have 63 percent of the Indian population.

11 Granted, there're only 34 urban Indian health

12 programs across the country. We don't -- --

13 COMMISSIONER MEEKS: And the U.S. Census

14 was the ones that said whoever said they were, were?

15 MS. CULBERTSON: Yes. Yes.

16 COMMISSIONER MEEKS: Okay.

17 MS. CULBERTSON: But I was at a meeting

18 in Denver and there was a tribal chairman from

19 Blackfeet. And he was talking about his tribal

20 numbers. And he was saying we have 50,000 tribal

21 members, 10,000 of them live on the reservation.

22 Okay. So where's that other 40 percent of those

23 enrolled tribal members?

24 COMMISSIONER MEEKS: Thank you. I don't

25 even know the question to ask.

1 MS. CULBERTSON: I know. There're two
2 of us sitting here from Fort Peck right now.
3 COMMISSIONER MEEKS: You know, you were
4 talking and asked Dr. Grim that one HHS initiative.
5 And I remember when that first came up and people
6 were concerned that that would result in a net loss
7 of Indian employees. And yet he seemed to -- and I
8 don't understand what else that entailed and didn't
9 get a really good chance to ask him about that. So
10 if you could just elaborate on it quickly?
11 MS. MUNSON: There are folks I work with
12 in the community of consultants and lawyers who work
13 with tribes who have more detailed knowledge of 1-
14 HHS, but I've sat through now two or three fairly
15 lengthy discussions with Dr. Grim and with other
16 folks about the 1-HHS.
17 And I think that IHS has done a terrific
18 job of trying to inform HHS and deal with the
19 Secretarial Initiative to integrate all these
20 programs. They've made a substantial inroad on the
21 issue of native hire when it came to the HR programs
22 by allowing them to stay where they were. But
23 unless I'm mistaken, it's certainly possible I am
24 but I don't think I am, the plan is they stay where
25 they are for a period of time. At the point at

1 which the vacancies, they may move. Whether they
2 move or not after a couple of years when the
3 position has something to do with the magic of the
4 federal personnel system, it hits a certain status,
5 then the position does move out of the IHS budget
6 into the HHS budget. And in the HHS budget, if it
7 switches categories, it cannot, as a matter of law,
8 be subject to Indian preference.
9 COMMISSIONER MEEKS: Right.
10 MS. MUNSON: That applies only so long
11 as the positions are retained in the IHS budget.
12 And I believe I sat in a briefing in which we were
13 clearly told that down the road those positions will
14 end up part of HHS. That means there will be a
15 loss.
16 Even if theoretically they could be
17 Indian preference positions as part of HHS, to the
18 extent some positions are consolidated, and clearly
19 that's the longer-term strategy, the pool of people
20 to hire will be smaller. The pool of people who have
21 had experience living on the reservation, living in
22 their own community will be smaller. And that
23 informs their understanding of the value of native
24 hire or Indian preference.
25 To somebody whose never seen what the

1 difference makes, you don't get it. You can't. I
2 mean, it just seems like you hire a really highly
3 qualified person, why isn't this really highly
4 qualified person fungible with the next really
5 highly qualified person? Well, in the simplest
6 terms I think about one of the programs I work with
7 a lot. Their president is a Upik person from the
8 region. I don't think educated at a college level,
9 but educated totally in the ways of his community
10 and how to get things done.
11 The new executive vice president is a
12 law school grad who came from that community is a
13 Upik woman who was born in the hospital where she's
14 getting care. And her two children have now been
15 born and where she has every expectation her great
16 grandchildren will be raised and be born in that
17 region.
18 They have a commitment to that health
19 care that's totally different.
20 Their two lawyers in this own in-house
21 counsel now are both from that region.
22 That makes a difference, and that
23 creates an impression throughout the community that
24 means that more young people in that community will
25 get a chance to be educated.

1 So Indian preference is far more than
2 just the jobs of the individuals, as I know you
3 understand.
4 The other part of the initiative I
5 referred to and I made reference to their need for
6 new appropriations. There's a huge financial
7 management project going on in HHS to try to improve
8 the financial management systems of the Department.
9 And I'm informed by lots of folks that it's badly
10 needed and a good project. But it's costing truly
11 hundreds of millions of dollars. And each agency is
12 expected to contribute through assessment to meet
13 that budget need. It's not being budgeted. Nobody's
14 going to the Congress and saying we're going to do
15 this only if we get these funds.
16 Well, we may need it, but do you need it
17 at the expense of what? I think those are the
18 choices throughout the 1-HHS. There's been
19 discussion. There was discussion of various other
20 aspects of it, some of which have been aside. We
21 don't know where others will end up.
22 COMMISSIONER MEEKS: So is the momentum
23 decreasing or increasing?
24 MS. MUNSON: I can't tell. There's been
25 quite a bit of push back from the Congress, at least

1 as it applies to the Indian programs, but not a bar
2 on it by any means. And it's clear that they -- 1-
3 HHS is certainly applying to IHS in the form of
4 reduction of positions are being applied across the
5 board, including to IHS, notwithstanding the huge
6 downsizing they went through when they said they
7 turned programs over to tribes, and tribal
8 organizations. They're still being required to cut
9 positions.
10 So they're certainly being included in
11 lots -- they're subject to recessions. They're being
12 included in lots of 1-HHS initiatives.
13 COMMISSIONER MEEKS: The other question,
14 you both referred to the 638 programs. Except that
15 I've not understood Kay's point. I mean, you said
16 when you talked about tribes 638, their health
17 services, that quality of care went up and services
18 and all that. But you said in Oklahoma, like Tulsa
19 and Oklahoma City, that when the tribe did it, it
20 actually went down?
21 MS. CULBERTSON: No, no, no.
22 COMMISSIONER MEEKS: Okay.
23 MS. CULBERTSON: I didn't say that. I
24 said that actually with the tribe, some of their --
25 it's a movement that when the tribe 638 that they

1 will only serve their tribal members, the people
2 that are from their tribe.
3 COMMISSIONER MEEKS: Oh, I see.
4 MS. CULBERTSON: So if Pine Ridge were
5 to 638, they could say we're only going to serve the
6 people from Pine Ridge. If they take over those
7 demonstration projects in Oklahoma City and Tulsa --
8 COMMISSIONER MEEKS: Right. Yes.
9 MS. CULBERTSON: -- the people that are
10 like me -- Albuquerque is not my area office.
11 COMMISSIONER MEEKS: Correct. Correct.
12 MS. CULBERTSON: You know, would lose
13 out on those services. Where would those people go
14 for services?
15 MS. MUNSON: I think one piece you have
16 to appreciate about -- and actually it responds to a
17 question earlier this morning. You have to
18 appreciate how limited what a tribe takes over. IHS
19 is dramatically under-funded. When a tribe takes
20 over the program, it gets the funds that IHS was
21 spending or would have spent in that service unit.
22 And then it gets the little bit of increases that
23 come or decreases that come from year-to-year
24 associated with that base recurring funding.
25 So whatever under-funding was there is

1 still there.

2 Tribes in my experience in a straight
3 line, and certainly not informally, but consistently
4 generally have moved fast to improve third party
5 recovery just because they've had to. They also can
6 say with some greater credibility with their members
7 and with their users that it benefits them to apply
8 for Medicare and Medicaid. When IHS says it, it
9 really is a slap in a face.

10 When a tribe says it, it's painful to be
11 told that you can only get your benefits if you go
12 on welfare. But folks are pragmatic and survivors
13 and they understand that those dollars will come
14 back into their own health system and provide some
15 more care that they otherwise would go without. And
16 so they're more willing to do it.

17 So there are many reasons that it helps
18 when the tribe takes it over.

19 COMMISSIONER MEEKS: I just have just
20 one last question.

21 You talked about, you know, people have
22 the cards and would that -- I mean, is there not
23 enough market then? Because, right, supposedly a
24 client could open and up they would get paid because
25 these people have, you know, everybody has a card.

1 I mean, wouldn't there not be enough market, and I
2 may be using the wrong terms, but to provide for
3 competitive health care and you'd want to hire
4 people from the area because -- no?
5 MS. MUNSON: Not a chance.
6 COMMISSIONER MEEKS: Okay.
7 MS. MUNSON: And I'll keep this short, I
8 hope. But let me give you about three reasons
9 really quickly.
10 First of all, look at how many providers
11 there are for Medicare beneficiaries who need to go
12 to a doctor. Just, you know, do a google or
13 something to find, or whatever one does to look up
14 newspaper stories about how difficult it is. Listen
15 to the story about Medicaid beneficiaries trying to
16 find a dentist.
17 COMMISSIONER MEEKS: Yes.
18 MS. MUNSON: Floors and ceiling is a big
19 problem. You give a card, what will the payment
20 rates be that attach to that card? If the payment
21 rates aren't high enough and if they're controlled
22 by the federal government, they certainly will not
23 be high enough over time.
24 Secondly, you're now building an entire
25 health system for Indian people on a cheaper service

1 or unit by unit by service basis. That's what the
2 rest of us have. And no American, in my opinion,
3 should ever go into a hospital without another adult
4 with them to monitor every single thing that
5 happens, no matter how high quality it is. In a
6 well run Indian program, IHS or otherwise, that need
7 is reduced some because that really is a community
8 in many respects. Everybody in that hospital will
9 know who you are and it's a smaller community.
10 Go into your local hospital and you don't get
11 that.
12 If you've ever tried to get specialty
13 care and you bounce from place to place trying to
14 get it, you don't have care home.
15 And finally, I just want to make
16 reference to managed care. Entitlement cards in
17 this country will drive toward managed care. That's
18 what every Medicaid program has done, that's what
19 Medicare wants, and the Administration badly wants
20 to do with Medicare. It's the fight going on in the
21 conference right now behind the closed doors.
22 Managed care providers are there to make
23 money for their stockholders. The theory of managed
24 care is they would have a long-term stake in
25 preventive care, because they'd be there for the

1 long haul, and so they'd reap the benefits of the
2 preventive care. But that is not what has happened
3 with managed care in this country.
4 The turnover among managed care
5 providers is enormous. That's a profit making
6 business like any other. And it is fundamentally
7 different than the way Indian tribes, tribal
8 organizations, urban Indian organizations, and the
9 Indian Health Service run their programs. They're
10 there for the long haul. They're going to be there
11 200 years from now.
12 COMMISSIONER MEEKS: Thanks. Cleared
13 that right up.
14 VICE CHAIRMAN REYNOSO: Yes. Ms.
15 Munson, I've got a difficult question for you.
16 You mentioned that dealing with health
17 strategies is a dual function. One is money, and
18 you ended up your testimony by saying money helps in
19 all the things that you have mentioned. But you did
20 mention one matter with many subsections of the
21 other part. And that had to do with the importance
22 of other realities in the Indian society. The
23 elimination of families, the elimination of
24 identity, the poverty results and so on.
25 What do you think the role of government

1 ought to be, and I have in particular mind the
2 federal government, in dealing with those matters?
3 The matters of funding and all that, one can easily
4 say well the rule of government ought to be to
5 simply fund it sufficiently. How about the other
6 matters?

7 MS. MUNSON: The other matters are about
8 sometimes getting out of the way and sometimes
9 putting barriers in front of deliberately or not so
10 apparently deliberately policies that have clearly
11 deleterious effects. And let me give you a couple
12 of thoughts about that.

13 The getting out of the way is in some
14 respects best characterized by what tribes have
15 accomplished through the self-governance projects
16 with Indian Health Service and Bureau of Indian
17 Affairs and even DOI, despite their resistance to
18 it. The other programs of the Department of the
19 Interior other than Bureau of Indian Affairs.

20 When tribes have the opportunity to take
21 over a variety of programs and redesign and
22 reallocate and run those programs, set their own
23 priorities and run them, they don't do what every
24 official who ever had to give up control of a grant
25 program is sure they'll do, which is take the money

1 and spend it on something totally unrelated. They
2 can't do that anymore than anybody else could,
3 because their members have a stake in that benefit,
4 whatever it is, whatever that program is. But what
5 they can do and what they do do is within months,
6 years, sometimes it takes years, they gradually
7 conform that program to match other priorities and
8 achieve a larger -- they achieve a synergistic
9 effect and they reshape it. And they, in fact, add
10 their own resources to it whether they're human
11 resources or where there's capacity, financially
12 resources. So you can get out of the way.
13 We're hopeful, and there are two bills
14 pending now in Congress just in introduced. The
15 Self-Governance amendments that would amend Title IV
16 of the Indian Self-Determination Act relates to
17 Department of Interior programs, including Bureau of
18 Indian Affairs Programs. And it will eliminate some
19 of the barriers there to full self-governance by
20 tribes with those funds. And a separate project in
21 Department of Health and Human Services, the Title
22 VI legislation that would authorize a demonstration
23 project for certain programs of HHS. More limited
24 than in my personal view it should have been, but
25 nonetheless, the intent there is to try to eliminate

1 silos. You know, this little bit of money comes for
2 HIV and comes with all of its grant rules and this
3 little bit of money comes for pregnancy abstinence,
4 and this little bit of money comes over here for
5 syphilis protection. And, you know, I'm not a
6 public health person in the sense of having health
7 care training, but when I was Commissioner I
8 remembered sitting in a room with the public health
9 people in my department and saying to them "Wait a
10 second. What do you mean you got three units doing
11 these three things; pregnancy prevention, STD
12 prevention and HIV? Tell me if I got it right, but
13 won't a condom cure all of those things?" Now that
14 oversimplifies it, but can't we measure some
15 successes across these lines at very least.
16 So get rid of silos. That's part of the
17 answer of self-governance.
18 The other piece in terms of eliminating
19 barriers is things like the Indian Child Welfare
20 Act, which went into effect in 1979. I mean, we
21 think about forced relocation and we think about the
22 boarding schools and those things as things in
23 fairly far past. But they're so recent.
24 In 1979 when the Indian Child Welfare
25 Act went into effect, it cited the statistics, which

1 were current. There were places where 50 percent of
2 the children were in out of home placement, and
3 substantial percentages of those off the
4 reservation, outside the -- even near accessibility.
5 When I used to do training on Indian
6 Child Welfare Act, and I spent a long time doing
7 child protective services and those things and
8 representing social workers in those proceedings.
9 You know, I talked to non-Indian folks. You don't
10 have to Indian or Alaska Native people about this.
11 But you talk to a non-Indian community and you say
12 to them what would happen in your community if over
13 the course of a year 25 percent of the children, let
14 alone 50 percent, were removed from their families
15 by the courts and placed in home with people of
16 different color, different language, different
17 experience, where visitation was not permitted? And
18 that was still happening.
19 And if you look at the foster care
20 statistics all over the country, they're still
21 appalling where Indian children are concerned. The
22 Indian Child Welfare Act helps with that, to some
23 extent, with more resources it would help a lot
24 more. If the Justice programs were funding tribal
25 courts in places that don't have them or building

1 them up and others, it would help even more.

2 Each of these pieces, each of these

3 things which recognizes that the Indian community

4 has a right to exist, that it's fundamental that it

5 has a right to exist, that honors that recognition

6 with real power and some resources to exercise that

7 power changes the dynamic and improves the

8 situation. And I think you see that wherever tribes

9 have had the opportunity to run programs themselves

10 and to exercise their rights.

11 VICE CHAIRMAN REYNOSO: Ms. Culbertson,

12 Ms. Munson agreed with the government officials that

13 the Indian health system is perhaps the only

14 integrated system we have in the country. And she's

15 just arguing to make it better, really.

16 You're saying it doesn't make sense for

17 the urban Indians. My question to you is how can

18 you make it exist?

19 MS. CULBERTSON: Well, I think that

20 there needs to be additional funding for urban

21 programs to be able to participate in the Indian

22 health system.

23 VICE CHAIRMAN REYNOSO: But it appears

24 to become easier in a tribal situation where you

25 know whose eligible and who isn't. Do you have

1 eligibility problems in an urban area? Will people
2 have to enroll it? How would you make those
3 decisions.
4 MS. CULBERTSON: Well --
5 VICE CHAIRMAN REYNOSO: Let me give an
6 example. In California we have, you know California
7 history and Native Americans is different than the
8 rest of the country.
9 MS. CULBERTSON: Yes.
10 VICE CHAIRMAN REYNOSO: In most of it.
11 And we have in fact Indians who are nowadays
12 identified as mission Indians. Well, they didn't
13 exist before the missions. What are mission Indians?
14 Mission Indians were Indians from different tribes
15 that were forced to go the missions, and that became
16 in some ways their identity. They lost some of their
17 individual identity.
18 Is that happening among urban Indians?
19 I know you and your family are not, but are some
20 losing their tribal identity?
21 MS. CULBERTSON: I would say as in any
22 community, that you do see other kids that are mixed
23 race that are still eligible for enrollment in their
24 recognized tribe.
25 Now, when you're talking about how do

1 you determine the eligibility --

2 VICE CHAIRMAN REYNOSO: We heard, for

3 example, testimony about Albuquerque.

4 MS. CULBERTSON: Yes.

5 VICE CHAIRMAN REYNOSO: 36,000 Indians

6 in Albuquerque.

7 MS. CULBERTSON: Yes.

8 VICE CHAIRMAN REYNOSO: Assume that the

9 government said, okay, we want to set up a health

10 system for the urban Indians in Albuquerque.

11 36,000, that's a lot.

12 MS. CULBERTSON: Yes. Yes.

13 VICE CHAIRMAN REYNOSO: And you need a

14 hospital, and you need clinics and so on. How do

15 you go about doing that? You need money, but beyond

16 that?

17 MS. CULBERTSON: You still need money.

18 And I think, you know, I would never be one to say

19 that I would want to determine who an Indian person

20 was.

21 VICE CHAIRMAN REYNOSO: Say that again?

22 MS. CULBERTSON: I would never want to

23 be the person who would determine who an Indian is.

24 VICE CHAIRMAN REYNOSO: Well, we get

25 into that--

1 MS. CULBERTSON: But -- but -- but.
2 VICE CHAIRMAN REYNOSO: Yes. Okay.
3 MS. CULBERTSON: But there are
4 mechanisms in place for determining if you're an
5 eligible beneficiary for Indian Health Service. And
6 one of them is that you're a member of a federally
7 recognized tribe.
8 Now, this is one thing that I think that
9 the government wanted us to lose our identity, and
10 so they decided to start keeping -- on us, and you
11 know, I've heard people compared to dogs and
12 pedigrees and such. But, you know, I have a
13 different perspective because I think in my own
14 growing up, I realized that if I marry out too much
15 further or that my children marry out too much
16 further, they will become of the dominant society.
17 Therefore, I made conscious choices.
18 Now, you come into my clinic and you
19 want to get a flu shot, you're coming in with your
20 tribal identification. It's up to the tribe to
21 decide who their tribal members are. I have no
22 problem with that. I think that anybody whose
23 working in Indian health, that is a tribal
24 sovereignty issue and we support it. And therefore,
25 it's very easy to determine who is an eligible

1 Indian.

2 VICE CHAIRMAN REYNOSO: So in

3 Albuquerque, and I got to hear from Denver, but we

4 heard more about Albuquerque early on. So in

5 Albuquerque you're saying that we have presumably in

6 Albuquerque Indians representing many, many tribes?

7 MS. CULBERTSON: Yes.

8 VICE CHAIRMAN REYNOSO: That they should

9 come with the appropriate rules in their own tribe

10 as to whether or not they are members of that tribe.

11 And that the clinic then, assuming a hospital or

12 clinic, should then recognize that?

13 MS. CULBERTSON: Yes. And I think that

14 also, though, urban Indian health programs can also

15 assist those people that are eligible for enrollment

16 within their tribes, to get enrolled with their

17 tribe. I think that's one of the things that parents

18 aren't doing that they should be doing is making

19 sure that their children are enrolled in those

20 tribes.

21 But, yes, I believe that they should

22 come with it.

23 VICE CHAIRMAN REYNOSO: But sometimes

24 the enrollments don't happen because the parents

25 don't see much benefit to it. But if they saw more

1 benefit to it, then it probably would happen more
2 often.
3 MS. CULBERTSON: Yes. Yes.
4 VICE CHAIRMAN REYNOSO: I mean, we've
5 seen that in California where a while back it was of
6 no benefit to be enrolled in a tribe or even to be
7 recognized as a tribe. But now with gaming and some
8 other matters, it becomes more important. So
9 there's a greater natural interest.
10 MS. CULBERTSON: And will become of
11 greater importance as you see Medicaid eligibility
12 becoming harder to qualify for as well as Colorado
13 is quitting enrolling new enrollees in the CHIP
14 program, the state Child Health program. So we
15 expected influx of Indian people coming into our
16 clinic because of those issues.
17 VICE CHAIRMAN REYNOSO: Now, we saw a
18 map earlier about where Indian Health Services are
19 provided.
20 MS. CULBERTSON: Yes.
21 VICE CHAIRMAN REYNOSO: And the spot
22 around Los Angeles was great, but it was there. And
23 that's a great center for urban Indians, actually.
24 MS. CULBERTSON: Yes.
25 VICE CHAIRMAN REYNOSO: So apparently

1 there are some urban --

2 MS. CULBERTSON: There are a lot.

3 VICE CHAIRMAN REYNOSO: -- provisions.

4 And, of course, you mentioned in your own clinic in

5 Denver.

6 MS. CULBERTSON: Yes.

7 VICE CHAIRMAN REYNOSO: So it's already

8 been recognized the great number of urban Indians.

9 What thus far has been the limitation on

10 expanding those services?

11 MS. CULBERTSON: How long do you have?

12 VICE CHAIRMAN REYNOSO: Some of us have

13 to catch a plane before midnight.

14 MS. CULBERTSON: I have to catch one at

15 6:30.

16 Actually, the barriers for expanding

17 those clinics are that you have to really look at

18 philosophically why you exist. And I know that with

19 our board of directors we searched why we exist and

20 determined that we are an Indian health provider.

21 Granted, we're not Indian Health Service. Granted

22 we're not a tribal provider. But we exist and our

23 mission is to take care of Indian people that live

24 in Denver.

25 Other urban Indian programs have taken a

1 different point of view, where yes they're an Indian
2 health provider, but they're going to throw open
3 their doors and become a 330 clinics, which are the
4 community health clinics. So that they can increase
5 the revenue to provide further services to their
6 Indian people.
7 I don't think our community would stand
8 for it. We have contracts with the community health
9 center where they really did not like going. to get
10 services from that provider or from those providers.
11 They felt that they never understood their health
12 issues. You know, something so basic -- my daughter
13 hates me when I use this example. But there are
14 certain bodily functions that you --
15 VICE CHAIRMAN REYNOSO: We won't strike
16 it from the record now.
17 MS. CULBERTSON: -- that you refer to
18 with your Indian language. And one time I took my
19 daughter to the hospital and the doctor was asking
20 her about diarrhea. And she being maybe 5 or 6, she
21 says, "Mom, what did he say." I said (speaks in
22 Indian language). Do you have (speaks in Indian
23 language)? And she's like "Oh, no." But I mean
24 even those simple things we can take care of in
25 those Indian clinics because we have a variety of

1 tribes there.

2 VICE CHAIRMAN REYNOSO: Sure.

3 MS. CULBERTSON: And I think that really

4 it is a philosophical issue of how much you're going

5 to provide those services to Indian people. And

6 fortunately my board of directors has decided that

7 we will remain an Indian clinic, that that's what we

8 are there for.

9 VICE CHAIRMAN REYNOSO: Thank you.

10 Something further, Elsie? No.

11 MS. MUNSON: Could I add one comment to

12 this discussion?

13 VICE CHAIRMAN REYNOSO: Certainly.

14 Certainly.

15 MS. MUNSON: I think the other part of

16 that answer could be one word, it's just money.

17 VICE CHAIRMAN REYNOSO: Sure.

18 MS. MUNSON: But the other part of that

19 answer is embedded in something people talked about

20 earlier today, and that is Indian people being

21 pitted against one another.

22 VICE CHAIRMAN REYNOSO: Yes.

23 MS. MUNSON: Indian people who are

24 members of tribes against people who are recognized

25 by their community as Indian but who for various

1 reasons may not be a member of the tribe and may not
2 be eligible for membership in a tribe, even though
3 they are both ethnically Indian and identify as
4 Indian and they participate in an Indian community.
5 But they may not be able to be.
6 Urban Indians against reservation
7 Indians. There isn't enough money in the system and
8 there is the constant and persistent threat that
9 tribal governments experience that being Indian will
10 be reduced to an ethnic status, and not a
11 recognition of political status. And in many
12 instances it will be tribal leaders who will resist
13 increased recognition of urban Indians not out of a
14 lack of sympathy for the need for health care, not -
15 - you know, it'll be their members, it'll be their
16 family members who would benefit in some instances.
17 But because it's the slow drift to another form of
18 assimilation. And assimilation occurs just as
19 readily to simply become another ethnic minority
20 with the elimination of political status as all the
21 other ways in which folks tried to achieve
22 assimilation of Indian people. Unsuccessfully in
23 many ways, successfully in some others.
24 And so this tension is embedded in the
25 fear of the loss of political status and it's a fear

1 that lives with great justification.

2 VICE CHAIRMAN REYNOSO: Yes. Well, thank

3 you both very much. You've done what I think

4 probably had to do, and that is take a broad picture

5 of what's happening and then say, you know, all the

6 little details can't be solved without looking at

7 the big picture, the issue of sovereignty, the issue

8 of political rights as well as ethnic rights, the

9 issue of not only of funding but what's happened in

10 the past and we need to do to try to correct that.

11 So I think you very much. I think you've

12 made your test.

13 OPEN SESSION

14 VICE CHAIRMAN REYNOSO: It is now time

15 for the open session. I understand that there are

16 20 people who have signed up to speak.

17 Our practice has been to have a very

18 limited time, sadly, for the speakers. We will call

19 them in groups of three and limit the testimony to 3

20 minutes for each of the testifiers.

21 So, with that said, I wonder if -- oh,

22 this is the list? Oh. All right. I have the names

23 here.

24 The first -- do I just call the two

25 initially? Oh, I see. Oh, I see.

1 The Honorable Bernie F. Teba. Secondly
2 Joyce Maseyowma-Chalon. Third Kathy Janis. With
3 apologies for mispronunciations.
4 Are those folk present?
5 I'm sorry. The staff reminds me that I
6 should ask whether anybody needs sign language at
7 this time? Apparently not. Thank you very much.
8 Thank you.
9 Please identify yourself and proceed
10 from my left, your right. Yes?
11 MS. JANIS: Good afternoon, panel.
12 VICE CHAIRMAN REYNOSO: Good afternoon.
13 MS. JANIS: Good afternoon, ladies and
14 gentlemen. I'm sorry I'm sitting with my back to
15 you. It's not in our culture to do that. I
16 apologize.
17 My name is Kathy Janis. I am a
18 representative of the Oglala-Sioux Tribe on the Pine
19 Ridge Indian Reservation.
20 And I sat and listened to some of the
21 testimony that was given today, but it wasn't what I
22 thought it was going to be. When I came here this
23 morning, I assumed when they said disparities in
24 treatment and the assumption that I had was we have
25 in Pine Ridge, like Mr. Jack said this morning,

1 state-of-the-art hospital facilities, but we are
2 under staffed. The people that we do have there are
3 paramedics. They are not medical professionals.
4 They do come there, I don't want to use the term
5 "off the street," but they're coming in. We're
6 getting people from out of the country there. The
7 majority of them we don't understand what they're
8 saying.
9 And with our elders, it's hard for them
10 to go to the hospital.
11 We have a case when the person does go
12 to the hospital, they're referred out to Rapid City.
13 They're referred to Gordon, which is Gordon is about
14 45 miles. Rapid City is 110 miles. There are
15 instances people don't go to the hospital until
16 they're on their death bed before they're referred
17 out.
18 And for broken bones, we're referred to
19 Rapid City.
20 There are some of the medical staff that
21 in emergency are sitting there doing their nails,
22 either writing in their diaries, I don't know what
23 they're doing. And here are the people laying back
24 here waiting to be seen.
25 We have cancer patients that they're not

1 diagnosed on their death bed.

2 My brother fell, broke his back. Went to
3 the hospital. They told him he had pulled muscles.
4 Took him to Rapid City. He had a broken back. He's
5 diabetic. There was nothing they could do for him.
6 Pine Ridge told him he had pulled muscles.

7 Okay. Now, IHS will not pay for that
8 because I just did not refer him out. So that bill
9 is on my brother.

10 There's cases, and I have one here, this
11 lady took her 2 month old child, she's a working
12 mother, she has insurance. Took her child to a
13 clinic, IHS clinic. Referred the child to Pine
14 Ridge. Pine Ridge referred the child to a specialist
15 in Rapid City. As soon as the child got there, they
16 flew the baby to Omaha, Nebraska. Went through
17 surgery, open heart surgery. Okay. The child is now
18 back, but IHS will not pick up the bill. Insurance
19 will not pay it because it's a treaty obligation is
20 what the insurance company is saying. Plus, IHS did
21 refer the child out. So the mother can't take the
22 child back for further treatment because she owes a
23 doctor bill.

24 Now this is what I thought we were going
25 to talk about -- discuss this morning where all

1 these disparities in treatment.

2 I can go to the hospital and I can be

3 seen. Another lady can go to the hospital; they

4 won't talk to her.

5 VICE CHAIRMAN REYNOSO: Yes. Well,

6 thank you very much. I'm sorry, but you've gone over

7 your time. But I should tell you, as you know, that

8 we did hear something about that and we saw a lot of

9 it yesterday as we traveled around. Because the

10 disparities seems to -- all of the witnesses to be

11 manifest. Yes. So thank you very much.

12 COMMISSIONER MEEKS: I mean, we did have

13 to limit the time here, but that's exactly why we're

14 having this panel now.

15 VICE CHAIRMAN REYNOSO: Yes.

16 COMMISSIONER MEEKS: It brings the

17 reality back. I mean, you know, we always hear the

18 numbers and all those other things. But that's what

19 these panels are for.

20 MS. JANIS: I wanted to thank Dr. Grim.

21 He did come with numbers and all that stuff, but

22 that's not what I thought it was.

23 VICE CHAIRMAN REYNOSO: All right. Well,

24 thank you very much. Yes.

25 MS. JANIS: Thank you.

1 COMMISSIONER MEEKS: Thank you.

2 VICE CHAIRMAN REYNOSO: You may remain
3 there if you will until the panel is done. Give
4 your colleague moral support.

5 MS. NASEYOUMA-CHALON: Good afternoon.

6 VICE CHAIRMAN REYNOSO: Good afternoon.

7 MS. NASEYOUMA-CHALON: Members of the
8 Commission and people in the audience that are to my
9 back. And I feel all this pressure on my back.

10 I am Joyce Naseyouma-Chalon. I'm Hopi
11 and Taos. I have lived in the pueblo of Taochla,
12 and right now I'm serving as the Director of the
13 Public Health Division for the New Mexico Department
14 Health. And I'm speaking to all today on behalf of
15 the Secretary of the New Mexico Department of
16 Health, Patricia Montoya.

17 VICE CHAIRMAN REYNOSO: Yes.

18 MS. NASEYOUMA-CHALON: I want to thank
19 you for giving us this opportunity to speak with you
20 to present our position, I guess, on what the
21 Department is doing on behalf of addressing Native
22 American health disparities for the state.

23 We have collected numerous data over the
24 years and are very aware in the state about what the
25 conditions people are faced with in New Mexico. And

1 I'm not here to go into any particulars about that,
2 but I just want to share with you what the New
3 Mexico Department of Health is doing.
4 We have actually recently published a
5 report on health disparities, and I will provide you
6 with a copy of that if I get your addresses and send
7 that to you.
8 VICE CHAIRMAN REYNOSO: Great. Thank
9 you.
10 MS. NASEYOUMA-CHALON: But that really
11 describes with what we're faced with in New Mexico.
12 But just for your information, Native
13 Americans right now according to the U.S. 2000
14 Census make about 9.5 percent of the state's
15 population. But they share disproportionately, the
16 burden of death with regard to heart disease,
17 cancer, accidents, and of course we all know about
18 the prevalence of diabetes among all racial and
19 ethnic groups in the state.
20 What I wanted to tell you is that the
21 state of New Mexico has experienced some major
22 changes in the political arena with the election of
23 Bill Richardson as our governor. He's made
24 promises. Actually, he sat down with tribes and made
25 promises to them that he respects -- while speaking

1 from the point of respect for sovereign status of
2 tribal nations in New Mexico, he's made promises
3 that the state will do all that it could to address
4 the devastating situations that the tribes are
5 facing today, which is probably why I am sitting
6 here presenting to you in the position that I am.
7 With that, he's appointed several Native
8 American individuals to prominent political
9 positions and expecting us to help address those
10 tribal needs.
11 We currently are on the way in
12 developing a statewide comprehensive health plan.
13 Included in that plan is going to be a Native
14 American tribal health initiative. And primarily
15 information that is going to complete this plan is
16 based on some town hall meetings and some input
17 processing sessions that the Secretaries for four
18 agencies in the Health and Human Services went
19 around conducting town hall meetings and collecting
20 this information. And they did that throughout
21 summer. They were from the Human Services
22 Department, the Health Department, Children, Youth
23 and Families Department and the Aging and Long Term
24 Services. Primarily hearing personal testimonies
25 from -- is that red light for me?

1 VICE CHAIRMAN REYNOSO: Yes.

2 MS. NASEYOUMA-CHALON: I'm almost done.

3 VICE CHAIRMAN REYNOSO: Three minutes go
4 by quickly, don't they?

5 MS. NASEYOUMA-CHALON: Well, anyway,
6 we're preparing this plan and we're hoping that this
7 will be a mechanism to being to address those health
8 disparities.

9 In addition to that, which is something
10 that's very new to this particular department, is
11 developing a position, a high level position that
12 we're referring to as a tribal health liaison to
13 begin to address some of the health issues for
14 tribes.

15 I know that this isn't going to do it
16 all. I mean, there's a lot of work that needs to get
17 done. And we know there is a lot of importance in
18 coordinating with our partners and identifying our
19 partnerships broadly. And we believe that
20 communication is a key. But more importantly, it's
21 appropriate and effective cross cultural
22 communication so that we're addressing health
23 disparities and respecting that there are groups of
24 people that we're working with.

25 On a personal note, in my previous job I

1 served -- I had many opportunities to serve in
2 different workgroups for the Indian Health Service.
3 And I do know, and am familiar with the level of
4 need -- level of funding that Indian Health Service
5 receives. And we all know at this time, and maybe
6 it's increased a little bit, but they were only
7 funded at 60 percent of what the required need was.
8 I sat on the workgroup that said the need was $12
9 billion. They're only funded at 2.3 billion, which
10 is alarming and appalling.
11 So, we will continue to do our work and
12 work with our partners to bring attention to these
13 inequities.
14 And this concludes my brief statement.
15 And I want to thank you on behalf of the Secretary
16 for allowing us this opportunity to present this to
17 you.
18 VICE CHAIRMAN REYNOSO: Great. Thank you
19 very much.
20 And if you have a printed statement,
21 we'd be happy to receive it.
22 MS. NASEYOUMA-CHALON: I got to get a
23 clean copy for you, though.
24 VICE CHAIRMAN REYNOSO: Okay. Thank
25 you.

1 MS. NASEYOUMA-CHALON: And I'll leave
2 you my card, so we'll be sending you more
3 information.
4 VICE CHAIRMAN REYNOSO: Great.
5 Thank you both very much.
6 I'd like to call the next panel. It's
7 Dan Jaco, Margaret Garcia and Keith Franklin. If
8 those folks are present, if they would please come
9 forward?
10 And I would like to have you proceed as
11 I called you.
12 Mr. Jaco first.
13 MR. JACO: Thank you. And let me
14 congratulate on your perseverance. This has been a
15 long day for you, I know.
16 VICE CHAIRMAN REYNOSO: Thank you.
17 MR. JACO: I very much appreciate the
18 opportunity and I'll be mindful of the time.
19 My name is Dan Jaco. I actually prefer
20 your pronunciation.
21 VICE CHAIRMAN REYNOSO: Yes.
22 MR. JACO: I'm the Chief Executive of
23 the New Mexico Medical Review Association, which the
24 Medicare federally qualified quality improvement
25 organization for the state of New Mexico. There are

1 organizations like us in every state in the country,
2 so we all work on behalf of the Medicare program to
3 improve the quality of care for Medicare
4 beneficiaries.
5 The quality improvement approach that we
6 have taken in working with primarily -- well,
7 largely with all health care providers, physicians,
8 hospitals, nursing homes, home health agencies,
9 managed care plans is really beginning to bear
10 fruit. We're seeing some measurable changes in the
11 quality of care.
12 We work off a set of clinical indicators
13 that are measured and re-measured. And we work in
14 concert and collaboration with providers to affect
15 those improvements.
16 So we're very interested in trying to
17 extend the work that we are doing more fully into
18 the Native American community in the state. One of
19 the constraints, in fact the constraint that
20 everybody has who has a contract with any government
21 entity, is there is always a funding limitation.
22 And CMS has a big job, as we do, to try to get the
23 largest improvement with the dollars we have against
24 the largest number of people. And sometimes that
25 means not being able to deliver the services to

1 specific groups within the state.

2 And, for example, here in New Mexico the

3 largest group is really Hispanic populations. So we

4 have this sort of dual responsibility to try to

5 reach these select populations. And, I guess, my

6 take home message from this opportunity is, because

7 we're focusing here on disparities, is to address a

8 little bit different disparity. And that's the

9 disparity in the access to the kind of services that

10 we as a quality improvement organization can

11 provide.

12 And I did have a little opportunity to

13 talk to Dorothy Dupree outside. And I think that

14 between or amongst CMS, IHS, the quality improvement

15 organizations across the country, the state health

16 department and a number of other stakeholders, we

17 really need to get together to see if we can more

18 fully extend the kind of work we're doing. Because

19 we've had some remarkable accomplishments,

20 particularly in diabetes, which is a problem of

21 course of enormous magnitude in the Native American

22 community. If you look at some rates, and we talk

23 about disparity. The hemoglobin $A_1C$, which is a

24 measure of blood glucose sugar -- eye examines,

25 which also looks at blood sugar, lipids which are

1 fats. Those are 3 tests which should be done 100
2 percent of time. In New Mexico they occur maybe
3 about 7 in 10 times among Medicare beneficiaries as
4 a whole, but in the Native American community you're
5 looking anywhere between 1 and 5 and 1 in 10. I
6 mean, it's alarming the discrepancy that exists
7 here.
8 So in terms of disparity, and that's
9 something that we really feel like we can help with.
10 So I'd just like to leave you with our
11 offer to work in anyway we can to help with this.
12 And I know I speak on behalf of the other 37
13 organizations like ours across the country that are
14 doing similar kinds of work.
15 VICE CHAIRMAN REYNOSO: Well, thank you,
16 Mr. Jaco. I think it's encouraging that one can
17 work together and try to diminish that disparity.
18 COMMISSIONER MEEKS: I'm glad we could
19 facilitate you and Dorothy getting to talk.
20 VICE CHAIRMAN REYNOSO: Yes. Yes.
21 COMMISSIONER MEEKS: Had some impact
22 here.
23 VICE CHAIRMAN REYNOSO: Yes.
24 MR. JACO: I have a written testimony,
25 too, which I'll leave.

1 Ms. Garcia?

2 MS. GARCIA: Good afternoon, honorable

3 members of the Commission. My name is Margaret E.

4 Garcia. I'm an enrolled member of the Suni Tribe,

5 and the Department Director for the Community Health

6 Department for my people.

7 I appear before you today to express my

8 sincere appreciation to the honorable members of the

9 Commission to take the time to hear about our

10 concerns.

11 The Indian Health Service has

12 historically been under-funded and has never

13 received the allocations to bring it anywhere near

14 the $18 billion that is needed to fully fund health

15 care for us. Adjustments for inflation and the

16 rising costs for providing health care to us has not

17 been taken into consideration by the government.

18 Specifically, the U.S. Congress and the

19 President of the United States, there is a federal

20 trust responsibility for the United States

21 Government to provide quality health care to us.

22 This responsibility has not been met. Instead,

23 billions of dollars are sent to foreign countries to

24 address their needs without taking into

25 consideration what the needs are in Indian Country.

1 Perhaps we can enjoy foreign aid status
2 and gain the benefits that the U.S. Government so
3 freely gives to foreign countries rather than
4 helping us here as the first citizens of this
5 nation.
6 In addition, I have reviewed the funding
7 levels for the federal prison system and the Indian
8 Health Service, and it was stated earlier, the
9 federal prison system receives more money. In my
10 mind, this is an egregious practice that has been
11 allowed to continue for many, many years and
12 something has got to be done about it.
13 There are major obstacles that exist
14 within the bureaucracy of the federal government.
15 There are policy conflicts between health promotion
16 and other governmental programs. For instance, while
17 we provide education about nutrition, the federal
18 government provides high fat, surplus commodities to
19 our communities and to the school lunch programs for
20 our children. With the poverty levels on our
21 reservations, the majority of our people are
22 eligible for these food products. And in turn, they
23 make the problem of diabetes, hypertension, heart
24 disease and obesity even worse than they are. How
25 different is this when you reflect back upon the

1 small pox epidemic that occurred because of
2 contaminated blankets?
3 Because of inadequate funding, we have
4 to wait anywhere from 2 to 3 months for an eye
5 examination and dental care. Services for
6 specialized care are not available. And in order to
7 access specialty care, a person has to jump through
8 the hoops of government regulations to get a
9 referral for services.
10 The system of health care for us is not
11 a very customer friendly system at all.
12 In the area of mental health services we
13 only have 2 providers, and they are expected to
14 serve approximately 10,000 people. Again, this is a
15 great unmet need.
16 And I see the red light come on.
17 I have submitted a written statement for
18 your review.
19 VICE CHAIRMAN REYNOSO: Very good.
20 MS. GARCIA: Thank you.
21 VICE CHAIRMAN REYNOSO: Yes. Thank you
22 very much, Ms. Garcia.
23 MS. GARCIA: Thank you.
24 VICE CHAIRMAN REYNOSO: Mr. Franklin?
25 MR. FRANKLIN: I want to thank the

1 Commission to give me the opportunity to testify
2 before.
3 I'm Keith Franklin. I am Commissioner
4 with the Albuquerque Commission on Indian Affairs.
5 And I'm also a member of the Albuquerque Metro
6 Native American Coalition.
7 And everything that I was going to state
8 here today is in some binders that is in your room
9 right now on your table.
10 VICE CHAIRMAN REYNOSO: Oh, very good.
11 Thank you.
12 MR. FRANKLIN: What I would like to
13 speak on today is, and you asked before you were
14 talking to Kay, we do have facilities here. We do
15 have a hospital and we do have a dental clinic that
16 urbans do frequent with whatever services they have.
17
18 And my statement is on good stewardship
19 of special urban funding.
20 SIPI Dental Clinic was due to close
21 because of P-638. All the tribes pulled theirs out
22 of the clinic. And there wasn't going to be any
23 money left. They were going to close it.
24 And I'll go into my facts now and read
25 it to you. The current resources for the IHS

1 primary service dental clinic located at the SIPI
2 Dental was originally funded by special
3 congressional appropriations awarded for the Urban
4 Dental Services and third party billing Medicaid
5 clients. A small amount of grant money from the All
6 Indian Pueblo Council was used in the administration
7 of third party billing for both Urban Dental Clinic
8 and the Urban Orthodontic Clinic, located in the
9 same building in SIPI.
10 Upon receiving the special congressional
11 funding 3 years ago, the dental clinic staff
12 indicated that dental service plan would be:
13 1: Service the Indian children in the
14 community not only because a majority of them needed
15 the services, but they also paid their way through
16 Medicaid;
17 2: Additional dentists and staff would
18 be hired to service the whole community when third
19 party billing and resources with the special
20 congressional appropriation reached a sufficient
21 level. And that was 1.5 million.
22 We did get appropriated a million, but
23 IHS gave us only 500,000. And then we got third
24 party billing over a million this year. So, we
25 reached that level.

1 At the present time only children and
2 young adults under the age of 22 are serviced by the
3 primary clinic on a routine basis. Adults over 21
4 are taken on emergency services.
5 The urban Indian community became quite
6 concerned on finding that the SIPI Dental Clinic
7 hired or reassigned four commissioned officers at
8 the grade of 06. 06 is, I believe your service. I
9 think that was a full bird colonel. So we have a
10 whole bunch of full bird colonels. We got 4 of
11 them. And one lieutenant colonel and one major.
12 That's our dentists.
13 The total manning for the dental SIPI is
14 4, 1 and 1. The IHS area has recently hired a CEO
15 under protest by the urban Indian representatives
16 and the salary for this staff member is being paid
17 out of the primary clinic. I mean, just a little
18 small amount of money we got. So we've got almost a
19 million dollars just in salaries.
20 The CEO is the supervisor for these
21 high-ranking commissioned officers. For information
22 purposes, an 06 in the Air Force runs an Air Force
23 base with more than 3,000 troops.
24 The total payroll for these commissioned
25 officers and CEOs is over 700,000. We feel with

1 prudent manning practices, hiring lower grade
2 commissioned officers and preferably civilians, the
3 dental staff would be as high as nine dentists and
4 could be serving the whole urban community where 68
5 percent of us are over 21.
6 The urban Indian community is also
7 concerned that orthodontics tribal funds have been
8 commingled with the urban funds. So now they've
9 pitting urbans versus tribal. And the CEO is making
10 the decision on how that tribal money is being spent
11 and she's being paid by urban funds.
12 Now, I want to just quickly, they're
13 talking -- red light. They're talking in the state
14 that they're going to lower the eligibility for
15 Medicaid. So that's going to cut largely into our
16 population if they take the top side of our
17 population out.
18 And also the question I would have to
19 the Commission to ask IHS is why hasn't the
20 Albuquerque IHS area director formed a grassroots
21 urban Indian advisory council to oversee and
22 recommend to the director on matters that pertain to
23 the health service for urban Indian clientele or
24 their representatives who use IHS service
25 facilities?

1 VICE CHAIRMAN REYNOSO: Yes. Thank you
2 very much. Those are good questions, and obviously
3 a lot of work still has to be done in that area.
4 Well, thank you to the panelists. Thank
5 you very much for your testimony.
6 I'd like to call the next panel. Mr.
7 Robert Nakai, Mr. Julie Claymore, Ms. Henrietta
8 Lewis.
9 If those folk are here present, please
10 come forward.
11 And I would like to have you present
12 your testimony as I call you, Mr. Nakai, Mr.
13 Claymore and then Ms. Lewis.
14 MR. NAKAI: Thank you very much. My
15 name is Robert Nakai. I am the Division Director of
16 Health and Human Services for the Ramah Navajo
17 School Board.
18 I'm a Navajo veteran of Vietnam and a
19 graduate of the University of California of public
20 school with a master's in health care
21 administration.
22 Ramah Navajo is --
23 VICE CHAIRMAN REYNOSO: What campus?
24 MR. NAKAI: Sorry?
25 VICE CHAIRMAN REYNOSO: What campus?

1 You just said University of California.

2 MR. NAKAI: Berkeley.

3 VICE CHAIRMAN REYNOSO: That's not the

4 only campus.

5 MR. NAKAI: It is to me. Thank you.

6 Ramah Navajo's number approximately

7 4500. The Navajo School Board established -- was

8 the first to utilize the 638 to establish the Pine

9 Hill Health Center in 1978. My 25 years of

10 experience, I've had a chance to work in the urban

11 reservation, Indian Health Service as well as rural

12 community.

13 And the Ramah bank of Navajo is a

14 satellite of a larger Navajo Nation. Unfortunately,

15 when anybody talks about Navajos, they talk about

16 Window Rock. And a lot of our issues don't get

17 resolved working with Window Rock, because we're

18 considered a stepchild. There're three communities

19 that are in that same boat.

20 I'm dropping things here just to make

21 sure that I'm not -- I just wanted to answer a

22 question earlier about the disparity in terms of

23 costs. You have a sheet on my testimony that

24 basically shows the breakdown of the different costs

25 for -- like IHS appropriation and collections for

1 user is $1,914 and all the way up to Medicare is
2 $5,914 in a list of my chart there as well.
3 I just want to also mention the treaties
4 of conveniences were made many years ago. There was
5 a question earlier about the Indians that were not
6 Indians but were Indians that lived in urban areas
7 but were not tribally membered. And New Mexico had
8 a history of those Indians. They were called
9 Ginaseros. And the Ginaseros were incorporated into
10 the historical Hispanic population because of the
11 English language and catechism and a way to become a
12 legitimate citizen of the state of New Mexico.
13 Communities were established. Cibiqui -
14 - not Cibiqui, but one on the Laguna. The Tomai and
15 Lasale as well as Abiqui were initially Indian
16 communities and later became Spanish communities.
17 We talk about resources for our people.
18 The Navajos were incarcerated in 1864 in Fort
19 Sumner. The total budget for health care at that
20 time was 3,800. 1800 for a physician and 2,000 for
21 a small hospital and medical supplies. Since then
22 we've tried to improve our health care, and we
23 dropped from a population of 14,000 to 6,000 in a
24 period of 40 years.
25 We have a lot of issues with regards to

1 those kinds of problems, and I just want to finally
2 bring to the conclusion on mine here what are some
3 solutions? How do we get resolved?
4 Well, your support and your report
5 definitely in listening to the disparities and
6 supporting our Indian Health Care Improvement Act,
7 and the Indian Self-Determination and Education Act,
8 as well as the Indian Child Welfare Act and others
9 that I couldn't name today.
10 I just want to also say that the
11 proclamation of the Statue of Liberty says "Give me
12 your tired, your hungry and your homeless." And I'd
13 ask that statue to turn around and also offer that
14 encouragement toward our people.
15 Just in closing here, I close with a
16 quotation from American General Carlton who saw the
17 plight of the Navajos at Fort Sumner. He wished the
18 Navajos to become a people whom you all can
19 contemplate with pride and satisfaction. A people
20 who in return for having giving you their country
21 have been remembered and carefully provided for by a
22 powerful Christian nation like ours. But unless you
23 make the laws all arrangements here contemplated,
24 you'll find this interesting and intelligent race of
25 Indians will fast diminish in numbers until within a

1 few years only one of those who boosted in the pride
2 name of Navajo will be left to abrade us for having
3 taken their birthright and left them to perish.
4 With other tribes whose lands we have acquired ever
5 since the Pilgrims stepped on the shore of Plymouth,
6 this has been done too often for pity's sake.
7 If not moved by any other consideration,
8 let us as a great nation for once treat the Indians
9 as it deserves to be treated. It is due to ourselves
10 as well as to them that this be done. The exodus of
11 this whole people from the land of their fathers is
12 not only an interesting, but a touching sight.
13 They are have fought us gallantly for
14 years on years, they have defended their mountains
15 and their stupendous canyons with a heroism which
16 any people might be proud to emulate. But when at
17 length they found that it was their destiny, too, it
18 has been that of their children, tribe after tribe a
19 way back towards the rising sun gave way to the
20 insatiable progress of our race, they threw down
21 their arms and as brave men entitled to our
22 admiration and respect, have come to us with
23 confidence in our magnanimity and feeling that we
24 are too powerful and too just a people to repay that
25 confidence with meanness or neglect feeling that for

1 having sacrificed to us their beautiful country,
2 their homes, their association of their lives, the
3 scenes rendered classic in their tradition. We will
4 not dole out to them a miser's pittance in return
5 for what they know and what we know to be a princely
6 realm.

7 Thank you.

8 VICE CHAIRMAN REYNOSO: Yes. Thank you
9 very much.

10 Ms. Claymore?

11 MS. CLAYMORE: Good afternoon.

12 VICE CHAIRMAN REYNOSO: Good afternoon.

13 MS. CLAYMORE: My name is Julie
14 Claymore, and I'm enrolled in the United Tribe, and
15 I'm also Chataka. I'm an urban Indian that has
16 resided in Albuquerque for over 25 years and living
17 on or near Indian reservations for most of my life.

18 I'm a single parent. I'm an eligible
19 beneficiary of the Indian Health Service. I'm
20 retired from the Indian Health Service. And I'm one
21 of the 36,000 American Indians living in
22 Albuquerque.

23 I'm thankful to be present at this
24 hearing. I feel like it's been long overdue, and I
25 congratulate you for being here.

1 Thank you.

2 The Indian Health Service mission to
3 elevate the health status of American Indians and
4 Alaska Natives is woefully under-funded, as I
5 believe as previous testimony has indicated. But
6 even as congressional committees are urged to
7 increase appropriations, I believe there also needs
8 to be a closer review of how IHS spends what funds
9 they do receive.

10 I applaud Senator Daschle's effort in
11 this record and will be providing him a package
12 along with the Albuquerque Metro meeting American
13 Coalition, which will be consistent with the package
14 that we gave to you.

15 One of several areas that warrants close
16 scrutiny is the continuing lack of attention that's
17 been paid to the 1996 GAO report on the
18 effectiveness of the U.S. PHS Commission Corps.
19 While we do have many dedicated Corps officers
20 performing key primary care in the field, that
21 report requested by 2 congressional offices,
22 indicated that the Indian Health Service could save
23 approximately $40 million per year, which was based
24 on 1995 salaries, if positions were filled by
25 federal civilian employees instead of the costly

1 commissioned Corps. This is especially important
2 when commissioned officers only perform
3 administrative functions.
4 From May of 1996 to date IHS continues
5 to ignore the cost saving implications of this
6 report and place commissioned officers in desk job
7 or administrative roles that do not deliver health
8 care as originally intended by the Corps. In
9 today's terms, we're talking about a savings close
10 to $60 million per year, which is significant.
11 These quasi-military employees, as the report refers
12 to, and their families, also access IHS health care
13 services without regard to Indian beneficiary
14 status. Such IHS is proposing, as we speak, to add
15 240 more USPHS commissioned officers to staff
16 programs nationally. This is not surprising since
17 many decision-making positions at the highest levels
18 in Indian Health Service are filled by Corps
19 officers.
20 Other areas of expenditures such as the
21 cost of contract nurses, absorbing DHHS employee
22 costs and excessive administrative overhead
23 certainly warrant a close look as well. But savings
24 close to $60 million per year would go a long way
25 toward making real the IHS slogan "Patient care

1 comes first."

2 As an American Indian and an American

3 taxpayer, I believe we deserve that accountability.

4 Thank you.

5 COMMISSIONER MEEKS: Thank you.

6 VICE CHAIRMAN REYNOSO: Thank you very

7 much.

8 Ms. Lewis.

9 MS. LEWIS: Thank you.

10 Honorable members of the Commission and

11 ladies and gentlemen in the audience, I thank you.

12 I would like to address some of the issues that I

13 feel are concerns.

14 I've been an advocate for our native

15 people for a number of years. I've participated on

16 task force committees addressing health care issues

17 within our Native American setting.

18 I am Navajo. I live within the urban

19 Indian population here in Rio Rancho. I've lived

20 within the adjacent towns of the IHS service

21 delivery areas as well as my immediate family also.

22 The philosophy recently of Indian Health

23 Services has been a one-stop shopping house care

24 model, which means that in order to support the

25 users who had difficulty getting to the service

1 units for their health care, they were able to make
2 appointments on a particular day.
3 There are, indeed, transportation
4 issues. Some of the transportation is contracted
5 and services rendered by private individuals through
6 Medicaid recipients. However, not all of our people
7 received the medical care that they're entitled to.
8 There's still a population out there who resort to
9 their traditional healings.
10 Some of the services as far as the
11 emergency medical transportation is contracted,
12 tribally operated. Those vehicles lack some of the
13 sophisticated kinds of equipment in order to
14 transport our Native people, as Ms. Meeks related to
15 the experience with a relative that she knew.
16 Contracted services, a lot of our people
17 who receive emergency care, of course, are brought
18 in by ambulances. I have not seen where our service
19 units are equipment with the emergency
20 transportation that is really necessary to take care
21 of our emergency needs.
22 The revolving door kind of philosophy as
23 far as our physicians within Indian Health Service.
24 I don't say this derogatorily about Indian Health
25 Service. After all, I am an employee with Indian

1 Health Service.
2 The affirmation plans aren't identified
3 to reflect the immediate needs of where our Native
4 American people can fill some of those positions or
5 they transition into the health care arena to
6 identify with some of the medical needs our people
7 have.
8 The other is as far as some of the early
9 preventions and interventions, I think there has to
10 be a collaboration with the educational systems,
11 outreach in the community areas to educate our
12 people. Not just pamphlets, not just one time
13 showing up at a chapter house, for instance, to
14 convey some of the diseases that are people are
15 faced with. The infrastructures, congressional
16 appropriations.
17 I worked under the Bureau of Indian
18 Affairs for a number of years. I was a safety
19 manager. I identified deficiencies within building
20 settings. I don't see that with Indian Health
21 Services. And so therefore I feel that there should
22 be an identification in order to acquire appropriate
23 kind of building structures for our health care
24 needs.
25 Third party revenues. We are going in a

1 direction where we say we are a managed care
2 organization within Indian Health Services.
3 Whenever we have patients being transported out to
4 other medical care facilities who IHS had contracted
5 with, because of higher levels of care we determine
6 medical appropriateness. There are two individuals,
7 myself and RN who work within Albuquerque to support
8 Navajo Area Service Units. I work for one
9 particular service unit. And the philosophy there is
10 to ensure that there is someone available where our
11 Navajo people can relate to.
12 They come into the cities for higher
13 levels of care. Cultural shock. They are received
14 by people who are not so much cultural --
15 VICE CHAIRMAN REYNOSO: I'm sorry.
16 You've gone a couple of minutes past. I wonder if
17 you could wrap it up.
18 MS. LEWIS: Yes.
19 VICE CHAIRMAN REYNOSO: And if you have
20 something in writing, I would be happy to receive
21 it.
22 MS. LEWIS: Okay. Yes, I will.
23 So therefore, I feel that some of the
24 disparities that are indicated as a result of the
25 Commission's visit, those disparities do exist.

1 There are state agencies also that contribute to
2 some of the disparities. Of course, I will present
3 something in writing.
4 Great. Thank you.
5 VICE CHAIRMAN REYNOSO: Thank you.
6 COMMISSIONER MEEKS: Thank you.
7 VICE CHAIRMAN REYNOSO: I'd like to call
8 the next panel. And I'm going to be calling four
9 people on this occasion. Alvin Rafelito, Raymond
10 Stanley, Edward Begay and Emmett Francis.
11 And, again, apologies if I mispronounce
12 names. If those four are present, if they could
13 please come forward.
14 And if you could proceed in the manner
15 in which I called you, Mr. Rafelito, Mr. Stanley,
16 Begay and Francis.
17 MR. RAFELITO: Thank you for giving me
18 this opportunity to testify before you in disparity
19 in health care.
20 My name is Alvin Rafelito. And I work
21 at Ramah Navajo Reservation as a contract health
22 specialist. I work in an ambulatory health setting.
23 To give you a feel of some of the things
24 that I have experienced in trying to deliver health
25 care to my people.

1 I'm sorry, you have alternate health
2 care, alternate service resources that you can use
3 or you are eligible to apply for alternate resource.
4 So who assists this patient to get on alternate
5 resources?
6 You get a letter back from Social
7 Security. Your disability is not severe enough to
8 meet our criteria. May be eligible to do gainful
9 employment in your region. You can lift 20 pounds.
10 You can sit for 8 hours. You can do gainful
11 employment.
12 You look at this and you say, what the
13 hell. We have an unemployment of rate of over 50
14 percent. How is this person going to work doing
15 light work? We do heavy work. That's why I'm
16 disabled.
17 I'm sorry, the service is available in
18 an IHS facility.
19 I'm sorry, you don't meet CHS priority
20 criteria.
21 I'm sorry, you didn't notify me in 72
22 hours, I cannot pay for your bill.
23 I'm sorry, you do not live in a contract
24 health service delivery area.
25 I'm sorry, your provider is in Gallup,

1 we cannot serve you through our service unit.
2 I'm sorry he doesn't belong to this
3 tribe.
4 I'm sorry, you're not socially actively
5 entitled to this tribe.
6 I'm sorry, you're not being referred to
7 contracted provider.
8 I'm sorry, your service is not a covered
9 benefit.
10 I'm sorry, you didn't get a prior
11 approval for your visit.
12 And our patient's concepts. If you don't
13 have insurance, you cannot get service. You might as
14 well die.
15 IHS is available, but I didn't get good
16 service at that hospital. The waiting time is too
17 long at that hospital.
18 I went to the ER department at that
19 hospital and waited to be seen for over an hour. I
20 heard so much, I went across the street to be seen
21 at their ER. Because there were still people
22 waiting to be seen that were ahead of me in the IHS
23 ER Department. I went across to the facility, showed
24 them my health card and I was seen right away. CHS
25 is going to deny payment on my medical balance bill

1 based on IHS's facility was available.

2 My child needs braces, but Medicaid
3 denied request due to not being severe enough. We
4 want braces for her and it's going to cost us
5 $3,945. My insurance is going to cover $1,000 of
6 this bill and I'm requesting CHS to help me with the
7 balance, either in full or in partial.

8 Trying to access health care should not
9 get you killed. Access to health care becomes a
10 choice. You live in reservation, you're in poverty
11 and have IHS health care or live off the reservation
12 to get out of poverty and not have access to health
13 care.

14 Employees around the reservations areas
15 don't offer health insurance because they depend on
16 IHS to provide that.

17 Under-funding causes prioritization in
18 delivery of health care, crisis delivery of care,
19 under-staffing, long wait time, low quality of care,
20 high costs, chronic care, low uses due to long wait
21 time in prioritizing care. You're not sick enough
22 yet.

23 There are not enough service benefits.
24 Or misdiagnosis trying to be conservative and not
25 aggressive in trying to treat a person.

1 Thank you.

2 VICE CHAIRMAN REYNOSO: Thank you very
3 much.

4 Mr. Stanley?

5 MR. STANLEY: Good afternoon.

6 VICE CHAIRMAN REYNOSO: Good afternoon.

7 MR. STANLEY: I thank you,
8 Commissioners, for taking the time to meet with the
9 Native Americans.

10 My name is Raymond Stanley, former
11 Chairman of San Carlos Apache Tribe for the last 10
12 years.

13 San Carlos Apache Tribe hospital is
14 about 50 years old. The building and equipment are
15 very obsolete. Proper health care is hindered, and
16 due to that, infants, youth and elderly are still in
17 pain, even though they go to the hospital. It also
18 increases public complaints about poor health care,
19 not to mention we do get good doctors, however we
20 lose these doctors because of the situation,
21 obsolete buildings and equipment.

22 I'm sure I'm speaking for many tribes
23 here.

24 I'd like to use one doctor as an
25 example. She became a best friend to my wife.

1 They're both Christian. We're Christian. One thing
2 that I admire, I inspire of this doctor is that she
3 took the time even to drive a yellow big bus, you
4 like the regular bus, unmarked. She drove them
5 around to pick up anybody that was going to church.
6 You know, if you imagine, it's pretty rare. It's
7 like an attorney, you know, driving a bus. You
8 know, you don't see that too often.
9 She's been there 7 years. And when she
10 was leaving, there was a big party, the elders and
11 the people. The elders were actually in tears and
12 actually tell them not to leave. But, unfortunately
13 she left to Tucson.
14 And I know, again, I'm sure I speak for
15 many tribes here that there are places that are
16 facing similar situation to where these doctors are
17 leaving. And it goes back to your funding.
18 I'm also thankful for -- and more
19 reminded to the United States Government of the
20 trust -- trustee, trustor relationship and the
21 government relationship. As a former chairman, I
22 highly respect it. And I do thank you for this
23 time.
24 Actually, I'm here on my own personal
25 expense. I really should be leaving. I just came

1 from a law conference, but because it means
2 something to me, even though I'm no longer in
3 office, but to speak for not just our tribe, but
4 many tribes the importance of wanting you to know
5 that as a Native American the suffering and the hurt
6 still goes on. And this way, I delayed my time
7 coming here, rather to drive 7 hours back to
8 Arizona.
9 So, thank you. And the Lord bless you.
10 God bless.
11 COMMISSIONER MEEKS: Thank you.
12 VICE CHAIRMAN REYNOSO: Thank you, Mr.
13 Stanley.
14 Mr. Begay?
15 MR. BEGAY: Good afternoon.
16 VICE CHAIRMAN REYNOSO: Good afternoon.
17 MR. BEGAY: Commissioners. I want to say
18 thank you for this time.
19 My name is Edward Begay. I'm Navajo.
20 VICE CHAIRMAN REYNOSO: Thank you.
21 MR. BEGAY: I work up in Farmington, New
22 Mexico.
23 VICE CHAIRMAN REYNOSO: We know where
24 Farmington is.
25 MR. BEGAY: A new program called Totah

1 Behavioral Health Authority.

2 VICE CHAIRMAN REYNOSO: Yes.

3 MR. BEGAY: It's a new pilot program
4 that was established under the Presbyterian Medical
5 Services. The first year that they were in
6 existence, we were in existence, we were looking at
7 a budget of $1.25 million. And the second year,
8 $1.16 million. After that, this year's funding,
9 $210,000. That's it. Okay.

10 We deal with inebriates, homeless, under
11 insured, uninsured both that have recurring
12 disorders that have fallen through the cracks of the
13 society. A lot of the relatives that we serve have
14 co-occurring disorders that have never been treated
15 because of limited resources. There's a lot of
16 homelessness in Farmington, Four Corners region.
17 There's a lot of things that we're looking at. And
18 as long term treatment, we're looking at Indian
19 Health Service what kind of programs are available
20 and health issues, health care, service providers.

21 A lot of times we had service providers
22 that really had no idea what the diagnoses co-
23 occurring disorders are. So from the testimony that
24 I have been hearing most of the morning, a lot of
25 the paraprofessionals instead of professionals due

1 to the limited funding, due to limited resources
2 that we have, a lot of this isn't seen.
3 And a lot of things that had been coming
4 up, we've worked with individuals that have no place
5 to go, that have no homes, that have no extended
6 family right off hand that will take them in. A lot
7 of the things that my relatives are dealing with out
8 there in the streets is PTSD. You know, we have a
9 lot of our veterans out there that have, you know,
10 no resources available. The nearest place you can
11 go is Albuquerque, Phoenix, you know. And these
12 metropolitan areas, a lot of times we look at that
13 and just like I was saying, you know, the budget
14 right now is $210,000. Whatever we have to carry
15 over possible, $450,000. If the government does
16 accept the $450,000, we're still short, you know. So
17 when you look at that, we're H-cap grant funded. We
18 deal with HRSA. And it's like the resources that we
19 have, PMS, we look at that. And we see -- we go
20 though Indian Health Service. We make an
21 appointment.
22 This person is eligible for treatment;
23 this person is eligible to go to long term
24 treatment. We have to have a physical. We have to
25 have a psychological evaluation done. And a lot of

1 times when he goes to IHS, he looks 2 or 3 months
2 ahead of schedule. You've got to be there 2, 3
3 months down the road in order for this to happen.
4 But this person was referred, was accepted into a
5 program. But unfortunately, due to lack of resources
6 available, we find we got to wait. So when
7 you look at that.
8 Now, as far as people were talking about
9 the treaty, June 1868 between the United States,
10 Lieutenant General Sherman, Colonel Samual Tappen.
11 Want to put Navajo Nation, a tribe of Indians
12 represented by their chiefs had been duly authorized
13 in part to act for the whole people, the said nation
14 or tribe.
15 Article I. From this day forward
16 between the parties that this agreement shall
17 forever -- the war between the parties, the
18 disagreement shall forever cease. The Government of
19 the United States desires peace and its honor is
20 hereby pledged to keep it, the Indian -- pledge
21 their honor to keep it too, as well. But right now
22 we're still at war. We're still being denied the
23 services, the things that -- we fought for. We
24 believe in a lot of things and I think that we
25 proved that during the times that we were held

1 captive as Navajos. And when we look at that, 4
2 years in captivity, we saw a lot of things
3 happening. And to this date we're still suffering
4 because of some of the things that were taken from
5 us, resources, our land was re-cultured. And a lot
6 of things.
7 So when you look at from that prospect,
8 you know, we need help here. You know.
9 I want to thank you for taking this time
10 to hear me out. And, you know, I could say a lot
11 more to it. But, you know, when I get this cleaned
12 up a little, I'm pretty sure I'll have something
13 sent your way.
14 Thank you.
15 VICE CHAIRMAN REYNOSO: Please do so.
16 Thank you, Mr. Begay. I think your
17 program sort of exemplifies some of the problems
18 we've been dealing with yesterday and today.
19 Mr. Francis?
20 MR. FRANCIS: Thank you, Commissioners.
21 My name is Emmett Francis. I'm Navajo.
22 I presently live in Albuquerque. And I also use the
23 Indian Health Service facility here in Albuquerque.
24 And I also am a volunteer helping the urban Indian
25 community in health issues, education issues,

1 housing issues, business development issues,
2 homeless issues and whatever else there is to be
3 assisted to the urban Indian community.
4 I just want to touch a little bit more
5 about the services and also the policies that affect
6 the urban Indian population here in the city.
7 Starting with regulations and laws,
8 we're all covered under the Snyder Act where it says
9 "all Indians are going to be provided health care,"
10 or some such language as that. And the Indian
11 Health Service uses Public Law 94-437 to provide
12 funding and services to Indians across the country.
13 Under Title II of that Act, it provides
14 funds to tribes to provide health services. Under
15 Title V of that Act it provides funds to 34 non-
16 profit organizations in addition to the Tulsa,
17 Oklahoma City health care facilities. However,
18 there's nothing mentioned anywhere about Indian
19 Health Service and services to urban Indians that
20 continue to use the Indian Health Service facility.
21 Nowhere have I found anything. So I don't know
22 whether it's illegal or whether there's another law,
23 or act or something that does allow Indian Health
24 Service to provide funding for urban Indians that
25 continue to use that existing health service

1 facility in Albuquerque.
2 We have a similar situation in Phoenix,
3 Gallup and some of those areas where they are
4 existing in the health service facilities. There
5 are what they call urban programs, but those are
6 non-profit organizations that run limited health
7 care services. There are 34 of them in this country.
8 And I understand there's something like 333,000
9 urban Indians that use those facilities. But I'm
10 talking about something very different. I'm talking
11 about those urban Indians that continue to use the
12 Indian Health Service facilities that are in the
13 urban areas. And those are the people really that
14 are forgotten. They're the invisible ones.
15 I mean, we talk about invisible Indians
16 here, but there are more invisible Indians as far as
17 the urban Indian in the community is concerned.
18 I just want to make that point. And I
19 hope that if I can have people understand that
20 point, hopefully they can begin to understand why
21 the urban Indian community in Albuquerque is so
22 concerned about health care services. And the
23 reason why it's so critical here is that once the
24 tribes under Title II start contracting under Public
25 Law 93-638, those services, all of the money that

1 comes through Title II included in the ones that
2 benefit the urban Indian, now go out to the tribes.
3 So therefore, there will be nothing if all the
4 tribes here in Albuquerque decide to contract. There
5 will be nothing left for the urban Indians.
6 And the SIPI Dental Clinic is an
7 example. Two years ago it was subject to close
8 because most of the tribes that contracted, there
9 was only a few dollars left and they could not serve
10 all the urban Indians in this community. So what we
11 did was go to Congress directly and try to get some
12 money, and we did get some money. But not all of
13 the money came down. Half of that money, a million
14 dollars, went to a non-profit organization because
15 of the situation that I described earlier. We're
16 not in 437. We're not talked about in 437. We're
17 part of Title II, I understand from the Indian
18 Health Service, and Indian Health Service is afraid
19 if they put the money in Title II it will be subject
20 to 638 contract. And that's why they don't want to
21 put it in there.
22 So what happened was they tried to route
23 it through a non-profit organization back to SIPI
24 Dental Clinic. But for that reason, we only got
25 $500,000 of the million dollars. But I think that

1 was more due to personal and political connections
2 all the way up to the Indian Health Service between
3 the director of the non-profit organization here and
4 the Indian Health Service. Because the director was
5 assigned from the Indian Health Service to run the
6 non-profit organization here.
7 And those kinds of shenanigans do go on
8 in the Indian Health Service system. And I wish
9 there'd be more investigation of those kinds of
10 things that go on in the Indian Health Service.
11 Thank you very much.
12 VICE CHAIRMAN REYNOSO: Thank you all
13 very much. Very much appreciate it.
14 COMMISSIONER MEEKS: Thank you.
15 VICE CHAIRMAN REYNOSO: And thank you,
16 again.
17 I'd like to call the next panel then. A
18 panel of three. Linda Stone, Lena Jim and Theresa
19 Fischer.
20 And if you could proceed in that same
21 manner; Ms. Stone, Ms. Jim and Ms. Fischer.
22 MS. STONE: Thank you members of the
23 Commission Civil Rights for letting us have the
24 opportunity to speak with you.
25 We're from First Nations Community

1 Source. My name is Linda Stone, I'm the Director of
2 First Nations Community Source.
3 To my left is Lena Jim, who is the
4 coordinator for our Medicaid enrollment program. And
5 then to her left is Theresa Fischer, who is our
6 interim director of primary care services and also
7 the diabetes educator and prevention specialist for
8 our clinic.
9 Just as a little bit of a background.
10 First Nations Community Health Source is a private,
11 non-profit urban Indian health center that was
12 established in 1972. We are committed to providing
13 culturally competent health services that integrate
14 traditional values to enhance the physical,
15 spiritual, emotional and mental well being of
16 American Indians in Albuquerque and the surrounding
17 tribes.
18 We are federally qualified health
19 center, and we are the only Title V urban Indian
20 health clinic in New Mexico.
21 We are located in the southeast quadrant
22 of Albuquerque, which is the area with the highest
23 concentration of urban American Indians.
24 We are a relatively small clinic. We
25 have a staff of about 35 people, 60 percent are

1 Native American.

2 The services that we provide reflect our
3 view that health encompasses not only physical
4 health but also spiritual, emotional and natural
5 well-being. We provide primary care, dental
6 services, traditional healing. We have a WIC
7 program. We have an HIV case management and
8 prevention service. We have a Medicaid enrollment
9 program, diabetes prevention program and behavioral
10 health services and a homeless outreach program.

11 We are one of two primary are providers
12 offering health services to the 36,000 urban
13 American Indians without regard to ability to pay
14 and at no cost.

15 In terms -- I won't go into the high
16 disease rates that are prevalent among the urban
17 American Indians. I think that was discussed
18 earlier. And for the sake of saving time.

19 I do want to identify some of the
20 barriers from our experience in delivering services
21 to the urban Indian population, some of these have
22 already been discussed before, but I'll just
23 identify them.

24 The urban American Indians are least
25 likely to have health insurance and least access to

1 health services. They have high rates of poverty
2 and unemployment, which undermines their ability to
3 improve their health. Transportation is a
4 significant problem for many.
5 The IHS budget cutbacks in services have
6 also added an increased difficulty for them in
7 accessing services, waiting periods for scheduling
8 appointments is beyond acceptable.
9 Affordability of health services is also
10 a problem because 65 percent of the families live
11 either at or below the poverty level.
12 Urban American Indians are also among
13 the highest users of emergency rooms for routine
14 care. Many of them do not qualify for contract care
15 because they have maintained residence out of the
16 reservation for more than 6 months. They can only
17 receive direct care.
18 Two out of three are uninsured and many
19 fall into the category of the working poor, which
20 means that they don't qualify for Medicaid and they
21 also are in a job that does not provide benefits.
22 What we try to do at First Nations, is
23 we try to provide accessible, affordable and
24 culturally appropriate services. And we also try to
25 fill in the gaps in terms of the service cutbacks

1 that have existed with IHS. We also work with other
2 community organizations to try to coordinate care.
3 We receive about $250,000 annually from
4 IHS. Our annual budget is about $2 million. The rest
5 of the funds that we get are from state, federal and
6 private grants.
7 We see -- the population that we see is
8 largely uninsured and under-insured. Only about 25
9 percent of our population has Medicaid.
10 In terms of our revenue collection, it's
11 at a rate of 20 percent. And clearly we do not
12 generate enough patient revenue to sustain our
13 services, which is what we really rely on in terms
14 of providing health services.
15 VICE CHAIRMAN REYNOSO: Yes. I'm sorry.
16 You've gone over.
17 MS. STONE: Okay.
18 VICE CHAIRMAN REYNOSO: I wonder if you
19 could wrap it up now.
20 Okay. You may proceed.
21 MS. JIM: My name is Lena Jim.
22 In today's discussion a lot of the
23 guests have spoken on using the various insurance to
24 pay for IHS getting reimbursed from either Medicaid,
25 Medicare. But as you know, that there's been a

1 setback on the funding for Medicaid. And cutting
2 down the funding. And we look at that, and most of
3 the people now are going to private practices or if
4 they have insurance, they'll go to other practices
5 to get their health care met. However, when they do
6 go, they're faced with racial or discrimination and
7 that's just another setback for them.
8 And my question for you is as you gather
9 these reports and data, I mean you stated earlier
10 that you're a second voice to what's been said
11 before. And we've stated, people have stated before
12 that when we've stated our concerns and wanted more
13 funding for certain cares, that it's all these
14 things have been -- have fallen onto deaf ears. How
15 can you -- how -- when you turn in these reports,
16 how do we know these things are not going to fall on
17 deaf ears as well to the Congress. When you turn in
18 these datas, when you turn in our concern, because
19 we've already turned in those statements before. I
20 mean, we're the first voice. You're going to be the
21 second voice. And that's my concern. That's my
22 frustration. That's my anger. That's my bitterness
23 to the government.
24 And I don't want to be emotional about
25 this, but it's just something that we have to face

1 everyday. And that my grandparents had to face,
2 because they're not getting their services met.
3 And, again, what are your hopes in making this panel
4 -- with this panel, what are your hopes with that?
5 VICE CHAIRMAN REYNOSO: Yes. Thank you
6 very much.
7 Just a brief response. Manifestly, it
8 helps to have many voices. And we're just one of
9 those voices that hopes to elevate the recognition
10 of this very serious problem by the Executive and
11 particularly the legislative branch. So that's why
12 we not only issued the report, but we're having
13 these hearings. Because we're getting into the
14 newspapers. We can raise the elevation of
15 understanding. So that's what we hope to do.
16 MS. FISCHER: I'm Terry Fischer, and I'm
17 from -- I'm an Ottawa from Michigan. And so I'm one
18 of the 36,000 people that are here in the area. And
19 I've lived here for about 6 years now.
20 I want to address why urban programs
21 need to have increased funding. And I'd like to put
22 a face on it. So if you'll take a 3 minutes journey
23 with me, and if you're not Native American, imagine
24 that your beloved relative is living in a foreign
25 country.

1 She's an older woman. Her name is
2 Arlene. She's our mom, she's our grandma, she's a
3 cousin. And she came into me, she was hobbling into
4 the center. She was dressed in her native clothes
5 and she wanted some care for her diabetes. She also
6 needed some shoes for her foot problem.
7 And I said, "Well, I can help you. I can
8 do some education and give you some stripes so that
9 you don't have to go back to the reservation more
10 often. And how come you're here in town?" And she
11 said "My husband is a paraplegic. He has to go to
12 the VA hospital." She said, "I'm elderly." She
13 said "He is in a wheelchair and I cannot take him
14 back to the reservation everything. I can't come
15 here and take him to the VA and go back to the
16 reservation for my issues."
17 So why are native people still
18 imprisoned on reservations just to get health care?
19 Aren't we allowed the freedom of living wherever we
20 want as other people do?
21 And my second story concerns our
22 agency's youth group. These children learn about
23 their traditions and about a healthy lifestyle
24 through camping and hiking. And Sam, who is 11
25 years old, couldn't keep up. He was having some

1 problems. So the youth leaders recognized that and
2 had Sam and his family come in. He was diagnosed
3 with diabetes. He's gotten some care, some
4 education. And 2 months later the leaders noticed
5 he could keep up. He was having fun; he'd lost a
6 little weight, quit drinking all that pop and all
7 that stuff. His family couldn't take time to go
8 back to the reservation. If not for our program, he
9 would be well along with diabetes before he was
10 diagnosed. Nobody would think of even checking him
11 until he was in his 20s and way overweight.
12 My third story is George. He's a
13 traveler from a northern tribe. He was here at the
14 gathering of nations. And his money got stolen. And
15 he came for our traditional healing service, and
16 we'd just gotten a new teepee. And we'd put it up.
17 And so he wanted to get a meal, too, I think, and
18 maybe some strength to continue home.
19 And so with the lights and the sirens of
20 the city behind us, we sat in the teepee with a fire
21 and the medicine man was chanting. And I could see
22 George relax and kind of get at ease.
23 He had met with a family and they kept
24 him overnight so that he could get ready to take the
25 bus back home the next day. I think he had a few

1 dollars in his pockets to get the ticket and stuff.

2 So this is what urban clinics are doing.

3 And this is what we could do more of if we were

4 given equitable funding.

5 And I thank the Commission for listening

6 to us. Thank you.

7 VICE CHAIRMAN REYNOSO: Thank you very

8 much. Those have been very telling stories. Thank

9 you for coming forward.

10 VICE CHAIRMAN REYNOSO: I'd like to call

11 the last panel, also a panel of four. Norma Peone,

12 Dave Baldridge, Rose Ebaugh, Celia Hildebrand.

13 I take it there are just three of you.

14 So please proceed in the manner in which I called

15 you.

16 MR. BALDRIDGE: Commissioners, good

17 afternoon.

18 VICE CHAIRMAN REYNOSO: Good afternoon.

19 MR. BALDRIDGE: My name is Dave

20 Baldridge. I'm a Cherokee Indian. And for the past

21 12 years have been Executive Director of the

22 National Indian Council on Aging in Albuquerque.

23 We're the foremost national voice for America's

24 older Indians and Alaska Natives.

25 When I came to my job in '91 you could

1 count on one hand the number of tribes who were
2 contracting. There were five. As we look in the
3 year 2000, more than 500. That's an extraordinary
4 change and it's clearly the story in Indian health
5 care over the last decade. This devolution.
6 We also, in some senses, call it a
7 balkanization because it very realistically has
8 affected the quality of public health for Indian
9 Country. Functions the IHS has traditionally
10 fulfilled, facility construction and maintenance,
11 environmental health and public health are now being
12 filled by the tribes on an individual basis. Tribes
13 without the infrastructure or the background,
14 sometimes the ability to deal with public health
15 issues as they're struggling to deal with primary
16 health care.
17 We heard this morning that 7 out of 10
18 diseases affecting Indian people have very strong
19 behavioral components. And nationally Indian
20 Country's public health effort is now led not by one
21 IHS, but by 500 tribes, perhaps in 500 different
22 directions. We're concerned about that, very much
23 so.
24 We're also concerned about the lack of
25 emphasis in Indian health data. The IHS has not

1 published trends in Indian health since 1998. A new
2 version came out this year, but it's still using
3 1998 data. Why? The RPMS is perhaps the most data
4 rich database in the world for health. It goes back
5 20 years with encounters nine deep sometimes for
6 patients. Yet we're still seeing '98 data.
7 Jon Perez this morning talked about
8 figures indicating a reduction in diabetes, an
9 improvement perhaps in the Indian Nation. Well, we
10 knew 4 years ago that those were to due to 3 states
11 inadequately utilizing CMS requirements in not
12 making the change. So a statistical inaccuracy that
13 is continued to this day, is being perpetuated.
14 We heard this morning that the
15 definition of insanity is continuing to do the same
16 thing and expecting different results. With Indian
17 health data, we're doing that.
18 We saw this coming 5 or 6 years ago, and
19 so we got an IHS grant. It cost a million bucks and
20 we created and completed this year an interactive
21 Indian health atlas. It uses state-of-the-art
22 geographic information system technology. It is an
23 extraordinary tool. I think it's the most powerful
24 public health surveillance tool created in the
25 nation over the past 10 years. Today it sits in the

1 garage. We think of it as our shiny red Masserati,
2 but it's not in use because IHS will not allow the
3 release of Indian health data.
4 Some tribes object, and it's a very
5 serious consideration. But IHS, despite our pleas,
6 has not resolved it nor sought resolution. If the
7 balkanization of Indian health data follows the
8 balkanization of Indian health care to the tribes,
9 we're looking at the end of a national public health
10 data picture and the resulting consequences to
11 Indian health funding will be dramatic. To Indian
12 public health care they'll be dramatic.
13 My third issue is a bit of a global one
14 --
15 VICE CHAIRMAN REYNOSO: And I'm sorry.
16 Could you be quick about it? We're running out of
17 time.
18 MR. BALDRIDGE: I will be very, very
19 quick.
20 The federal trust responsibility is
21 based on treaties, statute and case law. It's for
22 American Indian and Alaska Natives. It has very
23 direct financial implications for us. If we
24 continue to refer to ourselves as Native Americans,
25 disparities in Native American health care are a

1 very different issue. We hope that you will use the
2 correct term, American Indian and Alaska Native.
3 It's important to us.
4 Thank you.
5 VICE CHAIRMAN REYNOSO: Thank you very
6 much.
7 MS. EBAUGH: Honorable members of the
8 Commission and all in attendance. My name is Rose
9 Ebaugh, and I am of the Dineh Nation. I currently
10 reside in Albuquerque, New Mexico.
11 Through treaties, the federal trust
12 obligations, the Snyder Act and Public Law 437
13 American Indian and Alaska Natives were promised
14 services such as health and dental. As a full time
15 student, a single parent of low-income status and a
16 community advocate, I cannot afford private health
17 insurance or comprehensive health care for my family
18 and I.
19 The Albuquerque Indian Health Service
20 and the SIPI Dental Health Clinic do not have
21 adequate funding to provide comprehensive health
22 care for my family also. Plus, residing off of our
23 reservation for 180 days, I am termed as contract
24 care ineligible. Upon returning back to the
25 reservation, my family and I are ineligible to

1 receive health care services.

2 What is IHS doing to resolve this

3 loophole of ineligibility? I recommend that as a

4 student also, I recommend that Medicaid cover full

5 time students of low income status and whom are

6 single parents. Along with Kay Culbertson, I

7 recommend that you recognize the needs of Indian

8 people who live off reservations. Their needs are

9 often as great or worse than those who reside on the

10 homelands.

11 And thank you, and have safe travels.

12 COMMISSIONER MEEKS: Thank you.

13 VICE CHAIRMAN REYNOSO: Thank you very

14 much.

15 Ma'am?

16 MS. HILDEBRAND: Good evening, to those

17 in front of me and those behind. Thank you for the

18 opportunity to speak.

19 My name is Celia Hildebrand. I am a

20 licensed acupuncturist, doctor of oriental medicine.

21 And I am under contract with Indian Health Service,

22 recently under contract to help develop the area's

23 master health facilities and services plan.

24 I don't know if you're aware of that.

25 It's required under congressional mandate to do so

1 that all services and facilities can meet the needs
2 of American Indians by the year 2015. We're just
3 beginning that process right now in this area.
4 I also have been working for 3 years
5 with Santo Domingo Pueblo to help plan and finance a
6 new health facility there. I have permission from
7 the Santo Domingo Governor's office, as well as
8 council members that were present to use some
9 examples to illustrate a few issues, although I am
10 speaking for neither. I'm only speaking for myself.
11 About 3 years ago we at Santo Domingo
12 began negotiating with IHS for a new facility. The
13 IHS population formulas, the IHS uses a different
14 formula for determining population. It's based on
15 population as well as user data over the past 3
16 years. Those numbers are lower than Santo Domingo
17 Tribe's own census, and they're also about
18 equivalent to the U.S. Census Department. That has
19 been a consistent problem I know for Santo Domingo
20 as well as other tribes that the U.S. Census data is
21 often very different than from what tribes
22 themselves have claimed. And as you know, funding
23 follows data. So that's been a real problem.
24 IHS population data said that Santo
25 Domingo's population required a 35,000 square foot

1 building with approximately 32 employees. Within 20
2 minutes of saying that, they also had to say that
3 they could only afford an 11,000 square foot
4 building with 17 employees. It's better than the
5 current facility at Santo Domingo, which is
6 approximately 3500 square feet and has 14 employees.
7 This treats patients of up to 11,000 patients a
8 year.
9 VICE CHAIRMAN REYNOSO: Wow.
10 MS. HILDEBRAND: I know that the IHS
11 health facilities priority funding process overall
12 allows financing or building of only one or two new
13 facilities nationwide a year. So there's no money
14 out there for tribes to be able to use IHS dollars
15 to expand or develop new facilities.
16 If you go out of IHS, you can go to HUD,
17 Housing and Urban Development, the Indian Community
18 Development Block Grant program to get financing to
19 help build a new facility. But then you usually have
20 to go to USDA under the Community Facilities Land
21 Loan and Grant program. In New Mexico, that
22 contains $75,000 for all the entire state.
23 But loan financing is based on ability
24 to repay debt. IHS can only enter into a 5 year
25 lease with a 5 year to renew --

1 VICE CHAIRMAN REYNOSO: And I'm sorry,
2 could you wrap it up?
3 MS. HILDEBRAND: Yes.
4 VICE CHAIRMAN REYNOSO: Sorry.
5 MS. HILDEBRAND: That's basically it.
6 Some state and federal loans may require tribes to
7 compromise sovereign status by opening their books
8 to allow funding agencies to determine whether or
9 not they have ability to repay debt and if they have
10 money to lend or to grant towards the program
11 themselves. It's a very uncomfortable position.
12 VICE CHAIRMAN REYNOSO: Yes. Thank you
13 very much again to the panelists.
14 I understand that there were four
15 individuals who came late. They had to work late.
16 Who wanted to say a word or two. I'd like to call
17 them forward. So this turned out not to be the last
18 panel.
19 Alfred Bennett, Frank Adakai, Edward
20 Tafoya and Francis Blair, I believe. If those folk
21 are forward, if they could come and be seated. And,
22 unfortunately, I'm going to have to keep you to
23 straight time limits.
24 And if you could proceed in the manner
25 in which I called you, Mr. Bennett, Mr. Adakai, Mr.

1 Tafoya and Ms. Blair.

2 MR. ADAKAI: Can I correct you on the

3 name, Adakai.

4 VICE CHAIRMAN REYNOSO: You say Adakai.

5 MR. ADAKAI: Yes.

6 VICE CHAIRMAN REYNOSO: By all means.

7 Nobody put an accent here. Adakai.

8 But Mr. Bennett goes first.

9 MR. BENNETT: Good evening,

10 Commissioners. It's an honor and privilege to be

11 here. I'm a Navajo from Shiprock, New Mexico

12 originally. I was born in Farmington.

13 You know, I'm just here to make it know

14 that, you know, in health care facility, the Indian

15 Health hospital here in Albuquerque that, you know,

16 I live in Valencia County. The next county south of

17 here. And I've always wondered when my kids came at

18 me, told me that their visits to the hospital, that

19 on contract, you know, to be referred to like other

20 positions, that it wasn't being paid for because

21 they didn't live in Bernalillo County. And so it

22 made me wonder, because there are Navajos in

23 Valencia County. I do see a lot of them. Some of

24 them are railroad workers and they bring their

25 families. So I just wanted to bring that to the

1 surface on why this is an issue here with this
2 Albuquerque area office that I think something needs
3 to be done to remedy the problem that anybody that
4 walks through those doors should be accepted, no
5 matter where they live.
6 The other part is I deal in the mental
7 retardation field, developmental disabilities. And
8 recently we had the closing of our state hospital in
9 1997, hospital and training school. And there were a
10 number of Navajos that were medically fragile. They
11 were forced relocated because of a lawsuit called
12 Jackson vs. Lawsons Hospital and Training School.
13 And their parents wanted them to stay in the
14 facility because they knew that they could not get
15 adequate care out in the community. But, you know,
16 they were never given their freedom of choice, which
17 is afforded to them. Because I'm a guardian myself
18 of my brother who is mentally retarded. And we were
19 really never given the freedom of choice whether we
20 wanted to have a home group, a home living situation
21 or a group home or a facility.
22 And it has come to my attention through
23 the years that some of them that were medical
24 fragile, the Navajos that I know, have died. And I
25 think this is another area that is really lacking in

1 the Indian health care system that needs to be taken
2 a look at. Because, I did call it a genocide of this
3 population, especially the medical fragile that
4 resides in this situation. And it's happening across
5 this country. And so I just wanted to bring this to
6 your attention and hope that, you know, maybe in the
7 very near future take a look at especially all the
8 treaties of individual nations across this country.
9 I think that's something that needs to be taken a
10 look at, because right now two of them working on
11 water rights issue with the Navajo on the San Juan
12 River right now. And the last river, I think, that
13 has not been adjudicated.
14 So thank you very.
15 VICE CHAIRMAN REYNOSO: Yes.
16 COMMISSIONER MEEKS: Thank you.
17 VICE CHAIRMAN REYNOSO: Thank you.
18 Mr. Adakai?
19 MR. ADAKAI: Thank you, members of the
20 Commission. I want to compliment you for taking time
21 from your busy schedule to come to Albuquerque to
22 hear us out.
23 On your program it mentions that your
24 sessions ends at 6:00, so I was sitting back there
25 saying well I got 15 minutes in which time to

1 address the Commission.

2 VICE CHAIRMAN REYNOSO: No. Earlier on

3 we started some of the program early.

4 MR. ADAKAI: Well, I'm just saying, I

5 just wanted you to smile, but you didn't.

6 VICE CHAIRMAN REYNOSO: Yes.

7 MR. ADAKAI: But I do appreciate it.

8 And one other thing I wanted to mention was the

9 treaties that people talk about and that are there,

10 supposed to be there, says as long as the grass

11 shall grow, as long as the river shall flow what

12 amenities would be made available to the Indian

13 people of this nation.

14 The Rio Grande is drying up. And we

15 don't have very much rain out here. And the grass is

16 dying out. So I'm just wondering if this is the

17 reason why some of these disparities are in

18 existence.

19 But I'm going to be talking to you from

20 the heart. And I just wanted to mention that we are

21 not urban Indians, as people say. We just live here.

22 And we have Census numbers, we have enrollment

23 numbers, we have land back on the reservations and

24 so forth. So I don't consider myself as an urban

25 Indian. I'm Dineh and I just live here because

1 that's a choice that I made. But, I'm very
2 concerned about our Indian people here, 36,000 of
3 them right here in Albuquerque that are not
4 privileged to the same privileges as the dominant
5 society is privileged to. And for some of us we
6 have health insurance, so we're talking about health
7 insurance versus no health insurance. And the ones
8 that don't have health insurance, of course, they
9 are there not receiving the services. And you have
10 heard the people talk to you about the disparities.
11 We have a 40 bed hospital here in
12 Albuquerque that is no longer accepting inpatients.
13 It's just sitting there as an outpatient type
14 facilities.
15 The SIPI Dental Clinic, as it was
16 mentioned, they're only serving people up to 18
17 years old and the rest of them have to go and try to
18 find their own way of taking care of whatever
19 problems that may be existing.
20 And so we are here as an advocate for
21 the people. And we get complaints all the time.
22 I'm not employed with any organization
23 or anything. We are here as private individuals.
24 And I just wanted to mention that the disparities
25 are there. They have been mentioned. No sense for

1 me to sit here and reiterate and to repeat what has
2 already been said. And I hope they have been a part
3 of the record.
4 VICE CHAIRMAN REYNOSO: They have been.
5 MR. ADAKAI: And I just wanted to get an
6 opportunity to say hello and to reinforce the
7 aspects of the disparities that I hear.
8 Thank you.
9 VICE CHAIRMAN REYNOSO: Thank you, Mr.
10 Adakai.
11 Mr. Tafoya?
12 MR. TAFOYA: Yes. My name is Edward
13 Tafoya, and I'm from the Santa Clara Pueblo. And
14 I'm the Lieutenant Governor.
15 One of the things -- I also belong to
16 the Santa Fe Service Unit Board. And one of the
17 things that's been happening is I want to reiterate
18 some of the things that are happening.
19 There was a directive several years ago
20 from the area director that we should serve all
21 Indians within the state, no matter where they come
22 from. So under the service -- Santa Fe Service
23 Unit, we are giving services to all the natives,
24 even from the cities that are other tribes. And we
25 even have some people from Oklahoma come in every

1 month. They're on a monthly basis to receive those
2 services. So the Santa Fe Service Unit
3 budget, we're spending at least 45 percent of the
4 budget on those people that are living in the
5 cities.
6 And one of the other things also is the
7 BIA is the one that certifies the tribal members on
8 the certification of Indian blood. It has nothing to
9 do with the tribes. The tribes are only the ones
10 that enroll. But it's up to the BIA to do that.
11 And the Indian Health Service is the one that
12 requires that an Indian be one-fourth Indian blood.
13
14 So there needs to be some changes in
15 those types of policies and procedures.
16 Also, one of the other things is that we
17 are serving the natives from other tribes. And the
18 Commission should look into those service units that
19 are providing those types of services to those
20 Indians. Because we are running out of money and we
21 are also neglecting our own people from the
22 reservation to provide those services. So it's
23 incumbent upon you folks to look into this and see
24 if we can get more funding in them.
25 As some of the people mentioned here is

1 that Santa Fe Service Unit also has their ICU closed
2 because of the lack of funds. So any type of
3 emergencies we are trying to contract with other
4 private hospitals, in doing that. But in essence,
5 we're missing a lot of our people to give those
6 types of services. So we need to have more funded.
7 And that's where it all stand, is the funding of --
8 you know, adequate funding for the health care.
9 Thank you.
10 VICE CHAIRMAN REYNOSO: Thank you, Mr.
11 Tafoya.
12 Ms. Blair?
13 MS. BLAIR: Mr. Chairman and members of
14 the Commission, this is my 59th year as a
15 pharmacist. I spent many of those years happily at
16 the Indian Health Service. Loved the patients.
17 Loved my work. I agree, that there are many
18 disparities and it goes back to not observing the
19 Snyder Act, which said that the United States of
20 America will provide health care to tribes and their
21 descendants. And descendants doesn't have to be
22 divided into urban, it doesn't have to be divided
23 into tribal. Descendants are descendants.
24 So I believe that before you appoint
25 more people to many of these jobs, they should have

1 a good math background. Because $2.2 billion will
2 not serve over 5 million people.
3 VICE CHAIRMAN REYNOSO: Yes. Yes.
4 MS. BLAIR: Now, there are many ways
5 these things can be handled. Much of the relief
6 work can be done by getting professional people who
7 have to work two weeks out of each year to maintain
8 their licensure to do the relief work. And there
9 are a number of other things. But the whole thing
10 about it is that a patient is a patient is a
11 patient.
12 VICE CHAIRMAN REYNOSO: Thank you very
13 much.
14 We very much appreciate your coming
15 forward, particularly with all your years of
16 experience.
17 Ms. Rebecca Ortega has joined you, and
18 she has, I understand, something to bring to our
19 attention.
20 MS. ORTEGA: Yes. Thank you so much,
21 Commissioners, for coming to meet with us. And I'm
22 glad that finally somebody has thought to come and
23 visit the Gallup facility and, you know, come and
24 listen to us as Native people what our concerns our.
25 I'm actually from the Pueblo Santa

1 Clara. And the reason that I came today, I read in
2 the paper today that you were going to be having
3 public hearings. I wanted to come because for so
4 long now I'm a mother of 3 children, and I always
5 talk with other mothers, other grandmothers. We're
6 all very, very worried and concerned about our
7 children, about our elderly.
8 You know, we want so much for them and
9 we know that through the treaties we were promised
10 health care. And it really hurts all of us when we
11 see our children not being served the way that they
12 should be. And, you know, being that we're Native,
13 we don't have a lot of opportunities. We don't
14 really know anything about filling out forms and,
15 you know, some of us don't have jobs. I don't have a
16 job. But I don't have a job by choice because I
17 feel that the most important thing are my children.
18 And I have to live with almost nothing for myself,
19 I will because I want to be there to make sure that
20 my children go to school, make sure that they eat,
21 make sure that I'm there when they come home so that
22 they're not out there doing drugs or alcoholism, or
23 -- you know, a lot of our youth are involved with
24 alcoholism. Some of them fall into depression, you
25 know suicide because so many times it's so hard to

1 live out there on the reservations. And even in the
2 city as Native people we're not all that educated.
3 And, you know, we depend a lot on Indian Health
4 Service to take care of our medical needs.
5 And us mothers and grandmothers, we
6 don't understand why if we in the treaties we were -
7 - you know, we gave all our land, our land in the
8 United States of America is worth so much right now.
9 I don't -- you know, can you maybe -- I'm sure you
10 might have an estimate of how much all the land is
11 worth. And, you know, we feel like how come if we
12 gave all that up, why isn't our health care, why
13 hasn't it gone up as well as that much value, too.
14 You know, all the land is worth. Why is our health
15 care always being cut back, you know? Us mothers,
16 that's why I came today. I was at home. I read the
17 paper. I told my husband I have to come down here. I
18 have to go tell them how we feel as women, how we
19 feel as mothers and all the things, the stories that
20 we've shared as mothers on the reservations, in the
21 city about our children. And I'm here to please
22 tell you please, please talk to Congress. And I
23 feel we all don't understand why we have to accept
24 cutbacks when our land has gone up so much. And I
25 am so thankful. And I know all the women from all

1 the tribes are so thankful that you have come today
2 to hear us.
3 And I want to say thank you so much. God
4 bless you all and have a safe trip home.
5 VICE CHAIRMAN REYNOSO: Thank you for
6 all--
7 MS. ORTEGA: And please don't forget us.
8 VICE CHAIRMAN REYNOSO: Thank you for
9 all of you for coming. Because particularly in these
10 last hours you've put a face to all of the
11 statistics and problems that have occurred, though
12 we heard a lot about that yesterday, too, when we
13 actually visited the facilities and we saw the lack
14 of services that should be provided to a people
15 whose promise was given and yet not kept.
16 So I want very much to thank this last
17 panel. I want to thank all of the folk who testified
18 today, and the folk who helped us yesterday to bring
19 a great consciousness to the leaders of our country
20 about this need, this desperate need. And we trust
21 that with your work and our work, there'll be a
22 response to it.
23 So, again, thank you very much.
24 This hearing is adjourned.
25 (Whereupon, at 5:55 p.m. the hearing was

1 adjourned.)
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