

DEPARTMENT OF THE INTERIOR AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2005

THURSDAY, APRIL 1, 2004

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:36 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Conrad Burns (chairman) presiding.
Present: Senators Burns, Stevens, Domenici, and Dorgan.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

STATEMENT OF CHARLES W. GRIM, D.D.S., M.H.S.A., ASSISTANT SURGEON GENERAL, DIRECTOR

ACCOMPANIED BY:

EUGENIA TYNER-DAWSON, ACTING DEPUTY DIRECTOR
GARY J. HARTZ, ASSISTANT SURGEON GENERAL, ACTING DIRECTOR, OFFICE OF PUBLIC HEALTH
ROBERT G. MCSWAIN, M.P.A., DIRECTOR, OFFICE OF MANAGEMENT SUPPORT
WILLIAM C. VANDERWAGEN, M.D., ACTING CHIEF MEDICAL OFFICER

OPENING STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. It's a long drive from Regent; probably had traffic in Fargo on the way in this morning. We'll call this subcommittee hearing to order. Thank you very much for coming and good morning.

We have Dr. Chuck Grim, Director of the Indian Health Service, and some of his colleagues here this morning to review the Indian Health Service budget for fiscal year 2005.

Indian health services are delivered to more than 1.6 million American Indians and Alaskan Natives through a system that employs over 15,000 people and operates close to 600 health facilities, including 49 hospitals, 236 health centers, and more than 300 health stations. Proposed funding for the Agency in fiscal year 2005 is \$2.97 billion, an overall increase of \$46 million above the current year enacted level.

I'd just like to go over a few highlights of the budget request: an additional \$18 million for Contract Health Services, and we'll be talking more about that this morning because every time I go home

this is what I hear; \$23 million to meet staffing requirements at newly-constructed facilities; an additional \$10 million for sanitation facilities construction; and \$2 million for a disease prevention initiative. There are also a few gaps in this proposal, chief among them the proposed \$53 million reduction to the health facilities construction account. That recommendation probably will not be very popular with most of our subcommittee members who, for the most part, have supported doing more and not less to replace some of the facilities that we have that are getting into the senior age status.

In the next few days, Congress is expected to conference and pass a budget resolution. Shortly after that the subcommittee will receive its allocation and the real work will begin. It is doubtful that we will have much in the way of additional resources to distribute to the agencies funded through this bill given the realities of defense and homeland security spending. Let me assure you, however, we will work closely with you, Dr. Grim, and your staff in an effort to address the highest priorities of your Agency and, of course, the health care needs of our Native Americans.

PREPARED STATEMENT

Dr. Grim, thank you for being with us today. We look forward to your testimony. This is the first time you've been up before this committee and we appreciate the service that you've chosen in your line of work. I know that sometimes it has great challenges but nonetheless you appear to be a man that's up to those challenges. [The statement follows:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Good morning. Today we have Dr. Chuck Grim, Director of the Indian Health Service, and some of his colleagues here with us to review the Indian Health Service budget for fiscal year 2005.

Indian health services are delivered to more than 1.6 million American Indians and Alaska Natives through a system that employs over 15,000 people at close to 600 health facilities, including 49 hospitals, 236 health centers, and more than 300 health stations. Proposed funding for the agency in fiscal year 2005 totals \$2.97 billion, an overall increase of \$46 million above the current year enacted level.

Program highlights include:

- an additional \$18 million for Contract Health Services;
- \$23 million to meet staffing requirements at newly constructed facilities;
- an additional \$10 million for sanitation facilities construction; and
- \$2 million for a Disease Prevention initiative.

There are also a few gaps in this budget proposal, chief among them a proposed \$53 million reduction to the facilities construction account. That probably won't be too popular with our subcommittee members, who for the most part are supportive of doing more not less to replace health facilities that can be as much as 100 years old.

In the next few days, Congress is expected to conference and pass a budget resolution. Shortly after that, this subcommittee will receive its allocation and the real work will begin. It is doubtful that we will have much in the way of additional resources to distribute to the agencies funded through this bill, given the realities of defense and homeland security spending. Let me assure you, however, we will work closely with you in an effort to address the highest priorities for your agency and Native Americans.

Dr. Grim, thank you for being with us today. We look forward to your testimony and appreciate the opportunity to discuss the budget proposal with you.

Senator BURNS. I'm pleased this morning to be joined by my friend from North Dakota, Senator Dorgan, the ranking minority member of this subcommittee.

OPENING STATEMENT OF SENATOR BYRON L. DORGAN

Senator DORGAN. Mr. Chairman, thank you for that. You have a warped sense of direction, however, if you think that you drive through Fargo coming from Regent. But, Montanans have never had an acute sense of direction. You have good judgement in other areas so we will overlook that this morning.

Senator BURNS. You don't go east to get to here? You don't go through Fargo?

Senator DORGAN. No, you go through Aberdeen.

Senator BURNS. That's worse yet because you probably go through Shelby.

Senator DORGAN. Mr. Chairman and Dr. Grim, first of all let me say something about the Indian Health Service staff out around the country. I don't know much about you three, though Mr. Hartz was well educated, I know, at the University of North Dakota. But I must say the Indian Health Service staff that I have met around the country are extraordinary men and women. They're not paid a lot, they don't do this because they're maximizing income, they do that because they want to provide health care and assistance to people who desperately need it. And I walk away every time I visit one of those clinics and those areas where I see Indian Health Service employees and I think what a remarkable thing and how blessed we are that they've decided to commit their lives to this thing. So I just want you to know that, number one.

Number two, the Indian Health Service is dramatically underfunded and we are pretending, every year as we deal with these issues, we pretend that we're providing good health care and we're not. And it has nothing to do with you or your staff; you don't have the money. We're spending about 50 percent less on health care for American Indians than we are—per person—than we are for Federal prisoners and we're responsible for both. When we incarcerate someone we're responsible for their health and we commit money to provide for their health. And we are also responsible, under our trust responsibility, for Indian health. And yet we underfund that by about 50 percent relative to that which we spend for Federal prisoners. And one has a good reason, it seems to me, to ask why. And I won't go through the list.

I'm going to ask a series of questions today, and they are not questions meant to, in any way, describe malfeasance on the part of your Agency but they are meant to describe the sense of warped priorities we have. You know, I remember just recently—and colleagues are tired and probably my colleague from Montana is tired of hearing me say this—but just recently, with precious little debate, we shipped off nearly \$20 billion to reconstruct Iraq, build children's hospitals, buy garbage trucks, and God knows what else we're doing with \$20 billion. To try to soak just a little bit of extra money out of the Federal budget to build the Indian Health Service budget to where it ought to be is almost impossible because we just want to pretend that we're doing the right thing. And we're not, we're just not. It is not the priority it should be.

You're a dentist, Dr. Grim, I believe.

Dr. GRIM. Yes sir.

Senator DORGAN. And you know, I visited the dental facilities at Standing Rock and you see a dentist in a trailer house serving 5,000 people and that's not—and incidentally, when you see so many American Indians with teeth missing it's for a good reason, because they can't get a tooth replaced when it's pulled, as you know, so that has health consequences. So there's so much going on.

I just got off the phone a few minutes ago with some family members of a 14-year-old girl who hung herself on Tuesday on the Spirit Lake Nation Reservation and the Indian Health Service people and others there told me that that's not unusual. I mean, this little 14-year-old girl's sister hung herself as well, 2 years ago, committed suicide. We have a full-scale crisis in health care and the fact is the budget that you are here to represent, and you must represent it because you're part of the administration, will actually cause us to lose ground because you don't have a budget request that meets the population increase; you don't have a budget request that meets just the continuing needs. And so I'm going to ask a series of questions about that today. And again, I started deliberately because I wanted to thank the people who work in the IHS but we should stop pretending; we are not doing right by American Indians with respect to the health care budget that we have proposed. Not just this year but every year. Not just under this administration but under previous administrations as well. And we ought to decide, finally, it's our responsibility to begin doing the right thing.

So Mr. Chairman, thank you very much.

Senator BURNS. Thank you, Senator Dorgan. Dr. Grim, we look forward to your statement.

SUMMARY STATEMENT OF DR. CHARLES W. GRIM

Dr. GRIM. Thank you sir. I want to thank both of you, too, for your opening comments and for your understanding and for the support that you've given the Indian Health Service and our programs over the years. Your committee has a great understanding of our program.

My name is Dr. Charles W. Grim, the Indian Health Service Director, and I'm here accompanied by two people at the table, Dr. Craig Vanderwagen, our Acting Chief Medical Officer and Mr. Gary Hartz, our Acting Director for the Office of Public Health. I also have a number of staff with me here in the audience so that we can try to get answers to your questions should you pose some that we're not able to answer. I'll be the only one making an opening statement and then we'll take any questions you'd be pleased to ask.

I'm very pleased today to have this opportunity to testify on the President's fiscal year 2005 budget request for IHS. I'll make just some brief remarks and ask that my written statement be entered into the record.

Senator BURNS. Without objection, it will be.

Dr. GRIM. I'm here to provide information on behalf of the President, the Secretary, and the IHS for the programs that are critical to achieving our shared goals of health promotion, disease prevention and the elimination of health disparities among all Americans.

The budget request contains an \$82 million increase for our health services programs. That will allow us to add up to four new epidemiology centers and increase support for the existing seven centers that we already have. It would allow us to add 30 new community health aides or practitioners to provide service in Alaska native communities, raising the number of aides and practitioners to 516. It also has funds to cover some of the mandatory Federal pay costs and provide tribally run health programs with funds for comparable pay raises for their staffs. We've also asked for an additional \$18 million for Contract Health Services, which was mentioned in your opening comments, and an additional \$2 million is requested to expand our existing health promotion and disease prevention initiatives at the local community level.

FACILITIES

Our request on the facilities side includes an additional \$23 million to add staffing for five out-patient facilities that are scheduled to open during fiscal year 2005. Those are the Pinon and West Side Health Centers in Arizona, the Dulce Health Center in New Mexico, the Idabel facility in Oklahoma and the Annette Island Health Center in Alaska. When fully operational, these facilities will double the number of primary care provider visits and bring new services to these sites.

SANITATION CONSTRUCTION

We've also requested \$103 million for sanitation construction—that's an increase of \$10 million or 11 percent over our fiscal year 2004 level—to be able to provide safe water and waste disposal systems to Indian communities. Specifically, the President's budget request supports the provision of safe water and waste disposal to an estimated 22,000 additional homes.

HEALTH CARE FACILITIES CONSTRUCTION

There's also a \$42 million request to fund the completion of out-patient facilities construction at Red Mesa, Arizona, and Sisseton, South Dakota, and to provide necessary staff housing for the health facilities at Zuni, New Mexico, and Wagner, South Dakota. When completed, these out-patient facilities will provide an additional 36,000 primary care provider visits, replace the 68-year-old Sisseton Hospital, and bring 24-hour emergency care services to the Red Mesa area for the first time ever. The IHS is also going to be able to add 13 units of staff quarters and replace 16 house trailers that were built over 40 to 50 years ago. Having this new decent local housing will make it easier for us to recruit and retain health care professionals at these sites.

In addition to the increased request for sanitation facilities, there's also an increased request for facilities and environmental health support. In addition to providing funds for the provision of health care services to Indian people on or near reservations, our 2005 budget request also includes \$32 million to help support 34 urban Indian health organizations that provide services in cities with large numbers of Indian people.

NATIONAL BUDGET PRIORITIES/CONSTRAINTS

The budget request for the IHS continues to reflect the commitment of the President and the Secretary to meeting the health needs of Indian people within the scope of national priorities. The President's overall request provides substantial increases to improve our Nation's security and win the war on terror. It also increases funding for key priorities such as economic growth and job creation, education, and affordable health care, which are all key factors in influencing the health status of our people. To fund these priorities, the President's national budget request restrains overall increases in spending in other areas of the government and in discretionary programs to less than 1 percent. In support of the President's key priorities, his proposal for the Department of Health and Human Services discretionary budget authority is a 1.2 percent increase over fiscal year 2004 and the IHS request for 2005 exceeds the 1 percent national discretionary average and the 1.2 percent average for HHS. The IHS budget request is an increase of 1.6 percent, or \$46 million over the fiscal year 2004 enacted level. The total proposed budget authority for us in 2005 then is at \$3 billion and, if you add in funds from health insurance collections estimated at \$593 million, the designated diabetes appropriations of \$150 million and \$6 million for staff quarters rental collections, it increases our proposed budget from \$3 billion to \$3.7 billion in program-level spending. This increase will allow the continuation of quality health care services to Indian people and this increase above the national and HHS discretionary averages reflects the Department's tribal budget consultations and a continuing Federal Government commitment to provide for the health of members of federally-recognized tribes.

OVERALL DEPARTMENTAL BUDGET

The President's budget request for IHS must also be considered in the context of the proposed increases for the Department overall. Fortunately, we no longer exist in an era where the IHS is viewed by the Department as the sole source and agent for improving the health of Indian people. That responsibility has expanded to include all programs of the Department. An example of an increase elsewhere that will benefit Indian people and also the IHS is the Medicare Prescription Drug Improvement and Modernization Act of 2003. Items in this Act that are particularly important to the IHS, tribal, and urban Indian health programs include: a provision to increase the reimbursement rates for rural ambulance services, which will benefit numerous isolated tribal ambulance programs throughout Indian country; a provision that authorizes reimbursement to IHS and tribal health facilities for emergency services provided to undocumented aliens, which is particularly important for IHS and tribal facilities in remote border locations of the United States; and a provision that requires Medicare participating hospitals to accept Medicare rates as payment in full when providing in-patient hospital services to IHS beneficiaries who are referred for care, which is going to allow us to save more money in our Contract Health Services budget. There's also a 5-year authorization of reimbursement for increased Medicare B services, which will allow

us to increase our billings in that arena. And there are changes in critical access hospital reimbursements that are going to benefit many of our rural IHS and tribal hospitals. They've also increased the disproportionate share of low-income and uninsured patient rate from 5.25 to 12 percent and nearly all of our hospitals will benefit from that.

There are also provisions in that bill to support health promotion and disease efforts and, beginning this year, all newly enrolled Medicare beneficiaries will be covered for an initial physical exam, electrocardiogram and cardiovascular screening, blood tests, and those at risk will be covered for a diabetes screening test. Before this legislation was enacted, the IHS and tribes were providing these services but now we will be able to seek reimbursement for them, which will extend our health dollars even further.

Overall, the combination of budget increases and additional purchasing power provided by that Medicare Modernization Act will allow for the purchase of an estimated 35,000 additional out-patient visits or 3,000 additional in-patient days of care.

PREPARED STATEMENT

I want to thank you for the opportunity to discuss the fiscal year 2005 President's budget request for the IHS and again I'd like to thank this subcommittee for their support over the years to ensure that the IHS can continue to help American Indian and Alaska Native people across the Nation. I would be pleased, Mr. Chairman, to answer any questions that you have today.

[The statement follows:]

PREPARED STATEMENT OF DR. CHARLES W. GRIM

Mr. Chairman and Members of the Subcommittee: Good morning. I am Dr. Charles W. Grim, Director of the Indian Health Service. Today I am accompanied by Ms. Eugenia Tyner-Dawson, Acting Deputy Director, Dr. William Craig Vanderwagen, Acting Chief Medical Officer, Mr. Gary J. Hartz, Acting Director, Office of Public Health, and Mr. Robert G. McSwain, Director, Office of Management Support. We are pleased to have this opportunity to testify on the President's fiscal year 2005 budget request for the Indian Health Service.

The IHS has the responsibility for the delivery of health services to more than 1.6 million members of Federally-recognized American Indian (AI) tribes and Alaska Native (AN) organizations. The locations of these programs range from the most remote and inaccessible regions in the United States to the heavily populated and sometimes inner city areas of the country's largest urban areas. For all of the AI/ANs served by these programs, the IHS is committed to its mission to raise their physical, mental, social, and spiritual health to the highest level, in partnership with them.

Secretary Thompson, too, is personally committed to improving the health of AI/ANs. To better understand the conditions in Indian country, the Secretary or Deputy Secretary has visited Tribal leaders and Indian reservations in all twelve IHS areas, accompanied by senior HHS staff. The Administration takes seriously its commitment to honor its obligations to AI/ANs under statutes and treaties to provide effective health care services.

Through the government's longstanding support of Indian health care, the IHS, Tribal, and Urban (I/T/U) Indian health programs have demonstrated the ability to effectively utilize available resources to improve the health status of AI/ANs. For example, there have been dramatic improvements in reducing mortality rates for certain causes from the three year periods of 1972-1974 to 1999-2001, such as maternal deaths decreased 58 percent, infant mortality decreased 64 percent, and unintentional injuries mortality decreased 56 percent. More recently, the funding for the Special Diabetes Program for Indians has significantly enhanced diabetes care and education in AI/AN communities, as well as building the necessary infrastructure for diabetes programs. Intermediate outcomes that have been achieved since imple-

mentation of the Special Diabetes Program for Indians include improvements in the control of blood glucose, blood pressure, total cholesterol, LDL cholesterol, and triglycerides. In addition, treatment of risk factors for cardiovascular disease has improved as well as screening for diabetic kidney disease and diabetic eye disease.

Although we are very pleased with the advancements that have been made in the health status of AI/ANs, we recognize there is still progress to be made. As the Centers for Disease Control and Prevention recently reported, the AI/AN rates for chronic diseases, infant mortality, sexually transmitted diseases, and injuries continue to surpass those of the white population as well as those of other minority groups. The 2002 data show that the prevalence of diabetes is more than twice that for all adults in the US, and the mortality rate from chronic liver disease is more than twice as high. The sudden infant death syndrome (SIDS) rate is the highest of any population group and more than double that of the white population in 1999. The AI/AN death rates for unintentional injuries and motor vehicle crashes are 1.7 to 2.0 times higher than the rates for all racial/ethnic populations, while suicide rates for AI/AN youth are 3 times greater than rates for white youth of similar age. Maternal deaths among AI/ANs are nearly twice as high as those among white women.

The type of health problems confronting AI/AN communities today are of a more chronic nature. The IHS public health functions that were effective in eliminating certain infectious diseases, improving maternal and child health, and increasing access to clean water and sanitation, are not as effective in addressing health problems that are behavioral in nature, which are the primary factors in the mortality rates noted previously. Other factors affecting further progress in improving AI/AN health status are the increases in population and the rising costs of providing health care. The IHS service population is increasing by nearly 2 percent annually and has increased 24 percent since 1994.

This budget request for the IHS will assure the provision of essential primary care and public health services for AI/ANs. For the seventh year now, development of the health and budget priorities supporting the IHS budget request originated at the health services delivery level. As partners with the IHS in delivering needed health care to AI/ANs, Tribal and Urban Indian health programs participate in formulating the budget request and annual performance plan. The I/T/U Indian health program health providers, administrators, technicians, and elected Tribal officials, as well as the public health professionals at the IHS Area and Headquarters offices, combine their expertise and work collaboratively to identify the most critical health care funding needs for AI/AN people.

The President's budget request for the IHS will assist I/T/U Indian health programs to maintain access to health care by providing \$36 million to fund pay raises for Federal employees as well as funds for Tribal and Urban programs to provide comparable pay increases to their staff. Staffing for five newly constructed health care facilities is also included in the amount of \$23 million. When fully operational, these facilities will double the number of primary provider care visits that can be provided at these sites and also provide new services. The budget also helps maintain access to health care through increases of \$18 million for contract health care and \$2 million for the Community Health Aide/Practitioner program in Alaska. The increase for CHS, combined with the additional purchasing power provided in Section 506 of the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act, will allow the purchase of an estimated 35,000 additional outpatient visits or 3,000 additional days of inpatient care.

As mentioned previously, the health disparities for AI/ANs cannot be addressed solely through the provision of health care services. Changing behavior and lifestyle and promoting good health and environment is critical in preventing disease and improving the health of AI/ANs. This budget supports these activities through requested increases of \$15 million for community-based health promotion and disease prevention projects, expanding the capacity of Tribal epidemiology centers, and providing an estimated 22,000 homes with safe water and sewage disposal. An additional \$4.5 million is requested for the Unified Financial Management System. This system will consolidate the Department's financial management systems into one, providing the Department and individual operating division management staff with more timely and coordinated financial management information. The requested increase will fully cover the IHS' share of costs for the system in fiscal year 2005 without reducing other information technology activities.

The budget request also supports the replacement of outdated health clinics and the construction of staff quarters for health facilities, which are essential components of supporting access to services and improving health status. In the long run, this assures there are functional facilities, medical equipment, and staff for the effective and efficient provision of health services. The average age of IHS facilities

is 32 years. The fiscal year 2005 budget includes \$42 million to complete construction of the health centers at Red Mesa, Arizona and Sisseton, South Dakota; and complete the design and construction of staff quarters at Zuni, New Mexico and Wagner, South Dakota. When completed, the health centers will provide an additional 36,000 primary care provider visits, replace the Sisseton hospital, which was built in 1936, and bring 24 hour emergency care to the Red Mesa area for the first time.

The IHS continues its commitment to the President's Management Agenda through efforts to improve the effectiveness of its programs. The agency has completed a Headquarters restructuring plan to address Strategic Management of Human Capital. To Improve Financial Performance and Expand E-Government, the IHS participates in Departmental-wide activities to implement a Unified Financial Management System and implement e-Gov initiatives, such as e-grants, and Human Resources automated systems. This budget request reflects Budget and Performance Integration at funding levels and proposed increases based on recommendations of the Program Assessment Rating Tool (PART) evaluations. The IHS scores have been some of the highest in the Federal Government.

The budget request that I have just described provides a continued investment in the maintenance and support of the I/T/U Indian public health system to provide access to high quality medical and preventive services as a means of improving health status. In addition, this request reflects the continued Federal commitment to support the I/T/U Indian health system that serves AI/ANs.

Thank you for this opportunity to discuss the fiscal year 2005 President's budget request for the IHS. We are pleased to answer any questions that you may have.

BIOGRAPHICAL SKETCH OF DR. CHARLES W. GRIM

Charles W. Grim, D.D.S., is a native of Oklahoma and a member of the Cherokee Nation of Oklahoma. As the Director of the Indian Health Service (IHS), he is an Assistant Surgeon General and holds the rank of Rear Admiral in the Commissioned Corps of the Public Health Service. He was appointed by President George W. Bush as the Interim Director in August 2002, received unanimous Senate confirmation on July 16, 2003, and was sworn in by Tommy G. Thompson, Secretary of Health and Human Services, on August 6, 2003 in Anchorage, Alaska.

As the IHS Director, he administers a nationwide multi-billion dollar health care delivery program composed of 12 administrative Area (regional) Offices, which oversee local hospitals and clinics. The IHS is responsible for providing preventive, curative, and community health care to approximately 1.6 million of the Nation's 2.6 million American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for Indian people.

Dr. Grim graduated from the University of Oklahoma College of Dentistry in 1983 and began his career in the IHS with a 2-year clinical assignment in Okmulgee, OK, at the Claremore Service Unit. Dr. Grim was then selected to serve as Assistant Area Dental Officer in the Oklahoma City Area Office. As a result of his successful leadership and management of the complex public health dental program, he was appointed as the Area Dental Officer in 1989 on an acting basis.

In 1992, Dr. Grim was assigned as Director of the Division of Oral Health for the Albuquerque Area of the IHS. He later served as Acting Service Unit Director for the Albuquerque Service Unit, where he was responsible for the administration of a 30-bed hospital with extensive ambulatory care programs and seven outpatient health care facilities. Dr. Grim was later appointed as the permanent Director for the Division of Clinical Services and Behavioral Health for the Albuquerque Area and had the responsibility for working with all health related programs at the Area level. Dr. Grim was then appointed Acting Executive Officer for the Albuquerque Area, one of three top management officials for the two-state region, and was responsible for the fiscal and administrative leadership of the Area.

In April 1998, Dr. Grim transferred to the Phoenix Area IHS as the Associate Director for the Office of Health Programs. In that role, he focused on strengthening the Phoenix Area's capacity to deal with managed care issues in the areas of Medicaid and the Children's Health Insurance Program of Arizona. He also led an initiative within the Area to consult with Tribes about their views on the content to be included in the reauthorization of the Indian Health Care Improvement Act, Public Law 94-437.

In 1999, Dr. Grim was appointed as the Acting Director of the Oklahoma City Area Office, and in March 2000 he was selected as the Area Director. As Area Director, Dr. Grim managed a comprehensive program that provides health services to the largest IHS user population, more than 280,000 American Indians comprising 37 Tribes. The geographic area of responsibility covers the states of Oklahoma, Kan-

sas, and portions of Texas. Health care is provided through direct care, contract care, or tribally operated facilities. He was also a member of the Indian Health Leadership Council, composed of IHS, tribal, and urban Indian health program representatives. The Council is a decision making body of the agency that examines health care policy issues.

In addition to his dentistry degree, Dr. Grim also has a master's degree in health services administration from the University of Michigan. Among Dr. Grim's honors and awards are the U.S. Public Health Service Commendation Medal (awarded twice), Achievement Medal (awarded twice), Citation, Unit Citation (awarded twice), and Outstanding Unit Citation. He has also been awarded Outstanding Management and Superior Service awards by the Directors of three different IHS Areas. He also received the Jack D. Robertson Award, which is given to a senior dental officer in the United States Public Health Service (USPHS) who demonstrates outstanding leadership and commitment to the organization.

Dr. Grim is a member of the Commissioned Officers Association, the American Board of Dental Public Health, the American Dental Association, the American Association of Public Health Dentistry, and the Society of American Indian Dentists. Dr. Grim was appointed to the commissioned corps of the U.S. Public Health Service in July 1983.

Senator BURNS. Dr. Grim, thank you very much. I'm going to have about three questions and then I think we'll get a pretty good dialogue off of these three. I want to thank you for mentioning all of your wellness programs because we don't talk much about efforts to promote wellness on our reservations—one example is the screening programs that they'll be reimbursed for now to find out where our problems are and solve them early on. I'm also glad you mentioned the sanitation construction program. It seems like so many reservations we go to have real sanitation problems. I have two major water projects in Montana, ongoing now, that are high priority in my office; we want to complete those because I happen to believe that unclean water is probably the cause of a lot of our health problems. You can't believe what water, pure water, does for our wellness.

Also in the area of diabetes, as you know it is more prevalent on our reservations than in the rest of the country. I'll want to know how you're doing there because we funnel more money into the diabetes fund and I want to know if we're making any headway, are we seeing any visible results, what is the impact of that money.

CONTRACT HEALTH SERVICES

Contract Health Service dollars are critical because in Montana, and I think in other areas, too, where we're a long way from major IHS medical facilities, those services are met by hospitals and health care providers off the reservation. This becomes very expensive but it is also a very vital part of how we provide health services for our Native Americans. The IHS budget proposes to increase this program by about \$18 million for 2005.

Give me your assessment of that proposal. Even though I know that it sounds like \$18 million is a lot of money, if a shortfall exists in contract health care overall, can you give me an estimate of where we should be to provide adequate acute care through contract services? How many of the highest priority medical cases must be rejected annually because tribes just run out of money, and how far will this \$18 million increase go to alleviate some of these problems? That's a pretty broad field.

Dr. GRIM. Yes sir, that's a lot of questions.

Senator BURNS. It's a lot of questions all in one, isn't it?

Dr. GRIM. I'll see if we can start addressing those and if we don't capture all of the ones that you asked please feel free to ask again.

\$18 MILLION REQUEST

As you can see in our budget, that \$18 million request for increases other than our pay act inflationary increases is the largest increase that we asked for. That's one of the highest priority items in Indian country, that's the monies that we use to pay for care in the private sector that we cannot provide in our facilities. That \$18 million in large part goes to help offset the inflation that will incur in that particular budget this year. Earlier I mentioned the Medicare Modernization Act. We've not been able to fully estimate the impact of that Act because its regulations have yet to be written, but we're working very closely with the Centers for Medicare/Medicaid Services. We've estimated that just the one that allows us to have Medicare-like rates in hospitals where we've not been able to get those before and had to pay full bill charges is going to allow us to extend our CHS budget another \$8 to \$9 million in specific locations across the IHS Areas.

We're also working very, very hard to enhance our business practices all across the Indian Health Service. Prior to becoming Director of the Indian Health Service, I was the chairman of a business plan committee for the Agency that worked with all of our stakeholders to develop a business plan. One of the things that we're trying to do, as you know, our Contract Health Services budget is the payer of last resort and so we're doing everything we can in all of our facilities to exhaust other third-party resources that patients might have, like Medicare, Medicaid or private insurance. So we're trying to cover the front in all those arenas. We've asked for one of the largest increases in CHS; we're also looking at how Medicare modernization is going to affect our budget and then we're trying to enhance our business practices as well.

It's very hard to answer your question about some of the highest priority claims, how many will be denied. We don't capture them by priority level but we do know that there are priority one claims, which are considered an immediate threat to life or limb that are denied throughout the course of the year. That particular budget is discretionary, not an entitlement-type program like Medicare and Medicaid, and so we are required to stay within our appropriation for that budget. I can give you, for the record, some overall numbers about denials and deferred services and things like that but we don't collect by priority one, two and three the way we medically categorize care, we don't capture it in that fashion to be able to tell you how many of the most urgent care needs are denied on an annual basis.

Senator BURNS. Well, I think maybe those are some numbers that this subcommittee should have and Congress should know about. And what I would do after this year's budget, I think I would probably have somebody go over that and see how much more money we would need to take care of what we should, even using good business practices and even going and trying to save money where we can.

Tell me about the CHEF Program. That's along the same lines, I think.

CHEF PROGRAM

Dr. GRIM. Yes sir.

Senator BURNS. It's meant to cover catastrophic illness. Tell me about that program; we're hearing a little bit of feedback from our reservations on that.

Dr. GRIM. Yes sir. That's a—you took the words right out of my mouth. That was the next statement I was going to make to you. The CHEF Program right now is funded at \$18 million. Our overall CHS budget is approaching \$500 million—I believe it's going to be about, if we get our request this year, in the \$480 plus range—and of that amount \$18 million is taken off and set aside to handle catastrophic health emergency cases. Regulations set out the threshold that would have to be met by local contract health programs, and I believe for fiscal year 2004 that amount is around \$23,800. Whenever a facility spends more than that on a particular case, they apply to that fund and then they are reimbursed so that the catastrophic cases do not cause them to run out of funds early in the year. Congress raised CHEF from \$15 million a few years ago up to \$18 million, we have that authority, but that particular budget has been running out in about the third quarter of each year. And so in the fourth quarter of the fiscal year if any programs have catastrophic cases then they end up having to fund those themselves. We have estimates in our congressional justification that would indicate that probably \$30 million would be needed in that fund to capture known cases but it's very hard to predict from year to year because of the expense of medical care and the unknown types of cases we might encounter.

Senator BURNS. I've got a couple of other questions before—

Senator DORGAN. Why don't you finish up and I'll just—

Senator BURNS. Well I'm afraid you're going to wear your thumb out.

Senator DORGAN. No.

Senator BURNS. Okay. In your epidemiology—auctioneers handle that pretty well, don't they?—your epicenters. Tell me about those. I understand that you have established some and I think you're short of what you want nationally but you're getting there.

EPI CENTERS

Dr. GRIM. Yes sir. We currently have seven epidemiology centers and they're funded at approximately \$300,000 each. And those seven centers really only cover about 50 percent of the American Indian and Alaska Native population. We have several large Areas of Indian population—Albuquerque, Navajo, Oklahoma, Billings, and California—that are not currently covered by epidemiology centers. So the money that we're requesting in this year's budget will allow us to add, hopefully, four new centers and to upgrade the existing centers by \$100,000 each. As I said, we're funding them currently at \$300,000; we estimate for them to be fully functional that they would need around \$750,000. But those epidemiology centers take the money that we put in and they go after other grants, through States or through other programs, and are able to essentially use a lot of our money as seed money. Those centers have been very effective at working with tribes in those Areas to help

them analyze the large amounts of health data that are gathered through our system. And we also work with CDC, NIH, and State health departments to try and bring in additional funding for those epicenters. So the funding that we're asking for this year would allow us to go out with another request for funding proposals and hopefully capture four more centers.

Senator BURNS. Senator Dorgan.

FUNDING DISPARITIES

Senator DORGAN. Mr. Chairman, thank you very much. Dr. Grim, I mentioned in the opening statement the contrast between our responsibility as a Federal Government to provide for the health of Federal prisoners and the health of the American Indians. Could you and your staff at some point provide for me an estimate of what we would spend on the Indian Health Service if we provided funding for the health of American Indians at the same level that we provide for the health for Federal prisoners?

Dr. GRIM. Yes sir, we can provide that for you. I don't have those numbers before me.

Senator DORGAN. I understand. But my cursory glance is that we spend, on a per capita basis about 50 percent more for Federal prisoners' health care than we do for American Indians.

You know, you have a responsibility to come here on behalf of this budget and support the budget. I understand that, I'm not critical of that because that's your role. But you know and I know that you've described to us kind of like someone selling a car. You've said this is a great tail light and we've got a good door handle over here and I want you to see the shiny hood and we all directed our attention to what you wanted us to look at. But you know we're far short. Let me ask a couple questions.

CONTRACT HEALTH SERVICES

Indian people have had their credit ruined, as you know, because they were able to access Contract Health Services that were approved and then the payments weren't made. These are health services they couldn't get on the reservation so they go to a hospital some place, get the health care and then the payment isn't made and they come back to the Indian for payment and he doesn't have the payment so their credit is ruined. So we're far short of what's needed for Contract Health Services, and my understanding is that if you need a hip replacement, just continue working; you can't get a hip replacement because of the rationing of care at the present time. Is that correct?

Dr. GRIM. Yes sir. Many places are unable to provide that level of service.

Senator DORGAN. How about arthritis treatment?

Dr. GRIM. Again, it depends on the location. We have disparities of funding within the Service itself; some places are able to provide care for arthritis patients and others are not.

Senator DORGAN. My understanding is that allergy testing, stress tests for diabetics who do not have signs of heart disease, these are things, for example, that would not be covered under Contract Health Services. And I simply describe that to point out that we're just so far short of where we need to be. Because you're a dentist,

Dr. Grim, you know that dentists, I think, throughout the IHS, do not perform crown or bridge work. So if you go to a dentist on the reservation to have your tooth pulled you're going to walk around with an empty space because there's no crown or bridge work available. Is that correct?

Dr. GRIM. There are some places that are able to provide crown and bridge work but you are correct that as a whole we have very, very limited services that are provided in that realm.

Senator DORGAN. And, with Federal prisoners, do we do crown or bridge work, I wonder?

Dr. GRIM. I'm not sure.

Senator DORGAN. You wouldn't know that but I'm sure we do.

Senator BURNS. He's never been in prison.

Senator DORGAN. Yeah. Let me ask a question. I mentioned to you about the young girl that committed suicide on Tuesday on the reservation and I think her name was Avis Littlewind; her aunt told us of this and then I called to find out what had happened there. You know, this is a reservation like virtually all of them; one social worker, one psychologist. They tell me that man, they just struggle to keep up. I had a hearing on this subject some long while ago and the young woman who was supposed to be in charge of the office dealing with these kids, and this was dealing with mental trauma and sexual abuse, child abuse, in the middle of the hearing she was testifying about what she's trying to do, she's been there about 6 months, in the middle of the hearing she just broke down and began sobbing and couldn't continue. She said you know, I just have to beg to get a car to take a kid to a clinic; I don't even have wheels to take a kid to a clinic. And then she just quit; 30 days later she quit. And you know, this is on the same reservation, incidentally. So I called these folks this morning. They're just woefully, dramatically understaffed relative to the load they have. Is there anything in this budget that's going to give them hope? As I read this budget, it looks like we're underfunding the Indian Health Service once again. We're not going to even meet inflation needs. Would you not agree?

MENTAL HEALTH/SUICIDE PREVENTION

Dr. GRIM. We have provided some funding increases for the mental health program in this budget along with the criteria that we were to lay out. And one of the things that we've done on top of that, since I've been in as the Director and realizing the huge tragedy that suicide causes in Indian country, I've started an initiative. When I initially became Director we had just the year before that received a \$30 million increase to our budget, one of the largest increases we'd received in a number of years. And so we worked with Indian country to determine how we would distribute those funds and one of the things that we've done recently is we've started a suicide initiative; we have increased the data collection methods that we use, we're able to now spot areas where there might be potential suicide clusters beginning. We've tested that software and we think averted a crisis in one particular Area because of the way the data's gathered at a national level now. I've also begun a suicide task force that's made up from representatives from all of our regions. They're scheduled to have their first meeting this summer

in June and we're going to be working with them on various programs across the country. Any time that we have had suicide clusters and emergencies, we've dug into emergency funds to try to help those particular areas, to bring in experts.

PATIENT CONTACTS

Senator DORGAN. But Dr. Grim, whether it's dental health, alcohol and substance abuse or mental health, in every case we have fewer patient contacts. More money but fewer patient contacts. Is that not the case?

Dr. GRIM. I would have to check the patient contact—

Senator DORGAN. Well, let me give it to you from your evidence; 7,700 fewer patient contacts in the mental health despite the fact there's a \$2.5 million increase; in dental health, 12,000 fewer patients; alcohol substance abuse 29,000 fewer in-patient treatments, 13,000 fewer in-patient treatments. My point is, add a little money but actually don't keep pace with inflation and have less money actually for patient visits in all of these cases. Is that not the case?

RECRUITMENT

Dr. GRIM. That is part of the problem, sir. Another part of the problem is recruitment efforts. We have, especially in dental, we have some very high vacancy rates right now, also in pharmacy and physicians and nursing we have some very high vacancy rates and we're doing as much as we can around recruitment and retention efforts. I have a huge new initiative that we've instituted within the Agency. The Secretary and the President have also agreed to strengthen the Commission Corps by 1,000 new officers; they've dedicated 275 of that new 1,000 to the Indian Health Service in some of our most difficult-to-fill sites. So a portion of what you're saying about the inflationary issue is accurate and the other part of the story is the recruitment issue and the vacancies that we have.

Senator DORGAN. Well, my time has expired. Our colleagues are here. I'm going to submit a list of questions to you. Let me again say that we're spending 50 percent less per person on Indian health than we are on health for the Federal prisoners in Federal prisons. And I think we're pretending. We have a health care crisis and we're pretending that we're sort of meeting it but we're really not and we need somehow to do much, much better. So I'll submit a series of questions.

Let me again say thanks to the men and women of the Indian Health Service who are out there doing remarkable work in a dramatically underfunded area.

Dr. GRIM. I really appreciate that and I will make sure everywhere I go that I let them know this subcommittee had thanks for them.

Senator BURNS. Along the same lines of mental health, Art McDonald down on the Cheyenne, headed a program many years ago; we earmarked some money, \$250,000, for the psychology program in Montana and there are just a few other schools that participate—University of North Dakota is one of those that gets an earmark for such programs. We've long been an advocate for this program and we just kind of struggled along but it's a model that

I think that Art has made work down on the Cheyenne. So, he's a valuable resource and I'm pretty sure he'd make himself available if you would call on him.

We've been joined by Senator Domenici of New Mexico and the chairman of the full committee. I don't know how full he is but he has joined us. Senator Domenici.

STATEMENT OF SENATOR PETE V. DOMENICI

Senator DOMENICI. Thank you so much. I wanted to say to the Senator, it's good for me to find Senators that are willing to work on these issues. You know, I've been here for a long time and there weren't a lot of them. You take some of the issues, he takes some, I take some, and I think we're doing a much better job. There's no question, we must do better. But I thank you for what you do and I think you know there's been an enormous success, not relevant to this, but I just had an inventory done of how many new schools were built because we started 3 years ago with a notion of how it should be done. Compared to 10 years ago it's incredible what's being built for the kids in terms of new schools.

DIABETES

Dr. Grim, let me say there's many, many things we could talk about but I think when you see something that's just stark in your face you can't ignore it. Diabetes is it. I mean, we have some Indian tribes, as you know, that may have 50 percent diabetes. We also have showing up babies, kids, I don't mean babies but kids and most of them are Indian, with diabetes. So from my standpoint I'm deeply interested in your programs. You get some extra money.

Dr. GRIM. Yes sir.

Senator DOMENICI. Because we, fortunately, put \$150 million for America and \$150 million for Indians. So that was a pretty big amount. In my State we have a number of centers. How many Indian tribes are working with those programs, do you know?

Dr. GRIM. Almost all tribes across the Nation are benefiting from that money. And I want to thank you, each and every one of you, that had a part in that \$150 million; it's been put to great use by tribes across the Nation. We have over 300 grantees that are being funded by that now and we have some great results that are starting to show up. As you know, in fiscal year 2004 we received the additional \$50 million; prior to that the first 6 years had gotten up to \$100 million. We also have a report that I think Congress would be very delighted to see that's going to be available very, very soon that's going to have a lot of information and a lot of statistics about the good things that money has helped us accomplish. Just to give you an example of some of the things that we've done, in 2002, 71 percent of our diabetes grant programs reported availability of community-based physical activity programs for children, youth and families. Prior to us having those funds available, only 10 percent of our programs had such activities. In 2002, 53 percent of our grant programs reported availability of school-based physical activity programs; prior to that only 22 percent of our school programs had things like that. Around nutrition education, prior to those funds being available only 20 percent of the programs out there had established nutrition activities for parents and families of

school-age children; now we have 60 percent of our programs that have those sort of activities. This report that we'll be providing the Congress is just full of—

Senator DOMENICI. When will that be ready?

Mr. HARTZ. Senator, that was the report that was requested prior to the reauthorization so we have that at the printers right now. So it'll be forthcoming.

Senator DOMENICI. One of my questions was going to be, could you give us such a report?

Mr. HARTZ. Yes.

Senator DOMENICI. You had previously said you would but we didn't see it. So it'd be important that we look at it because diabetes is costing a lot of money and we understand dialysis requirements in Indian country are just skyrocketing and that's not very cheap in terms of the program but you've got to do them.

Dr. GRIM. Besides those programmatic sorts of indicators that we'll be able to show you, Senator, we'll also have clinical indicators, like Hemoglobin A1c that are markers, and we can show where we're seeing a strong downward trend in that, better control in our diabetics and I think you'll be very, very pleased to see how the money has been put to use and the type of impact it's had on the health of our Indian people.

Senator DOMENICI. Well, I want to say, the chairman of the full committee truly helped us with that. The chairman of the subcommittee worked—and that actually happened sort of as a fluke when we did the balanced budget. Newt Gingrich and I right at the end said oh, we've done everything and we've got \$60 million sitting here. Nobody understands how we could have it but we did. We decided to spend it since he was worried about diabetes and I had you all, I said well, why don't we split it? And he said between whom? I said Indians get half and diabetics get half; now we've gone on keeping that ratio.

Dr. GRIM. We certainly appreciate it. And I think you will see in this report that it's been money well spent.

Senator DOMENICI. Okay. I want to switch for a minute. It's my understanding that the BIA's considering moving or establishing a children's hospital near Gallup, New Mexico. Would you please comment on the progress of that project.

Dr. GRIM. I'm not aware of that, Senator. We'll have to submit that for the record for you.

Senator DOMENICI. Will you please?

Dr. GRIM. Yes sir.

[The information follows:]

The IHS is not aware of nor have we been involved in this project with the BIA.

GALLUP INDIAN MEDICAL CENTER

Senator DOMENICI. Now we also understand that the regional hospital in Gallup, New Mexico, which I assume you've seen.

Dr. GRIM. Yes sir.

Senator DOMENICI. Is very, very old and I understand that it is in need of replacement. What's happening on that front?

Dr. GRIM. In the 2000 Appropriations Committee report, the Indian Health Service was asked to take a look at all the facilities needs across Indian country. We're in the process right now of

going through tribal consultation; we've had a committee that's put together recommendations; we've asked all of our regions to begin doing a health services master planning effort, and we'll be going out some time this summer with requests for consultation across the country on a new priority methodology to look at health care needs. We're hoping that will be a much broader and much more comprehensive look at the facilities health care needs than in our current system because over time Congress has given us some additional avenues other than our normal facilities appropriations like joint ventures and small ambulatory programs. Right now we still have four hospitals that are on our current priority list and five out-patient health facilities. Once those are completed that new list, the one that we're looking at now will be going into effect. Gallup's currently not on it but what Gallup has been doing with a lot of the monies that they raise through third party revenues and also with the maintenance and improvement funds that come through the Indian Health Service is to maintain and upgrade the facility as needed until we're going to be able to replace it.

Senator DOMENICI. Well, I just want to say, anybody that would go there, especially since it's regional and right in the middle of the main effort with reference to diabetes, anybody that would look at that would, in my opinion, have to conclude that we can't continue to use it very much longer. It is truly a decrepit hospital compared to what we have in this country. And I'm not trying to usurp any committee or commission but I think we can't go so slow, we've got to get on with it. So I urge that that occur.

Dr. GRIM. Actually sir, they are in the process, I was just told, of completing a program justification document which is a necessity prior to getting on the list and we're in the process right now of a \$10 to 12 million maintenance and improvement project with them to upgrade the facility until such time as it can be replaced.

Senator DOMENICI. To upgrade the——

Dr. GRIM. Existing facility, yes.

Senator DOMENICI. Yes. So what would I be able to tell these people that keep asking me? Can you put that in the human language instead of technical language? What about the hospital, Doctor? I'm telling the people in Gallup, so could you answer that?

Mr. HARTZ. Yes sir. I was out there within the last year or thereabouts and there's actually construction going on to the back of the hospital, between the hospital and the quarters to the south so that we can, as Dr. Grim was pointing out, address some of those facility needs because of the tremendous workload that comes into GIMC. And that's that \$10 to \$12 million that actually is underway.

Senator DOMENICI. All right. Senator, I have some questions to submit. I'll just submit them, and I thank you very much, Mr. Chairman. They have to do with sanitation facilities, a terribly difficult problem; I'd like your views and in particular would like to know how we might put more emphasis on it.

Dr. GRIM. Yes sir.

Senator DOMENICI. And professional staff shortages, I had some questions about it but if you've been asked, fine. I'm going to submit mine in the event there are not overlaps and ask you to answer.

Dr. GRIM. Be glad to respond to those, Senator.
 Senator DOMENICI. Thank you.
 Senator BURNS. Thank you, Senator. Senator Stevens.

STATEMENT OF SENATOR TED STEVENS

Senator STEVENS. Well, thank you very much Mr. Chairman. I've just come by really to say hello to Dr. Grim and his colleagues and to thank Dr. Grim for coming to Alaska. Some of you may not know that Dr. Grim was sworn in in Anchorage, the first of the Indian Health Service directors that has been sworn in in Alaska; we consider that a great honor. And it's important to us because I think we have the highest percentage of Native people of any State in the union. It's approaching one-fifth of our population now, double the percentage of any other State. Of course, we have a small population base so that makes them even more important. I think that it's the only place where the Indian Health Service, working with the Native people, allows them the greatest role in management, which has led to our people having even higher regard for the system because they're directly involved in it.

I think that when you look at it we've got to work to improve the situation with regard to funding. I agree with that. The budget caps are very tight right now but we believe we get more for the dollar up there because of our telehealth program that you have helped pioneer and people from all over are now coming to study it, I understand. So I hope we can work together with the chairman and this subcommittee to make sure we get the resources for a lasting Community Health Aide Program.

I was visited, Doctor, by the American Dental Association; they're seeking to partner with you and our regional corporations through their non-profit subsidiaries that deal with health problems to see if we can't use the facilities of the Community Health Aides for dental services which they will see if they can't actually raise the money to pay for traveling dental assistants to come right to the villages and we may have to put some facilities in those community health—well, there are community health facilities there but we have to put dental facilities in them if we're going to work with the dental people. So I would encourage you to do that.

We have inadequate Native hospitals in Nome and Barrow that we're going to have to replace; I don't know where they are on the list yet but—

Dr. GRIM. They're close.

Senator STEVENS. They're close? I understand that we've waited our turn before. But clearly the one concept we don't have adequate control over is substance abuse, particularly among the village children. So, Mr. Chairman, we have lots to do. Maybe when you come up you might take a trip out to a few Native villages this year.

Senator BURNS. Yes. I tell you what I'd like to see up there because we're trying to design the same kind of telemedicine program on our reservations up in Montana. In fact, we've made great strides in that respect as you have made up there. You know they say necessity is the mother of invention and imagination is necessary when you've got distances to cover like both of our States. Ours is not the magnitude of yours but nonetheless we still have

a tremendous distance to cover whenever we start providing health care services.

We looked, in the State of Montana, when you get in the rural areas where you have an aging population. I mean, we're going to have to deliver health care services in a different way. And of course, I don't think there's been anybody that's been as much on the cutting edge as Senator Stevens has and both of us have worked on wireless technologies in rural areas, where we can use that tremendous technology and do broadband and move lots of information and take care of lots of things. And I appreciate your interest in that because it's been an interest of mine ever since we started talking about telecommunications and revamping that whole area over the last 10 to 12 years now, and the 1996 Act.

I also have some more questions but—

Senator STEVENS. Senator, if I could point out to you, I've just come back from Iraq and Afghanistan. Those two nations would fit into my State and leave room for your State.

Senator BURNS. We might move it up there. We're getting a little—

Senator STEVENS. Well, we're spending a lot of money in those two nations and I'm not opposed to it but I do think when we get through this current phase of trying to help some people overseas that we ought to start bringing back some of that money and putting it to work in States like yours and mine.

Senator BURNS. Yes.

Senator STEVENS. But the distances in ours are just mind boggling when it comes to delivering health care and that's all there is to it. And I pointed that out to the dental people when they came in and I hope that they visit with you and you bring some reality to their minds about how to deliver dental care along with the health care that you have pioneered so much in our State.

Senator BURNS. We look forward to coming up.

Senator STEVENS. I think you should visit a couple villages.

Senator BURNS. Well, you know, I sent my number one agent up there and she spent 30 days with your health service.

Senator STEVENS. He's talking about his daughter.

Dr. GRIM. I was trying to recruit her this morning, too.

Senator BURNS. Oh, were you up there when she did that 30-days?

Dr. GRIM. I wasn't there.

Senator BURNS. Well she came back and she said if you think we've got problems in Montana, you want to come up here, Pop.

Senator STEVENS. I think she went to where there's more men available; women outnumber us in Alaska now, did you know that?

Senator BURNS. Women outnumber you guys?

Senator STEVENS. Yes.

Senator BURNS. That's the way it was at the University of Missouri. When I was at school there we had Stevens and Christian Colleges; wasn't a bad place to go to school, you know.

Senator STEVENS. Thank you very much, Doctor.

Dr. GRIM. Thank you, thank you Senator Stevens.

Senator STEVENS. We're drifting aside here.

Senator BURNS. We've got some other things that we'll talk about in the weeks ahead and we really can't say yay or nay to anything

this morning, Dr. Grim, as you well know. The budget resolution, we hope, gets done this week, and our allocations come out. And then we'll start the real work of trying to cover those bases that we understand. But we've got mutual problems and I understand the problems you have and we all have in this area. But a lot of people don't realize that we also have other means of providing services to our reservations other than the Indian Health Service so when you look at that money when it comes in it's not as bad as it sounds but it could be better. And we're going to continue to try to increase those facilities and everything else in the way we deliver our services.

Thank you for your service, all three of you, and all the men and women of the Indian Health Service. We appreciate that and we see its evidence every day in my State of Montana.

ADDITIONAL COMMITTEE QUESTIONS

We're going to hold the record open for a couple of weeks. If there are any questions coming from other subcommittee or full committee members we ask that you respond to them and to this committee and thank you for your appearance this morning.

Dr. GRIM. Thank you, Mr. Chairman.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR CONRAD BURNS

ASSESSMENTS/REIMBURSEMENTS

Question. It is estimated that IHS will reimburse the Department of Health and Human Services for over \$40 million worth of services in fiscal year 2005. In addition, assessments to the IHS operating budget for participation in Department-wide initiatives and government-wide administrative functions is estimated to be another \$440,000.

What types of reimbursable services does the Department provide to IHS?

Answer. The Department provides the following types of services:

- Human Resource Services: automated personnel and payroll systems and payroll processing.
- Commissioned Personnel Services: active duty payroll, personnel management systems and support, and recruitment for active-duty Public Health Service Commissioned Officers.
- Financial Management Services: accounting systems and services; payment management systems; preparation of financial statements; and audit liaison services.
- Inclusion in new HHS-wide information systems: Unified Financial Management System; Enterprise Infrastructure (overall systems integration and security).
- Participation in safety, health and environmental management for the quality of worklife of the HHS employees.
- Participation in Government-wide activities: principally the Chief Financial Officers Council; Chief Information Officers Council; President's Council on Bioethics; and GSA First-Gov.

Question. What benefits does the IHS-tribal partnership derive from its participation in government-wide and department-wide initiatives? Please describe what sorts of initiatives IHS will be required to help fund.

Answer. The government-wide and department-wide initiatives provide greater access for the IHS-tribal partnership, i.e., personnel systems that support the 15,500 IHS personnel including approximately 2,000 Federal personnel working for Tribes (IPAs and MOAs), and payment management systems that make timely payments for Tribal contracts, grants, and funding agreements. The department-wide initiatives also provide for economies of scale and common administrative systems, thereby resulting in more resources available for mission services.

Initiatives to which IHS will contribute in fiscal year 2005 include:

- Human Resources Services
- EEO Complaints Processing
- Commissioned Personnel Services
- Financial Management Services
- Federal Occupational Health Services (Employee Assistance Programs)
- UFMS
- HHS Enterprise Infrastructure
- Employees Quality of Worklife
- IT Access for the Disabled
- Media Outreach
- National Rural Development Partnership
- Government-wide Councils (CFO, CIO, Bioethics)

EPIDEMIOLOGY CENTERS

Question. IHS is working with organizations such as tribal health boards to create regional Epi Centers. To date, 7 have been established. The budget includes an increase of \$2.5 million, part of which will be used to establish 3 or 4 more.

Billings is one of 5 IHS Areas that does not have an Epi Center. Has the tribal health board there expressed an interest in participating in this program? What criteria would an Area like Billings have to meet in order to be selected? Is this a competitive program?

Answer. The Montana/Wyoming Tribal Chairman's Health Board has expressed an interest in developing an epidemiology center. However, they did not submit an application in fiscal year 1996 and thus we have had no method of funding an Epi Center in the Billings Area. We are in the process of finalizing a Request For Proposals (RFP) at this time to allow not only the Billings Area tribes the opportunity to apply but also other American Indian Health Boards representing other IHS Areas that do not have Epi Centers.

We have cooperative agreements with the 7 currently funded tribal Epi Centers that had to meet the following criteria:

- Must represent or serve a population of at least 60,000 American Indians or Alaska Natives.
- Provide letters of support from all tribes in the catchment area.
- Provide tribal resolutions supportive of the Epi Center from the Indian tribe(s) served by the project.
- Must be a non-profit American Indian or Alaska Native organization.
- Submit an application in accordance with Office of Grants Management and Policy (OGMP) guidelines responding to the RFP that will be out by mid-summer for awards in September 2004.

It is a competitive program. The RFP will be for cooperative agreements with successful applicants.

Question. Please provide examples of the benefits that Epi Centers offer to their tribes. What are the annual operating costs of an Epi Center? To what extent are these funds used to leverage dollars from other sources?

Answer. Operating from within tribal organizations such as regional health boards, the Epi Centers are uniquely positioned to be effective in disease surveillance and control programs, and also in assessing the effectiveness of public health programs. In addition, they can fill gaps in data needed for the Government Performance and Results Act (GPRA) and Healthy People 2010. Some of the existing Epi Centers have already developed innovative strategies to monitor the health status of tribes, including development of tribal health registries, and use of sophisticated record linkage computer software to correct existing state data sets for racial misclassification. These data may then be collected by the National Coordinating Center at the IHS Epidemiology Program to provide a more accurate national picture of Indian health.

There are currently seven Epi centers funded at \$300,000 each. These funds are used to support basic operations; all of the centers write other grants and attract funds from a variety of sources to accomplish their mission. The Epi Centers utilize the award from IHS to attract funds from States, non-profit organizations, and other Federal funding sources. If the additional \$2.5 million requested in 2005 is provided, we plan to fund 4 additional centers at \$400,000 each, and increase the budget of each existing center by \$100,000. Remaining funds would be used by the National Epidemiology Program to hire project officers for the expanded program and to serve Areas that do not have a center.

TELEMEDICINE

Question. The IHS budget justification does not seem to focus on telemedicine as a means to deliver more and better health care to tribes, particularly those in remote areas. Wouldn't an investment in this technology offer significant benefits to tribes in large, land-based states like Montana.

Has IHS looked at ways to better integrate telemedicine into its services? How much of the IHS annual budget is dedicated to expanding or operating this kind of network? How much more would the agency have to invest to provide significantly greater access to this technology than currently exists? Have tribes expressed interest in developing this kind of infrastructure? Does the Service have a plan for developing a national network?

Answer. The IHS is now evaluating several areas for adoption of telemedicine including diabetic retinopathy screening, teleradiology, telepsychology, and telepediatric care (in child abuse cases). As studies confirm the improvement in clinical outcomes and cost effectiveness of these newer solutions to reaching rural tribes, replication of the successful programs is occurring. Currently, several projects have been initiated, particularly in the Southwest, and partnerships have been established, notably with the Arizona Telemedicine Program, to serve as a demonstration of this care modality.

The IHS spends \$500,000 to \$1,000,000 annually for telemedicine activities. We estimate that \$10 million annually would support entry-level telemedicine capability at all sites. Resources needed to provide an entry-level system include national coordination and clinical education, increased telecommunications infrastructure to handle the large volumes of files and live video feeds, resources for replacement of existing incompatible equipment to digitally based medical equipment, resources to incorporate the digital imagery into our electronic health record software, and resources to address long term archival storage on a regional basis.

Tribes are interested in developing this kind of infrastructure. Telemedicine is emerging as one of the central themes in the formulation of Area strategic plans. Tribes are seeing this as a way to provide high quality medical care close to home at a greatly reduced cost. We believe that this modality will also reduce stress on the patient's family, as many procedures and follow-ups may be done locally as opposed to traveling great distances.

Planning has begun on a regional basis, notably with the Southwest Telehealth Consortium, leveraging existing programs with private and university-based partners to produce a regional t-health program to have capacity to evolve as needed to serve larger agency needs. Additional opportunities are being explored with the VA and other federal health partners. Our desire is to expand this to a nationally coordinated effort and take advantage of economies of scale and best practices.

This Subcommittee also appropriated funds for a mobile women's health unit in fiscal year 2004 that will be dedicated later this year. We will be able to do "realtime" reads of digital mammography imagery and eliminate call backs of our patients, in addition to offering a full range of services in this women's health unit. Many Areas/tribes are interested in how successful this demonstration will be in the Aberdeen Area. Operational and staffing aspects of this demonstration are proving to be quite challenging.

CHANGE IN HEALTH PROBLEMS

Question. The budget justification points out that the kinds of diseases affecting Native Americans today are changing. Obesity, injuries from domestic violence, and alcohol and drug abuse, for example, are beginning to replace the acute illnesses IHS has traditionally treated. As a result, chronic illnesses like heart disease, diabetes, liver disease, cancer and injuries that require costly long term treatment are on the rise.

How is IHS changing its delivery of health care to meet these new challenges? What adjustments will be necessary to address this growing set of health problems? What programs will need to be expanded? What costs are we looking at down the road?

Answer. The IHS system has been a public health and prevention-oriented program since its inception. The major effort in these areas has been (and still must be maintained) in maternal and child health where a variety of public health and disease prevention efforts have had great impact. Expanded emphasis on prevention and public health primary care activities must be focused on children of school age, adolescents, and young adults to promote primary prevention of these chronic diseases. This will require expanded efforts at the community and ambulatory level. There is also a need for greater emphasis on clinical prevention such as better management of diabetes to prevent or delay the secondary effects of this (and other) dis-

ease. Because of enhanced clinic and community care programs, the number of patients hospitalized has declined significantly, allowing the agency to reduce its construction and use of hospital beds.

Tribal leadership in addressing these issues has been so very helpful. Greater tribal emphasis and control of community prevention programs is critical to changing the behavior and expectations of community members. In addition, tribal leaders can bring together all the non-health entities that can influence health outcomes in ways that are more effective than the federal government. This would include the justice, education, labor, and economic development entities that are needed to improve the quality of life in Indian communities. We can and must be active partners in supporting such community-wide efforts to expand opportunities at the Indian community level. Without this coherent approach, the many factors that influence health outcomes will not be changed.

Community-based and ambulatory programs will need expansion. The emerging successes of the diabetes programs in Indian country are showing the ways and means to achieve healthier communities. Utilizing the approaches now showing effect in diabetes to address cardio vascular disease, cancers and behavioral disorders is the roadmap for the future.

ALCOHOLISM

Question. The incidence of alcoholism is reported to be more than 600 percent greater among Indians than the general population. Drug and alcohol abuse accounts for 25 percent of deaths among Indian women. These are devastating statistics.

What will it take to turn these statistics around? What additional resources do tribes need to reduce these numbers? This disease takes a particular toll on families. Fetal alcohol syndrome, child neglect and domestic violence are just a few of the problems that can result. Are there treatment programs targeted at women and children that have demonstrated some effectiveness in reducing these problems?

Answer. Alcohol and substance abuse has and continues to be one among the most pervasive health and public health concerns in Indian Country. Their effects are widespread, pervasive, debilitating, and highly resistant to intervention. They are not only personal and public health issues, but social issues of far reaching effect. Every family is touched in one form or another by their widespread and devastating effects. Like problems discussed in other behavioral health areas, these problems are complex, highly resistant to change, and require coordinated efforts from family to federal leadership. They are also among the most intransigent and difficult to treat. Unlike many other diseases with direct and, by behavioral health standards, fairly uncomplicated causes and treatments, alcohol and substance abuse problems represent extraordinary arrays of interconnections between biology; psychology; history; the individual; families; communities; economics; politics; spirituality; and the interplay between hope and possibility versus hopelessness and commensurate helplessness. Simple and quick answers will not be found here. But answers are there and effective interventions from individual to community levels can be found. They are not necessarily simple, easy, nor quick, but they are there. The key, as usual, is having the appropriate approaches and resources to implement and sustain them.

A significant change in the past 10–15 years has been the increase in tribes taking over their own services and interventions for alcohol and substance abuse. Now, a full 97 percent of the alcohol and substance abuse budget goes directly to tribally operated programs. Tribes are now responsible for formulating and delivering their own services to their people. Subsequently, IHS is shifting its focus from direct service provision in alcohol and substance abuse, to one of supporting tribal programs in their service delivery.

There are many programs and service delivery models which represent tribal and urban approaches to alcohol and substance abuse. The more effective Native American programs have five major components that are in place to support not only a person's recovery process, but also the family's recovery as well.

a. Firm support for and use of Tribal Traditions in the healing process. It is not a separate process, but integral to the healing process.

b. Holistic approach to recovery including full array of behavioral health specialties and services; job/vocational support; education about and support for household financial planning and decision making; parenting skills training/support; educational evaluation and support for school-aged children.

c. Family involvement and, for mothers, care for dependent children, preferably on site.

d. Accredited programs utilizing defined outcomes measures and database programmatic decision-making in creating and managing treatment programs.

e. Continued support and treatment for recovery after residential treatment is completed because program completion is not the end of treatment, but rather the beginning of long-term recovery.

Representative programs with these components for mothers include Native American Rehabilitation Association of the Northwest, Inc., in Portland, OR; Friendship House of American Indians, in San Francisco, CA; Rainbow Center on the White Mountain Apache Reservation (known federally as the Fort Apache Indian Reservation) in Whiteriver, AZ; and Native American Connections, Inc., in Phoenix, AZ.

There are 11 Youth Regional Treatment Centers across the country that fully embrace these major components and continue to serve tribal youth with the most fully integrated treatment services in Indian Country.

DIABETES FUND

Question. The Balanced Budget Act of 1997 established the Special Diabetes Program for Indians initiative. Through this program, more than \$600 million has been funneled to the tribes for diabetes prevention and treatment work. These funds are in addition to the appropriated dollars provided by this Subcommittee for diabetes.

Please give examples of the kinds of work that is supported with this funding. Are there trends IHS can point to that offer some encouragement that this initiative is having a positive impact in Native American communities?

Answer. The SDPI grant programs are providing a variety of diabetes prevention and treatment services in their respective communities, based on local community needs and priorities. Listed below are some examples and outcomes on how the SDPI funds are being used in tribal communities.

- 86 percent of the programs reported that general screening for diabetes and pre-diabetes screening was available compared to 14 percent.
- 83 percent reported screening children and youth for obesity and overweight to provide an opportunity for early intervention and 60 percent reported the development of weight management programs for children and youth.
- 91 percent reported screening adults (ages 26–54) for overweight and obesity and 91 percent of the programs reported that they developed programs to promote healthy lifestyles.
- IHS has been able to demonstrate significant improvements in blood glucose control over time, greater than 1 percent point drop for each age group, as measured by A1c.
- As a result of the SDPI grant funds, programs have both enhanced existing diabetes activities and developed new activities. Specific program activities are proven to improve diabetes care outcomes. SDPI grant programs integrated these program activities into their programs as follows:
 - 83 percent of programs now track their diabetic patients through diabetes registries;
 - 81 percent have diabetes teams in place to provide better care;
 - 66 percent of programs report that basic diabetes care is now available for people with diabetes in their communities;
 - 87 percent of programs now have diabetes education services available;
 - 86 percent of the SDPI programs report that screening for pre-diabetes and diabetes is available; and
 - 73 percent of the programs conducted community needs assessments.

Question. Is IHS collaborating with other agencies through this program, and if so, please describe the types of activities that are being supported.

Answer. The IHS National Diabetes Program developed and built upon collaborations and partnerships with federal and private organizations as a result of the Special Diabetes Program for Indians. These include:

- Department of Health and Human Services Agencies (Centers for Medicare and Medicaid Services, National Institutes of Health, Centers for Disease Control and Prevention Division of Diabetes Translation, Head Start Bureau).
- AI/AN Organizations (American Indian Higher Education Consortium, National Indian Council on Aging, Association of American Indian Physicians, National Indian Health Board, American Indian Epidemiology Centers, Urban Indian Nurses Association).
- Diabetes Expert Organizations (American Diabetes Association, Joslin Diabetes Center, American Association of Diabetes Educators, National Diabetes Education Program, American Academy of Pediatrics, Juvenile Diabetes Research Foundation, Diabetes Research and Training Centers, International Diabetes Center, MacColl Institute of Group Health Cooperative of Puget Sound).

- Academic Institutions (University of New Mexico, University of Arizona, University of Southern California, University of Colorado, University of Montana).
- Other Organizations and Agencies (U.S. Department of Agriculture, Boys and Girls Clubs of America).
- Six pilot Boys and Girls Clubs of America have implemented a diabetes prevention initiative for 9–12 year olds. The initiative is in partnership with the National Congress of American Indians and Nike Corporation.

CONTRACT HEALTH SERVICES (CHS)

Question. Contract Health Service dollars are a critical component of the IHS program. It is key for some of the tribes in my state of Montana, who depend on these funds to purchase health care from the private sector. The IHS budget proposes to increase this program by \$18 million in fiscal year 2005.

How much of a shortfall currently exists in contract health care funding overall? How many of the highest priority medical cases must be rejected annually because tribes run out of money? What impact would the proposed increase for fiscal year 2005 have in alleviating this problem?

Answer. The Indian Health Service (IHS) Contract Health Services (CHS) programs operate within budget and must not obligate the Agency beyond their appropriations and cannot operate programs at deficits. The IHS medical priority system was established to ensure that the most needed medical services are provided within available funding levels.

The fiscal year 2005 President's Budget includes an increase of \$18 million for Contract Health Services, (+4 percent) over the fiscal year 2004 enacted level. This funding increase, combined with the additional purchasing power provided by the recently enacted Medicare Modernization Act, will allow IHS to purchase an estimated +35,000 additional outpatient visits or +3,000 additional days of inpatient care. Section 506 of the Act will increase IHS' buying power by allowing IHS to purchase inpatient care at rates determined by the Secretary. The IHS CHS program does not track payment or denials by priority levels.

Question. The Subcommittee has heard complaints from tribes that the CHEF set-aside, which is meant to cover the medical costs of catastrophic illness, does not meet the full need in Indian country. Tribes are forced to use their CHS dollars for these most expensive cases, eroding the amounts that are available for more routine care and illness. How much would be required to shore up the CHEF fund? About how many cases are eligible annually for CHEF payments but aren't being taken care of because the fund has run out of money?

Answer. Once the Catastrophic Health Emergency Fund (CHEF) fund is depleted by the 3rd quarter, Areas, Service Units, and Tribal programs cease reporting high cost cases that could be designated as CHEF cases. In the past year an additional 800 cases amounting to over \$12 million for a total of \$30 million would have been needed to fund all cases submitted or CHEF funding. It is possible that there is underreporting of some high cost cases.

INDIANS INTO PSYCHOLOGY PROGRAM—MONTANA

Question. I've been a longtime supporter of the Indians into Psychology program at the University of Montana. Has this program been successful in its goal of bringing greater numbers of Native Americans into mental health professions?

Answer. The Indians into Psychology program at the University of Montana was initially funded in fiscal year 1999. According to the American Psychological Association, statistics indicate students take an average of 7½ years to complete a doctoral program. The students at the University of Montana will be completing their studies in 6½ years which speaks highly of the quality of the program as well as the quality of the students.

Currently, there are 8 American Indian students in the clinical psychology program and 2 will graduate in fiscal year 2006 which is well within the time frame for their program.

All students are given the opportunity to work within their practicums at locations that serve American Indians.

Question. Are there other programs—my colleague's support for the nursing recruitment program at the University of North Dakota comes to mind—where relatively small amounts of money are having a significant impact in training young Native Americans for careers in the health care profession?

Answer. Yes, the following are examples of these types of programs:

- Indians into Psychology program at the University of North Dakota;
- Indians into Psychology program at Oklahoma State University;

- RAIN (Recruitment of American Indians into Nursing) program at the University of North Dakota;
 - Indians into Medicine (INMED) programs at the universities of North Dakota and Arizona;
 - Nursing Residency Program—IHS employees who are LPN's, LVN's, Associate Degree Nurses, or Diploma Graduate Nurses, can return to school on a work-study program to obtain their RN degrees, either Associate or Bachelor's;
 - Indian Health Service Scholarship Program—supports Native American students in their efforts to become health professionals.
 - Preparatory scholarships assist students in studies such as prenursing, prephysical therapy, and prepsychology for up to 2 years.
 - Pre-professional scholarships assist students in premedical and predental studies for up to 4 years.
 - No service obligation is associated with either of these scholarships.
 - Professional scholarships assist students in professional schools, such as medical school, nursing school, pharmacy school, etc., for up to 4 years in return for their agreement to serve at an Indian health facility for from 2 to 4 years, depending on the length of their support.
 - Indian Health Service Extern Program: Supports IHS professional scholarship recipients to gain experience in their field of study during non-academic periods.
- Question.* Does IHS collaborate with tribal colleges to provide additional opportunities in health care education for Indian students?
- Answer.* Many IHS scholarship recipients attend tribal colleges for their preparatory classes. Many also attend the Salish-Kootenai College in Montana and the Oglala Lakota College in South Dakota for their nursing training. We worked closely with the United Tribes Technical College as they developed their Associate Degree in Injury Prevention Program. They are now seeking to expand it to a four-year program. They also have the program on an Internet-based curriculum.

INJURY PREVENTION PROGRAM

Question. The injury prevention program is one of the best examples of IHS and tribes working to make a real difference in Indian communities. Within a relatively small annual operating budget, it has achieved a 53 percent reduction in injury-related deaths between 1972 and 1996.

Is there data to indicate that this downward trend is continuing? What activities funded through this program have proven most effective in preventing deaths and eliminating injuries?

Answer. The IHS injury trends indicate the downward trend is continuing. The most recent data shows between 1996 and 2001 there was a 4.2 percent decrease in unintentional injuries. The IHS Injury Prevention Program advocates the development of a public health oriented, community based strategy that relies on determining the trends and patterns of injury in specific Indian communities; forming community coalitions to address local injury problems; providing injury prevention training to community-based practitioners; and developing community-based strategies to identify and implement best practices to address local problems. This is a summary of some of the categories of successful initiatives and projects.

Road hazard identification and reduction.—Numerous epidemiologic studies of motor vehicle crashes and pedestrian fatalities in Indian communities have resulted in roadway improvement projects that have provided roadway lighting, pedestrian walkways, traffic channeling through communities; speed zone and signage; and guard rails and barriers along roadways.

Occupant Protection.—Multiple efforts have taken place to increase seat belt usage through the passage and enforcement of seat belt codes across reservations. A variety of child passenger protection initiatives are underway, including child passenger safety training and certification, seat distribution, development of the (Safe Native American Passengers (SNAP) training program; RideSafe, a Head Start Center based occupant protection program.

Fire/Burn.—Through a partnership with the U.S. Fire Administration, IHS has developed SleepSafe: a competitively awarded, Head Start Center based program to increase the utilization of smoke alarms in Indian homes. Community-based smoke alarm distribution programs are also in place in many Indian communities.

Drowning.—Drowning is a large public health problem facing Alaska Natives where the rivers are the roadways. Alaska Area has made significant commitment and impact on the drowning problem through the implementation of community-based float coat sales programs and "Kids-Don't Float" programs. Float coats are winter jackets with Coast Guard approved liner material that is a flotation device. "Kids-Don't Float" is a PFD loaner box located at marinas and boat launches. Fami-

lies that don't have PFD's can borrow one for their kids for their boat trip and return it when they return. These programs are widely available and supported by rural Alaska communities.

Fire Arm Safes.—A promising new strategy piloted in Alaska, the provision of gun safes in homes in rural Alaska villages. Eighty-six percent of households that were provided a safe had their firearms properly locked in the safe a year after distribution. Rural Alaska experiences suicide rates up to 13 times the national rate. Firearm related suicides in homes are a leading method of suicide. Firearm safes are a strategy to address this problem; community members are demonstrating their acceptance of this strategy for injury intervention.

Question. What is the current funding level for this program? Are there preventive measures that IHS is unable to implement within current funding levels? What would be the optimal annual budget for this program?

Answer. IHS currently has \$1.779 million dedicated to Injury Prevention. These funds support the HQE administered Tribal Injury Prevention Cooperative Agreement Program and national program initiatives. The Cooperative Agreement program provides approximately \$1.5 million annually to competitively award tribal injury prevention infrastructure development projects and direct intervention projects. Additional IHS funds support 25 full and part-time Injury Prevention Specialists throughout the 12 IHS Area's; and an Injury Prevention Practitioners and Fellowship training program.

IHS is able to provide a basic level of support to injury prevention initiatives with the funding available. Additional funds are received from 5 Federal agency partners to support specific injury prevention initiatives; the agency partners are National Highway and Traffic Administration, U.S. Fire Administration, Consumer Product Safety Commission, Centers for Disease Control and Prevention, and Health Resource Services Administration.

FACILITIES CONSTRUCTION PRIORITY LIST

Question. The Subcommittee understands that IHS is in the process of developing a new priority list for the construction of replacement hospitals and clinics.

When does IHS expect the new list to be in place? What input has the agency received from the tribes regarding possible improvements to the current system?

Answer. Congress directed the IHS to review and revise the facilities priority system in fiscal year 2000 conference report language. A Tribal workgroup developed recommendations for a process to identify need and suggested revisions to the existing priority system. This revised system and an implementation strategy will be presented to all Tribes for consultation before finalization. The revised system is expected to be in place no later than the fiscal year 2008 budget cycle.

Question. The budget indicates that the Department of Health and Human Services has instituted a Capital Investment Review Board to review all IHS health care facilities construction projects. Can you give us additional information on this Board, why it was created and how it will function?

Answer. The Board was instituted to help ensure that a coordinated and consistent approach to facilities construction exists within the Department. The Board consists of the Assistant Secretaries for Administration and Management; Budget, Technology, and Finance; and other members including land-holding Operating Divisions. The purpose is to implement a non-IT capital facilities investment review process, with projects that cost more than \$10 million reviewed and approved by this Board.

Question. Given that tribes are already frustrated by the lengthy process of project approval, why won't they see this Board as an additional bureaucratic hurdle?

Answer. The IHS is working closely with the Department to minimize the time that may be involved under the Board's review and approval process.

JOINT VENTURE CONSTRUCTION PROGRAM

Question. Dr. Grim, a few years ago this Subcommittee provided the first funding for a new program called Joint Venture. Under this competitive program, the costs of facilities construction are met by the tribes and IHS provides the funds to equip, supply, operate and maintain the health centers.

No funds are requested to continue the program this year. Why doesn't there seem to be support here? Doesn't this program help the tribes and IHS get quality care out to Indians at a fast pace than would be possible through the traditional construction program alone? Are tribes not interested in participating in the program?

Answer. Funding for the Joint Venture Program was provided to initiate four projects in fiscal year 2001 and fiscal year 2002. The fiscal year 2001 funding was utilized to enter into two Joint Venture agreements from proposed projects on the IHS Health Care Facilities Outpatient Priority List. These agreements were with the Tohono O'odam Nation and the Jicarilla Apache Nation. The fiscal year 2002 funding was utilized to fund two Joint Venture Agreements that were not from priority lists but were competitively awarded from 15 applications submitted for this program; they were with the Choctaw Nation, and the Muscogee Creek Nation. In fiscal year 2003 and fiscal year 2004 funds to support additional Joint Ventures were neither requested by the Administration nor provided by Congress. The fiscal year 2005 budget request completes the four highest priority projects on the construction priority lists but does not initiate any new projects. The fiscal year 2005 budget request does support the Joint Venture Program by requesting an increase of \$17 million for the staffing and operational costs for 3 of the 4 projects which are anticipated to be open in fiscal year 2005.

HOMELAND SECURITY/BIOTERRORISM

Question. The budget request briefly mentions a Department of Health and Human Services initiative related to homeland security, and more specifically, bioterrorism.

Please provide more about this initiative, its impact on IHS, the cost of implementation and how these costs will be met.

Answer. The funding available to the Department of Health and Human Services, approximately \$1.4 billion, is appropriated by Congress to be used by States, and a few large metropolitan areas, to improve State, Local and Hospital preparedness for bioterrorism and other public health emergencies. Tribal nations are not eligible as direct awardees, however HHS explicitly requires all jurisdictions to include Indian tribes in the development, implementation and evaluation of their bioterrorism work plans. Awardees are also asked to provide documentation of Indian tribal governments' participation in state and local emergency preparedness planning. The funds flow through the Health Resources and Services Administration and the Centers for Disease Control and Prevention as grants for hospital preparedness and public health infrastructure development (respectively). Our experience has been that some States have been very inclusive in providing Tribes the opportunity to participate in policy development, training, and funds distribution (Arizona, Alaska, Maine, New Mexico, to name a few).

The Indian Health Service participates in disaster planning and exercises as part of its ongoing medical emergency response and quality assurance programs with excellent support coming from some States. No additional resources have been devoted to this effort.

MEDICAL EQUIPMENT

Question. The budget for the purchase of medical equipment is currently funded at \$17 million. Increases over the past several years have been minimal and no increase is proposed in fiscal year 2005.

As more sophisticated and expensive technologies become available for the diagnosis and treatment of disease, how has the Service's purchasing power been reduced? What amount would be needed to provide more and better medical equipment to IHS and tribally operated facilities?

Answer. The average life expectancy for today's medical devices is approximately 6 years, depending on the intensity of use, maintenance, and technical advances. Given a medical equipment inventory of \$320 million, an annual replacement amount of \$53 million would allow replacement of one-sixth of the inventory each year. The current funding level for replacement medical equipment is \$11 million. The Medical Equipment request also includes \$5 million for equipment for newly constructed tribal facilities and \$1 million for equipment purchased through TRANSAM (DOD excess equipment) and ambulances.

HEALTH FACILITIES CONSTRUCTION DECREASE

Question. In fiscal year 2005, the budget request for construction of replacement health care facilities is \$42 million, a proposed reduction of more than \$50 million from the fiscal year 2004 funding level.

Given that the average age of IHS facilities is 32 years, and some as old as 100, what is the rationale for cutting this program in half?

Answer. The fiscal year 2005 request allows IHS to complete construction of the 4 highest ranked health facilities and staff quarters construction projects—Red

Mesa, AZ outpatient facility, Sisseton, SD facility, Zuni, NM staff quarters and Wagner, SD staff quarters. No new facility construction projects would be initiated.

Question. What amount do you estimate would be required annually in base funding to operate this program most effectively?

Answer. Funding for health facilities construction is determined on a project-by-project basis. In developing plans for new facilities construction, IHS must take into account not only construction costs but also the cost of operations for new and existing facilities. The fiscal year 2005 request allows IHS to focus on its priorities while taking both construction and operations costs into consideration.

QUESTIONS SUBMITTED BY SENATOR PETE V. DOMENICI

SANITATION FACILITIES CONSTRUCTION

Question. Sanitation construction and refurbishment is direly needed in many areas of Indian Country. Wastewater facility construction is among the most discussed issues by the tribes in New Mexico. A number of New Mexico tribes have systems over thirty years old. The IHS states its mission is to "raise the health status of the American Indian and Alaska Native people to the highest possible level by providing comprehensive health care and preventive health services." The foundation for any health system must certainly be partially based upon adequate sanitation facilities.

The modernization of these facilities is also of concern for a state in the midst of a devastating drought. Increasing the efficiency of wastewater facilities and improving the recoverability of wastewater is an essential step in addressing life in drought. This is especially true when competition for water is on the rise due to numerous factors including drought and protecting endangered species.

Question. Comment on the resources that IHS can bring to address this problem.

Answer. The current total need for waste water disposal facilities for American Indians and Alaska Natives (AI/AN) is \$508 million and of that total need, \$255 million is considered to be economically and technically feasible. Through the IHS regular funding for existing homes and Environmental Protection Agency (EPA) Clean Water Act Indian Set-Aside (CWAISA) funding plus other contributors funding, this feasible need has been reduced by \$21 million since 2002. The waste water disposal needs have been decreasing over the last several years, in part due to the recent increase in the EPA CWAISA. While we have made significant headway in addressing the waste water needs, the water supply requirements have been very slight and generally the trend in water supply deficiency have been increasing due to inflation, population growth and new environmental laws including changes to the Safe Drinking Water Act. In addition to the EPA funding, IHS continues to work with Tribes, other federal agencies, and States to find additional funding for sanitation facilities. In fiscal year 2003, the IHS received \$42 million in outside contributions through the IHS finance system.

Question. Would it make sense to placing areas suffering from drought on a higher priority for water and sewer assistance so as to get more and cleaner water to those with the most immediate need?

Answer. The Sanitation Deficiency system used by IHS to inventory the sanitation needs for AI/AN, is a priority system and not a waiting list and since this inventory is updated annually, emerging needs such as drought, can be addressed as they arise. Health impacts and tribal priorities can raise the score of a project and the funding priority.

DIABETES PROGRAM

Question. Almost 105,000 Native Americans and Alaska Natives, or 15.1 percent of the population, receiving care from Indian Health Services (IHS) have diabetes. As you know, the consequences of diabetes are debilitating, including heart disease and stroke, which strike people with diabetes more than twice as often as they do others. Other complications include blindness, kidney disease, and amputations.

Diabetes is the fifth-deadliest disease in the United States. According to the American Diabetes Association, the total annual economic cost of diabetes in 2002 was approximately \$132 billion, or 1 out of every 10 health care dollars spent in the United States.

Given that diabetes affects such a large percentage of Native Americans, I am deeply interested in IHS progress and programs.

New Mexico is home to a number of diabetes centers and programs. How many tribes in New Mexico and the Nation have programs working directly with them?

Answer. All 27 tribes in New Mexico have a Special Diabetes Program for Indians (SDPI) grant program. There are a total of 34 SDPI grant programs in New Mexico. The majority of the NM SDPI programs, 85–90 percent, provide primary prevention activities.

Nationally, the IHS awarded Special Diabetes Program for Indians grants to 318 programs under 286 administrative organizations within the 12 IHS Areas in 35 states. The SDPI grant programs work with their local service unit programs, Area Diabetes Programs, 19 Model Diabetes Programs and the National Diabetes Program. The NM SDPI grantee programs work directly with the Albuquerque Area Diabetes Program, their local service unit diabetes programs, and the two NM Model Diabetes Programs located at Zuni Pueblo and Albuquerque Service Unit.

Question. Diabetes programs now receive \$150 million annually as reflected in the President's fiscal year 2005 budget request. Could you please discuss how this money is being spent on diabetes prevention and treatment and help the committee understand any inroads into the diabetes epidemic this funding has made possible? Could you also comment on the Gallup Indian Medical Center and its contributions?

Answer. The SDPI grant programs have made tremendous inroads in addressing diabetes prevention and treatment. The IHS has shown through its public health evaluation activities that the SDPI programs have been very successful in improving diabetes care and outcomes, as well as the start of primary prevention efforts, on reservations and in urban clinics. The CDC's Framework for Public Health Evaluation, using a mixed methods approach (both qualitative and quantitative methods), has been implemented and an analysis completed. A number of positive short term and intermediate term outcomes have been identified. In addition, the IHS NDP has improved the accuracy of baseline long-term measures (prevalence and mortality) and established a Diabetes Data Warehouse and "Data Mart" using RPMS data to measure accurately the long-term complications of diabetes.

Prior to the SDPI, AI/AN communities had few resources to devote to primary prevention of diabetes. In 2002, an overwhelming number of diabetes grant programs (96 percent) reported that they now use funds to support diabetes primary prevention activities in their communities. The implementation of secondary prevention efforts—the prevention of complications such as kidney failure, amputations, heart disease and blindness—and tertiary prevention efforts to reduce morbidity and disability in those who already have complications from diabetes has also been a focus of SDPI activities. Improvement in the treatment for risk factors of cardiovascular disease, the prevention of and delay of progression of diabetic kidney disease, and the detection and treatment of diabetic eye disease have also been achieved since the implementation of SDPI.

The Gallup Indian Medical Center serves the Navajo Nation and focuses on providing lifestyle education for their patients. Accomplishments include providing a comprehensive school health program for youth, physical exercise programs, Standards of Care for Diabetes and clinical interventions.

Question. What is the typical program doing in the prevention and treatment areas and at what levels of funding?

Answer. The SDPI grant programs are providing a variety of diabetes prevention and treatment services in their respective communities, based on local community need. For example:

- 83 percent reported screening children and youth for obesity and overweight to provide an opportunity for early intervention and 60 percent reported the development of weight management programs for children and youth.
- 91 percent reported screening adults (ages 26–54) for overweight and obesity and 91 percent of the programs reported that they developed programs to promote healthy lifestyles.
- IHS has been able to demonstrate significant improvements in blood glucose control over time, greater than 1 percent point drop for each age group, as measured by A1c (a long term measure of glycemic control).

Question. Can we expect a report detailing the programs and their successes and needs?

Answer. Yes. Although Congress moved the actual due date for a final report on the SDPI to 2007, IHS is in the process of finalizing in fiscal year 2004 an interim progress report on the SDPI.

PROFESSIONAL STAFF SHORTAGES

Question. About 20 percent of the U.S. population resides in primary medical care Health Professional Shortage Areas as designated by Bureau of Health Professionals. This problem is magnified in Indian Country where health facilities are often few and far between. Staffing at many Indian health facilities are at critically

low levels—not only are facilities to attract and keep health care workers lacking in many New Mexico Indian health centers, I have heard of instances where salaries were delayed or nearly went unpaid.

Please describe what steps IHS is taking to address these staffing and facility shortfalls.

Answer. IHS efforts to address staffing shortfalls include, but are not limited to, the following:

- Establishing and maintaining a World Wide Web site that contains information regarding health professional needs at IHS, tribal, and urban Indian health facilities;
- Utilizing special pay and bonus authorities as much as possible;
- Visiting health profession training programs to discuss opportunities in Indian health;
- Attending national, state, and local health profession association meetings to inform attendees about opportunities in Indian health;
- Accepting health professions students and residents in training positions at IHS facilities;
- Establishing internship arrangements between IHS facilities and health profession training programs;
- Advertising in professional journals and in the Military Transition Times, a publication that is distributed to all United States and foreign military facilities bases and installations in an effort to attract health professionals who are leaving the military;
- Attending health fairs at colleges;
- Attending high school career days;
- Adding funds to the IHS Loan Repayment Program;
- Establishing special salary rates under the Title 38 authority;
- Sending direct mailings to practicing and student health professionals;
- Establishing 7 Dental Clinical and Support Centers, whose activities include addressing the issues of recruitment and retention;
- Establishing workgroups of professionals to address the issues of recruitment and retention;
- Surveying current employees to see what attracted them to Indian health and what has made them stay on or may incline them toward leaving;
- Working with the National Health Service Corps to make Indian health facilities eligible to employ NHSC scholarship recipients;
- Encouraging high school and college students to enter the health professions;
- IHS Scholarship Programs;
- Tribal Matching Grants;
- Health Professions Recruitment and Retention Grants;
- Nursing Scholarship Program;
- Nursing Residency Program;
- Advanced General Practice Residency Program for dentists;
- Extensive use of the Junior and Senior Commissioned Officer Student Training and Externship Program (COSTEP) of the U.S. Public Health Service commissioned corps to help develop health professionals who are interested in working in the IHS; and
- Use of the commissioned corps Commissioned Corps Readiness Force, Ready Reserve, and Inactive Reserve to help fill needs for health professionals on a temporary basis.

In addition to the above, the Division of Nursing has launched an on-line continuing education (CE) program available to all Indian Health Service, Tribal and Urban Nurses at no cost. The program offers over 126 continuing education units, including mandatory updates regarding Joint Commission on Accreditation of Healthcare Organizations requirements.

Facility shortfalls are being addressed as follows: The IHS fiscal year 2005 request includes funds for 244 staff at 5 newly completed health care facilities and construction funds to complete 2 additional outpatient facilities in Red Mesa, AZ and Wagner, SD and 2 staff quarters projects in Wagner, SD and Zuni, NM.

Question. What resources does IHS have at its disposal in this regard?

Answer. For addressing staffing shortfalls, IHS resources include:

- Specifically identified recruiters in several professions;
- Staff professionals who work in conjunction with the recruiters to speak at professional schools, colleges, high schools, and elementary schools to talk about opportunities in Indian health programs and the requirements to become a health professional;
- A scholarship program that helps to train Indian students in the health professions;

- Programs that help to identify students with the potential to become health professionals, assist them to obtain the academic prerequisites for entry into health professional training, and provide cultural and academic assistance during the training;
- A loan repayment program that helps professionals work in Indian health programs and pay off the loans they had to incur in order to attend health professional schools; and
- Staff members who are very concerned about both the quality and quantity of health services provided to Indian people and are willing to commit time and resources to address them.

Question. What tools would enhance the ability of IHS to better meet its obligations for adequate staffing?

Answer. The following tools would enhance IHS' ability to improve recruitment and retention:

- The Junior Commissioned Officer Student Training and Extern Program (JsCOSTEP) to allow summer experience at IHS and Tribal facilities for a minimum of 30 days and maximum of 120 days for students, who have not completed their degree program.
- The Senior Commissioned Officer Student Training and Extern Program (SrCOSTEP) to assist students financially during their final academic year in health profession programs in return for agreements to work for IHS after graduation for twice the time sponsored (i.e., 18-month employment commitment for 9 months of financial support).
- The utilization of medical students through the Uniformed Services University of the Health Sciences (USUHS) in return for a 10-year service obligation time upon graduation from USUHS and completion of their residency programs.
- Under Public Law 94-437, Indian Health Care Improvement Act, the IHS is authorized to maintain scholarship and loan repayment programs. The scholarship program is a valuable tool to prepare students and train students for critical health professions. This program also provides opportunities for students to gain practical clinical experience in their chosen health disciplines during non-academic timeframes prior to graduation. The loan repayment program provides the authority to repay loans in return for service in critical service locations. Both of these programs are very effective and the continued and expanded utilization will improve our recruitment and retention efforts.

QUESTIONS SUBMITTED BY SENATOR BYRON L. DORGAN

BASE FUNDING

Question. The fiscal year 2005 budget justification notes a decrease in services in several service areas, including dental health and mental health. How much additional funding beyond the budget request is needed in pay, increased population growth, and inflation to maintain a "current" level of services?

Answer. The budget addresses salary costs by including an increase of \$36.2 million for Federal and Tribal pay costs. Within this amount, IHS will also have to manage within grade increases for Federal employees. The budget request also includes an increase of nearly \$18 million for contract health care, which will offset inflation experienced in purchasing health care from the private sector. Using estimates of medical inflation costs of 3.3 percent (\$49 million) and population growth of 1.8 percent (\$39 million), the estimated cost of fully addressing these items is \$88 million.

CONTRACT HEALTH SERVICES

Question. If your need for service was the same in fiscal year 2005 as in fiscal year 2004 for contract health services, how much would you need to cover all current services, given inflation?

Answer. In order to provide services at the current level the Contract Health Services Program is requesting \$18 million to address issues of inequity and disparities of healthcare and off set medical inflation. This funding increase, combined with the additional purchasing power provided by the recently enacted Medicare Modernization Act, will allow IHS to purchase an estimated +35,000 additional outpatient visits or +3,000 additional days of inpatient care. Section 506 of the Act will increase IHS' buying power by allowing IHS to purchase inpatient care at rates determined by the Secretary.

Question. How much additional funding is needed to cover medical care beyond priority I? Please provide this information by priority level.

Answer. The IHS does not have a fixed CHS funding standard and is not able to determine the level of funding needed beyond priority I. In addition, the IHS CHS program does not have an accurate account of all CHS denials or deferred services and does not track and collect data by priority levels.

Question. Will the fiscal year 2005 budget request be sufficient to cover all priority I medical costs in each region?

Answer. The fiscal year 2005 President's Budget includes an increase of +\$18 million for Contract Health Services, (+4 percent) over the fiscal year 2004 enacted level. As mentioned above, this funding increase, combined with the additional purchasing power provided by the Medicare Modernization Act, will allow IHS to purchase an estimated +35,000 additional outpatient visits or +3,000 additional days of inpatient care. IHS does not track or collect data by priority level.

SUDDEN INFANT DEATH SYNDROME

Question. Please provide an update on IHS efforts to combat SIDS in Indian country. Specifically, what types of SIDS risk reduction training is provided to Indian Country through IHS?

Answer. Direct care programs provide standard of care per the American Academy of Pediatrics (AAP), American Academy of Family Practice (AAFP), American College of Obstetricians and Gynecologists (ACOG) guidelines—including messages on evidence-based practices of “Back to Sleep”; tobacco and alcohol perinatal exposure; early and timely prenatal care and follow-up; and well child visits. Other efforts to prevent SIDS include:

- Prenatal Home visits through Public Health Nurses (PHN) are a priority 1 task.
- Tobacco.*—Perinatal tobacco exposure and tobacco control measure in the form of abstinence and cessation include—patches, the American College of Obstetricians and Gynecologists 5 A's “Ask, Advise, Assess, Assist, Arrange—6th Assure,” provider survey to assess training needs is underway with National Partnership to Help Pregnant Smokers Quit, a Robert Wood Johnson (RWJ) funded program.
- Breastfeeding and lactation consultant promotion.
- Biennial Pediatric Conference and Update.
- Biennial OB-GYN Conference and Update.
- Maternal and Child Health (MCH) IHS National conference calls on emerging issues and SIDS update.
- Working with numerous foundations and HHS agencies:
 - CJ SIDS Foundation.*—SIDS Reduction Resource Kit Dissemination
 - American Academy of Pediatrics (AAP).*—Committee on Native American Child Health—advocacy, site visits, child health and newborn outcomes, teen health and teen pregnancy are addressed.
 - First Candle and SIDS Alliance.*—Child Care Provider Training.
 - SIDS Impact.*—Active list serve on leading edge forensic and case investigation, diagnostic shift since 1998, differential diagnosis and need for standardized training and investigation.
 - HRSA funded Healthy Start programs in the Aberdeen Area.
 - CDC.—Coroners and Death Scene Investigation.
 - National Partnership to Help Pregnant Smokers Quit.*—Poster and provider questionnaire on perinatal tobacco control, patient interaction.
 - Phoenix Area.*—National Diabetes Program reprint of “Easy Guide to Breastfeeding that includes section on back to sleep and safe sleep environment with CPSC endorsement.
 - Consumer Product Safety Commission—IAA.*—Back to sleep information and bedding information included in “Easy Guide to Breastfeeding” booklet to be reprinted 50,000 copies.
 - National Native American Emergency Medical Services.*—Dissemination of SIDS Resource Kit.
 - Child Fatality and Child Death Review.*—State and national leads. MCH coordinator to present at August 2004 National on IHS linkages to states.
 - CDC—Division of Reproductive Health.*—MCH Research Agenda setting Planning meeting May 10. Perinatal issues are preeminent.
 - NICHD.*—Serial meetings planned for teen parent focus group study to address media and health literacy needs for infant wellbeing and SIDS reduction in northern tier Tribes and Alaska.

Question. What is current IHS spending dedicated to SIDS risk reduction? What is needed?

Answer. Funds are appropriated in very broad line-item accounts and provided from other sources within the Department and private foundations. Our cost ac-

counting system is not currently set up to accumulate this level of specificity. Most care in this area would be covered in the following line item budgets—all of which provide direct services to the prenatal and early infancy population:

1. Hospital and Clinics.—Direct Health Care Provision
2. Public Health Nursing
3. Community Health Representative
4. Health Education/Health Promotion and Disease Prevention

Question. Are you partnering with any organizations on the SIDS issue?

Answer. The Indian Health Service, Tribal, and Urban programs partner with the following organizations:

- CJ SIDS Foundation.*—SIDS Reduction Resource Kit Dissemination
- American Academy of Pediatrics (AAP).*—Committee on Native American Child Health—advocacy, site visits, child health and newborn outcomes, teen health and teen pregnancy are addressed.
- First Candle and SIDS Alliance.*—Child Care Provider Training
- SIDS Impact.*—Active list serve on leading edge forensic and case investigation, diagnostic shift since 1998, differential diagnosis and need for standardized training and investigation.
- HRSA funded Healthy Start programs in the Aberdeen Area
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- CDC—Division of Reproductive Health—MCH Research Agenda setting Planning meeting May 10.* Perinatal issues are preeminent.
- NICHD.*—Serial meetings planned for teen parent focus group study to address media and health literacy needs for infant wellbeing and SIDS reduction in northern tier Tribes and Alaska.

INDIAN HEALTH CARE IMPROVEMENT FUND (IHCIF)

Question. Did tribes recommend funding for the IHCIF during your consultation process on the fiscal year 2005 budget? If so, how much?

Answer. The Tribes recommended a minimum increase of \$24.3 million for the Indian Health Care Improvement fund in fiscal year 2005.

CONCLUSION OF HEARINGS

Senator BURNS. Thank you all very much. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon at 10:30 a.m., Thursday, April 1, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]