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INDIAN HEALTH

FIELD HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

AUGUST 15, 2007

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INDIAN HEALTH

WEDNESDAY, AUGUST 15, 2007

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Crow Agency, MT

Pursuant to notice, the Senate Committee on Indian Affairs Field Hearing was held on August 15, 2007, at the Crow Tribal Multi-Purpose Building, 4 Cap Hill Road, Crow Agency, Montana.

[Opening prayer offered by Mr. Earl Old Person.]

[Crow Tribe Color Guard and Drum Presentation.]

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

Senator DORGAN. Ladies and gentlemen, we will call to order this U.S. Senate Committee Hearing. It's the Committee on Indian Affairs in the U.S. Senate.

I'm Senator Byron Dorgan, the Chairman of the Committee. I am joined by Senator Jon Tester, a member of our Committee from the State of Montana.

We are joined by Sara Garland, who is the Chief of Staff on the majority side of the Committee, and David Mullon, who is the Chief of Staff on the minority side of the Indian Affairs Committee.

I want to thank, first of all, all of you for being in attendance. I know from just having visited with a number of you, we have Indian leaders and members of tribal governments and folks from all around this region, and I very much appreciate your taking the time to be with us today.

I want to especially say to Chairman Venne, with whom I've had a chance to have a lengthy conversation today about these issues, thanks to your leadership, thank you for hosting us. I'm deeply honored to be here with the Crow Nation.

To Earl Old Person, thank you very much for the blessing today. Earl and I were able to ride on a subway car underneath the United States Capitol about three, 4 weeks ago, and I asked him how long he has been in tribal leadership, and I think Earl told me that he's been the Tribal Chair since 1964. And if you want a definition of commitment and leadership, look at a commitment from 1964 to today. God bless you.

Thank you very much for being here, Earl.

I want to especially say, because I am in the State of Montana, how appreciative I am of being able to serve with Senator Max Baucus, with whom I've served for some long while. Max does a great job for Montana and for our country, and pays a lot of attention to and works hard on Indian issues.

I want to also say that we have been joined in the U.S. Senate by someone new, someone who I think brings a real breath of fresh air to the U.S. Senate and to the Senate Indian Affairs Committee, and that is Senator Jon Tester.

We are, as you know, pushing very, very hard to get the Indian Health Care Improvement Act done and to the President for signature. No one has been more important to that push and to our success in getting it out of the Indian Affairs Committee, our success in getting a commitment—Senator Baucus is going to mark it up on September 12th in the Finance Committee—our success in getting the majority leader, Senator Harry Reid, to say that he will give us opportunities on the floor of the Senate to get this passed.

No one has been more instrumental in that than Senator Jon Tester. He is a tireless worker on behalf of American Indians; a tireless worker in search of good, thoughtful, sensible policies that address health care, housing, education and all the things that we know need addressing on Indian reservations in this country.

So, I can't thank you enough for sending a real partner to Washington, D.C. to work on these issues.

Now, I'm here because I was invited. I've taken over the reins of the chairmanship of the Committee of the Senate, the Committee on Indian Affairs. I've held some listening sessions around the country. We've held some hearings.

I've decided this; I'm just a little tired of waiting for good things to happen. We have to make good things happen. We shouldn't have patience. When we have people dying because we don't have adequate health care on the reservations of the first Americans, the people who were here first, we ought not have patience to let that happen.

When we have people living in inadequate housing, I'm out of patience. We shouldn't say that's okay. When we have children going to school through classroom doors that we know are not real class settings, we shouldn't accept that. And so, I'm just out of patience. I'm a little out of sorts.

I believe that we ought to impose on everyone in the decision-making capacity in our government to say, keep your promise. You made the promises, you've broken too many. It's time that you ought to keep them. And that deals with health care, education, housing and more. And this Committee is going to work to see that happen.

I was given the honor of an Indian name in a ceremony with the Standing Rock Sioux Tribe some long while ago, and the Indian name given me was Cante un Wiyukcan, which they said means "thinks with his heart."

Well, my heart tells me that we don't have a lot of time. My heart tells me that there are people living among us who need us, and need answers. They need good schools; they need better health care, and they need decent shelter. And that's the mission of this Committee.

So, I want to thank Senator Tester for inviting me here to Montana.

Let me just say one additional point. I wish very much I could stay for about three or 4 days. Chairman Venne gave us a little ride around the area where there's a lot of camping going on, a lot

of preparation for a very big event in the Crow Nation. I've not been to this event at the Crow Nation, but I've heard a lot about it.

I sat next to a person on the airplane coming into Billings today, who was coming here from Iowa. He said well, I come to this celebration every year on the Crow Nation.

So I've heard about it and I wish I could stay, but I can't. But I know that you all are going to have a great, great few days ahead of you.

So, Senator Tester, we will hear testimony from a wide-range of witnesses today, but before we do, again, I want to thank you, thank you for your leadership, thank you for focusing a laser on these issues.

You and I and other members of the panel of the Indian Affairs Committee are going to get things done, and we're going to push until that happens.

So, Senator Tester, let me call on you for some comments, and again, thank you, very much.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman, for taking the time out of your busy schedule to come to Montana and visit with us. To the people of the State of Montana here in Indian Country, it's critically important. It's no small measure, I know how busy you are, and I appreciate you making the time to be here.

I also want to welcome all my friends that are here that have come to listen and testify.

You know, I think Montanans really appreciate, Mr. Chairman, you holding this hearing in Montana to address what we all know is a very critical issue.

Health care in Montana's Indian Country is in serious trouble. American Indian citizens are suffering, and we really need to address the problem now.

I am truly outraged by the statements, and I heard it again today by Chairman Venne, and that is you don't get sick in June, after June in Indian Country. That is absolutely unacceptable, and I'm sorry you have to wait until your illness gets to a point where you may lose a limb or your life.

Those are examples of health care in Third World countries. We don't live in a Third World country. American Indians are Americans, American citizens who are entitled to deserve respect in this country. Our Federal Government signed binding legal treaties many years ago and those treaties are still in effect today. Those treaties promised that in exchange for millions of acres of land and vast amounts of natural resources, our government would use some of those dollars that emerged from those lands to provide American Indians with adequate health care, education and housing, economic development to distinct quality of lives.

Everybody in this room knows over the past several hundred years the government has failed to tell the truth to the American Indian, cheated the Indians, and failed to fulfill promises made many, many years ago.

The government got what it wanted out of the deal, but so far, Mr. Chairman, the government has failed to hold up its end of the deal. The result is that several generations later, our government still has legal obligations to live up to its end of the bargain.

Since then, the price of health care has literally gone through the roof and will continue to go up. We need to address the situation now. We need to fund the system. This cannot wait to be funded any longer. We need to change the national priorities and introduce legislation to fix this broken system.

All of us in the room know that merely to explain about the problem is not enough, we need to act and we need to act now.

For my part, I'm seeking for some of the following actions; cosponsoring the Indian Health Care Improvement Act that Senator Dorgan talked about, that hopefully will be out of Finance by September 12. The last time it was passed was 1999. That's totally, totally ridiculous, and unacceptable.

Also, I have introduced THE PATH Act that is a result of some hearings that I had in Browning 3 months ago. This important legislation will award grants and draft cooperative agreements with the Department of Health and Human Services and the tribal colleges and universities, to help Indian Country meet their staffing needs in health care.

It will establish a coordinating officer to assure seamless transition and administration; establish community-based health and wellness affairs, and begin to address illness and injury before it gets to a life or limb situation.

It will develop and expand public health professional educational opportunities, establish an endowment for rural tribal colleges to expand health education, and create health prevention and disease prevention research, particularly in the areas of diabetes.

Tribal colleges and universities Faculty Loan Forgiveness Act, it does what it says, it will help forgive loans to individuals that want to teach in tribal colleges, to recruit and train more qualified professors at those tribal colleges or universities, particularly in the field of nursing or health-related fields.

Our goal, Mr. Chairman, should be to give equal access to health care for all Montanans. Make no mistake, Mr. Chairman, I'm not here today working to provide Indians with superior quality health and quality of life, I'm simply working to fulfill the promises our grandfathers made over a hundred years ago.

Today, we focus on three vital issues in American Indian health care, immediate health care needs, recruiting and retaining of health care professionals, and improving the reimbursement process.

In the end, Mr. Chairman, it is truly my goal on this committee, to re-prioritize issues affecting Indian Country. If the President can justify spending $3 billion a week to first destroy and then rebuild Iraq, the government certainly has the money to fund an Indian health care system.

This issue is not about money, Mr. Chairman, it is about priorities, and American Indians deserve to be a higher priority in this country. For that reason, I want to thank you very, very much for coming to Montana and making Indian health care a national priority.

I look forward to working with you, Mr. Chairman, in this session of Congress, to continue to shift our priorities to improving Indian health care.

With that, I just want to thank you very, very much for the opportunity that you've given all the good people here to talk about an issue that's so critically important.

Mr. Chairman.

Senator DORGAN. Senator Tester, thank you very much.

This is a formal hearing of the U.S. Senate, but I want to do something just a little bit unusual. As I saw the flags brought in, I saw some very beautiful people behind the flag-bearers and one of them caught my eye. And if I could ask to have that young lady brought forward, I want to tell you something.

[Kailyn Old Crow brought forward.]

What I wanted to tell you is as I watched her come in following the flags, it occurred to me that we're talking about all these issues today, but what we're talking about is not about us, it's not about me, it's not about you, it's about Kailyn. That's what this is about. It's about our children. It's about our future, and I can't think of a more beautiful symbol of our future than this young lady. God bless you.

Thank you very much.

Dr. Charles North is the Acting Chief Medical Officer of the Indian Health Service, and Dr. Westley Clark, the Director of the Center for Substance Abuse Treatment. I'd like both of them to come forward and take their chairs at the witness table, please.

Dr. Charles North, the Acting Chief Medical Officer of the Indian Health Service is accompanied by Mr. Pete Conway, the Director of the Billings Area Office of the Indian Health Service, and Dr. Westley Clark, Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

We appreciate both of you taking time to be with us today at our invitation, and we will obviously include your entire statement as a part of the permanent Committee records.

We would ask that both of you summarize, following which we would like to ask a series of questions. As you testify, I'd like to ask that you pull the microphone as close as possible so that everyone in the audience can hear clearly the testimony you are giving.

Dr. Charles North, you may proceed.

STATEMENT OF CHARLES Q. NORTH, M.D., M.S., ACTING CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE; ACCOMPANIED BY PETE CONWAY, DIRECTOR, BILLINGS AREA OFFICE, INDIAN HEALTH SERVICE

Dr. NORTH. Good morning, I am Dr. Charles Q. North, Acting Chief Medical Officer of the Indian Health Service.

I am glad to be here this afternoon, and I would like to thank Chairman Venne also for having us at Crow Agency.

Today I am accompanied by Mr. Pete Conway, the Area Director for the Billings Area of the Indian Health Service, and we're both pleased to have the opportunity to testify on behalf of the Indian Health Service Director, Dr. Charles Grim, on the status of the Indian Health Service and the health of Indian people.

The Indian Health Service has the responsibility for the delivery of health services to more than 1.9 million federally-recognized American Indians and Alaska Natives through a system of Indian Health Service, tribal and urban operated facilities and programs governed by statutes and judicial decision.

The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the populations that we serve.

The agency's goal is to insure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population.

We are here today to discuss Indian health and the IHS focus on improving the health of Indian people, and eliminating health disparities through health promotion and disease prevention, behavioral health and chronic disease management.

We will also address issues related to Indian health manpower, access to health care, consultation and contract health care.

I would like to also note that the Health and Human Services Department summer of 2007 Indian Country bus tour to promote prevention and healthier living is here today and will follow the hearing.

As part of the "Healthier US Starts Here" initiative, the U.S. Department of Health and Human Services is joining local officials and health care partners to raise awareness of the importance of preventing chronic disease and illness, promoting Medicare preventive benefits, and providing information about how individuals can take action to maintain and improve their health.

This effort supports the Indian Health Service goal to create healthier American Indian and Alaska Native communities by developing and implementing effective health promotion and chronic disease prevention programs.

We want to recognize the Crow Tribe for the outstanding work it does to promote healthy living in its community. Chairman Venne has been a great friend to the Department by hosting our former Deputy Secretary and our Assistant Secretary for Health, and we are here to thank his staff for all their efforts to make Indian Country healthier.

While the mortality rates of Indian people have improved dramatically over the past 10 years, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population.

Alcoholism rates are 550 percent higher; diabetes rates are almost 200 percent higher; unintentional injury rates, 154 percent higher; suicide is 57 percent higher, and homicide is 108 percent higher than the general population.

Making significant reductions in health disparity rates can be achieved by implementing the best practices in medicine, using traditional community values, and building the local capacity to address these health issues and promote healthy choices. Since 1997, the Special Diabetes Program for Indians funding of $150 million has expanded our diabetes prevention and treatment efforts. These funds support over 300 IHS tribal and urban community-based diabetes prevention and treatment projects, along with a demonstra-

tion project focused on primary prevention of type 2 diabetes in 35 separate American Indian and Alaska Native communities.

The competitive grant initiatives focus on American Indian and Alaska Native adults with pre-diabetes to determine if an intensive life-style intervention can be successfully implemented in our communities.

One of the models we are using was developed by the National Institutes of Health that proved that diabetes could be prevented. This program will cover a four-year period. The outcomes of the demonstration project will enable us to learn what may be applicable to other communities throughout Indian Country.

Indian health manpower is a critical issue, it's a critical issue here in Crow. IHS tribal and urban Indian health programs cannot function without adequate health care providers.

Indian Health Manpower programs, which is also authorized in the Indian Health Care Improvement Act that you mentioned earlier, consists of the Indian Health Service Scholarship Program, the IHS Loan Repayment Program; and the IHS Health Professional Recruitment Program.

The IHS Scholarship Program plays a major role in the production of health care and professionals of American Indian and Alaska Native descent. Since its inception in 1977, more than 7,000 American Indian and Alaska Native students have participated in the program.

The IHS Scholarship Program has been the starting point for the careers of a number of health professionals now working in the Federal, tribal and urban Indian health programs.

Many are also involved in academia continuing to help identify promising young American Indian and Alaska Native students and recruiting them to the health professions.

The IHS Loan Repayment Program is very effective in both the recruitment and retention areas. There are currently 723 health professionals in the Loan Repayment Program.

Access to health care can be promoted by the Environmental Health and Engineering Program of the Indian Health Service, which is a comprehensive public health program administered by Indian Health and tribes.

Indian self-determination and self-governance and consultation are extremely important to this administration. The IHS has been contracting with tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act, Public Law 93–638, as amended, since its enactment in 1975.

Indian Tribes now administer 54 percent of our budget with IHS funds transferred through self-determination contracts and compacts. IHS adheres strongly to its long-standing tribal consultation policy.

The Indian Health Service purchases medical and dental services from providers in the private sector though its Contract Health Services program, which is a component of the Indian health care system.

In Fiscal Year 2007, the CHS program is funded at $543 million. Patients are referred to the private sector health facilities, programs and practitioners for treatment when needed services are unavailable as direct care through the Indian health care system.

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

Mr. Chairman, this concludes my oral statement. Thank you for the opportunity to report on Indian Health Service programs serving American Indians and Alaska Natives and their impact on the health status of our populations.

We will be happy to answer any questions that you may have.

[The prepared statement of Dr. North follows:]

PREPARED STATEMENT OF CHARLES Q. NORTH, M.D., M.S., ACTING CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good morning, I am Dr. Charles Q. North, Acting Chief Medical Officer for Indian Health Service (IHS). Today I am accompanied by Mr. Pete Conway, Area Director, Billings Area IHS. We are pleased to have this opportunity to testify on behalf of Dr. Charles W. Grim, Director, IHS on the status of Indian Health.

The IHS has the responsibility for the delivery of health services to more than 1.9 million Federally-recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs governed by statutes and judicial decisions. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our duty is to uphold the Federal Government's responsibility to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major statutes are at the core of the Federal Government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): The Snyder Act of 1921, P.L. 67-85, and the Indian Health Care Improvement Act (IHCIA), P.L. 94-437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the provision of Federal programs, services and activities to address the health needs of AI/ANs. The IHCIA also includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for urban Indian people and the construction, replacement, and repair of health care facilities.

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

HHS Summer 2007 Indian Country Bus Tour to Promote Prevention and Healthier Living

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

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

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

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

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

Health Disparities

While the mortality rates of Indian people have improved dramatically over the past ten years, Indian people continue to experience health disparities and death rates (2001–2003) that are significantly higher than the rest of the U.S. general population (2002: National Vital Statistics Reports: Vol. 53 No. 5. National Center for Health Statistics):

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

These statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them is influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

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

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

Cardiovascular disease (CVD) is the leading cause of mortality among Indian people. This is a health disparity rate that the President, the Secretary of Health and Human Services, and the IHS are committed to eliminating. The Strong Heart Study, a longitudinal study of cardiovascular disease in 13 AI/AN communities, has clearly demonstrated that the vast majority of heart disease in AI/AN occurs in people with diabetes. In 2002, IHS was directed to address "the most compelling complications of diabetes," including the most critical complication of heart disease. The IHS is working with other HHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health's National Heart Lung and Blood Institute, to develop a Native American Cardiovascular Disease Prevention Program. Also contributing to the effort are the IHS Disease Prevention Task Force and the American Heart Association.

Our primary focus is on the development of more effective prevention programs for AI/AN communities. The IHS has begun several programs to encourage employees and our tribal and urban Indian health program partners to lose weight and exercise, such as "Walk the Talk" and "Take Charge Challenge" programs. Programs like these are cost effective in that prevention of both diabetes and heart disease, as well as a myriad of other chronic diseases, are all addressed through healthy eating and physical activity.

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

Health Service showed that the AI/AN people experience some of the highest oral disease rates reported in the world. The 1999 IHS survey of Oral Health Status and Treatment Needs indicate the following:

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

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

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

The incidence and prevalence of diabetes has been increasing dramatically since 1972. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the United States (source: 2003–2004 National Health Interview Survey and 2004 IHS Outpatient database). The prevalence of type 2 diabetes is rising faster among American Indian and Alaska Native children and young adults than in any other ethnic population, increasing 106 percent in just one decade from 1990 to 2001 (source: IHS Division of Program Statistics). As diabetes develops at younger ages, so do related complications such as blindness, amputations, and end stage renal disease. Fortunately, the diabetes mortality rate for the entire AI/AN population did not increase between 1996–1998 and 1999–2001, so we are hopeful that we may be seeing a change in the pattern of diabetes mortality. In fact, the overall mortality rate for American Indians and Alaska Natives decreased approximately 3 percent between these same time periods (source: IHS Division of Diabetes Statistics and CDC Center for Health Statistics). And there is good news in that we have recently measured a slight, but statistically significant, decline in kidney failure in the AI/AN diabetic population as well.

What is most distressing however about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the chances of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventive approach to diabetes management is an important consideration, since the cost of caring for diabetes patients is staggering. The cost of managing care for treating diabetes ranges from $5,000–$9,000 per year with the annual cost per patient exceeding $13,000 (source: American Diabetes Association).

In 1997, the Special Diabetes Program for Indians (SDPI) grant program was enacted and provided $30 million per year for a five year period to IHS for prevention and treatment services to address the growing problem of diabetes in AI/ANs. In 2001, Congress appropriated an additional $70 million for Fiscal Years 2001 and 2002. The program was funded at $100 million in Fiscal Year 2003. Then in 2002 Congress extended the SDPI through 2008, and increased the annual funding to $150 million for FY 2004–2008 with the directive to address "primary prevention of type 2 diabetes and the most compelling complication of diabetes—cardiovascular disease." We are proud to announce that in FY 2004 our Division of Diabetes Treatment and Prevention launched a competitive grant to implement two demonstration projects. One is focused on primary prevention of type 2 diabetes in people diagnosed with pre-diabetes to determine if an intensive life-style intervention can be successfully implemented in AI/AN communities. This effort is based on the NIH sponsored study called the Diabetes Prevention Program which provided evidence that type 2 diabetes could be prevention with lifestyle intervention. The other dem-

onstration project is focused on cardiovascular risk reduction in people diagnosed with type 2 diabetes. Thirty-six AI/AN communities were awarded diabetes prevention demonstration projects and 30 AI/AN communities were awarded cardiovascular risk reduction demonstration projects in November 2004. These demonstration projects will cover a four year period. The outcomes of the demonstration projects will enable us to learn what may be applicable to other communities throughout Indian country. The last year of the demonstration projects will be aimed at dissemination of lessons learned to other tribal communities across the nation.

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

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

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care and public health efforts including massive vaccination and sanitation facilities construction programs. As the population lives longer and adopts a more a western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population as evidenced by the increasing rates of cardiovascular disease, diabetes, and oral health problems. Most chronic diseases are affected by lifestyle choices and behaviors.

In summary, preventing disease and injury, promoting healthy behaviors, and managing chronic diseases are a worthwhile financial and resource investment that will result in long-term savings by reducing the need for acute care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. This is the path we must follow if we are to reduce and eliminate the disparities in health that so clearly affect AI/AN people.

Indian Health Manpower

IHS, Tribal and Urban Indian health programs could not function without adequate health care providers. The Indian Health Manpower program which is also authorized in the Indian Health Care Improvement Act (P.L. 94-437, as amended) consists of several components:

- The IHS Scholarship Program;
- The IHS Loan Repayment Program; and
- The IHS Health Professional Recruitment Program

The IHS Scholarship Program plays a major role in the production of AI/AN health care professionals. Since its inception in 1977, more than 7,000 AI/AN students have participated in the program, with the result that the number of AI/AN health professionals has been significantly increased. The program is unique in that it assists students who are interested in or preparing for entry into professional training. Most scholarships only provide assistance to those who have been accepted into a health professional training program.

The IHS Scholarship Program has been the starting point for the careers of a number of AI/AN health professionals now working in IHS, tribal, and urban Indian health programs. Many are also involved in academia, continuing to help identify promising AI/AN students and recruit them to the health professions, thereby helping to produce a self-sustaining program. We have had several instances of parents going through the program, followed later by their children and not a few of the reverse, with children being followed by their parents. The average age of our students is 28 years, well above the norm for college students. It is not uncommon for students to have attended 5 or more colleges or universities during the course of their academic careers, not because they failed in the first four, but because they had to move in order to have the employment they needed to support their families.

The IHS Loan Repayment Program (LRP) is very effective in both the recruitment and retention areas. There are currently 723 health professionals in the LRP. The scholarship and loan repayment programs complement one another. Scholarships help individuals rise above their economic background to become contributing members of the community and participate in improving the well-being of the community; while loan repayments are a way for participants to provide service in return for assistance in repaying loans that could otherwise be overwhelming.

The recruitment program seeks to maximize the effectiveness of both programs, as well as to make the IHS more widely known within the health professional community and to assist interested professionals with job placement that best fits their professional and personal interests and needs.

Access to Health Care: The Environmental Health and Engineering Program

The Environmental Health and Engineering program is a comprehensive public health program administered by IHS and Tribes. Two examples are the sanitation facilities construction program which provides safe drinking water, wastewater disposal, and solid waste disposal system; and the injury prevention program which focuses on unintentional injuries. As a result of these two successful programs, 88 percent of AI/AN homes now have safe water and mortality from unintentional injuries has been reduced by 58 percent between 1972–1974 and 2001–2003. Unfortunately, 12 percent of Indian homes still lack adequate sanitation facilities compared to one percent of the rest of the United States population; and the leading cause of death for AI/ANs between the ages of 1 and 44 years of age is unintentional injuries. Improvement in these areas is integral to our mission.

The Environmental Health and Engineering program, provides access to health care services through the health care facilities program, which funds federal and tribal construction, renovation, maintenance, and improvement of health care facilities. There are 48 hospitals, 272 health centers, 11 school health centers, over 2,200 units of staff housing, 320 health stations, satellite clinics, and Alaska village clinics, and 11 youth regional treatment centers supporting the delivery of health care to AI/AN people. The IHS is responsible for managing and maintaining the largest inventory of real property in the DHHS, with over 9.6 million square feet (899,000 gross square meters) of space, and the Tribes own over 6 million square feet (571,000 gross square meters). This is in part the result of Tribally funded construction of millions of dollars worth of space to provide health care services by the Indian Health Service funded programs.

Over the past decade, $600 million in funding has been invested in the construction of health care facilities which include, 1 Medical Center, 5 Hospitals, 9 Health Centers, 3 Youth Regional Treatment Centers, 500 units of Staff Quarters, 27 Dental Units, and 21 Small Ambulatory Program construction projects. Most of these facilities were replacements of inadequate health care facilities. We have substantially improved our health care delivery capability in the newer health care facilities and continue to improve access to services through health care facilities construction—health care facilities construction remains a priority.

In response to a Congressional request to revise the Health Care Facilities Construction Priority System, we have been working to better identify the health care delivery needs. This will enable us to prioritize the need for health care facilities infrastructure. We are using a master planning process to address the complex nature of health care delivery for AI/AN communities. Both the Federal Government and Tribes will be able to use these plans to identify our greatest needs for services and health care facilities, and to plan carefully on how to best utilize any available resources. The IHS Health Care Facilities Construction program is fully prepared to address the needs identified through this process.

Indian Self Determination/Self-Governance

The IHS has been contracting with Tribes and Tribal Organizations under the Indian Self Determination and Education Assistance Act, P.L. 93-638, as amended, since its enactment in 1975. We believe the IHS has implemented the Act in a manner consistent with Congressional intent when it passed this cornerstone authority that re affirms and upholds the government to government relationship between Indian tribes and the United States. The share of the IHS budget allocated to tribally operated programs has grown steadily over the years to the point where today over 54 percent of our budget is transferred through self determination contracts/compacts.

Consultation

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

The policy, which was developed by IHS and Tribal Leaders, contains an improved definition of consultation and the circumstances under which it needs to occur. The

policy also commits the IHS to assisting Tribal governments in establishing meaningful dialogue and consultation with other HHS agencies and State governments. It revises the budget formulation process within IHS to allow for more meaningful Tribal participation and it contains requirements that IHS report to Tribes on IHS consultation, its outcomes and effectiveness.

Overview of CHS program

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

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

The CHS funds are used in situations where:

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

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

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

Eligibility

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

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

Payor of Last Resort Rule

The IHS is the payor of last resort and therefore the CHS program must ensure that all alternate resources that are available and accessible, such as Medicare Parts A and B, state Medicaid, state health program, private insurance, etc. are used before the CHS funds can be expended. An IHS or Tribal facility is also considered a resource, and therefore, the CHS funds may not be expended for services reasonably accessible and available at IHS or Tribal facilities. In FY06, IHS received $681 million in Medicaid, Medicare and Private Insurance collections And, the agency continues to strive toward maximizing these other sources of payment.

Medical Priorities

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

Catastrophic Health Emergency Fund (CHEF)

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

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

Senator DORGAN. Dr. North, thank you very much.

Next we will hear from Dr. Westley Clark. Dr. Clark is the Director for Substance Abuse Treatment.

Dr. Clark, you may proceed.

STATEMENT OF H. WESTLEY CLARK, M.D., J.D., M.P.H., DIRECTOR, CENTER FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICE ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. CLARK. Thank you, Mr. Chairman, and I want to acknowledge Senator Tester and committee staff.

I'm speaking on behalf of Dr. Terry Cline, who is the Administrator of the Substance Abuse and Mental Health Service Administration, commonly called SAMHSA.

I am pleased to have this opportunity to join you and share with you how SAMHSA is working to create healthier tribal communities.

I am Dr. H. Westley Clark, the Director of the Center for Substance Abuse Treatment. It is important for us to acknowledge the issues of substance abuse and mental health problems experienced among American Indians and Alaska Natives.

We know that American Indians and Alaska Natives suffer disproportionately from substance use disorders, and they interfere with health, interfere with major obligations at work, school, or home.

According to combined data from the National Survey on Drug Use and Health, American Indian and Alaska Natives over the age of 12 were more likely than members of other racial and ethnic groups to have a past year alcohol use disorders, to have past year illicit drug use disorders, and specifically, rates of past year marijuana, cocaine, and hallucinogen use, were higher among American Indians and Alaska Natives than other groups.

With respect to mental health concerns among American Indian and Alaska Natives, between 1999 and 2004, suicide was the second leading cause of death among youths between the ages of 10 and 24. We also know that trauma and PTSD are significant critical issues for the American Indian community.

Our work at SAMHSA requires partnership and the passion of others in order to make the largest impact possible. We work with the Indian Health Service, the Department of Justice, and the Bureau of Indian Affairs in ways that are instrumental in our success in assisting tribal communities in training and technical assistance.

Our state partners are partnering with tribes and tribal communities to meet service needs. Tribal leaders across the country are expanding dialogue with SAMHSA every day. We acknowledge the importance of self-governance and self-determination.

One important tool to enhance collaboration are the tribal training and technical assistance sessions that SAMHSA, the Department of Justice, the Office of Justice Programs and the Department of the Interior, Bureau of Indian Affairs have conducted this year focusing on tribal priorities related to public safety and public health for families and communities.

Four of these cross-agency sessions have been held this year, and they were designed so that Federal agency partners could share information on funding opportunities and agency initiatives with tribes and tribal organizations.

Also included on the agenda for these sessions were opportunities for tribal leaders to consult with Federal officials on public safety, justice, and public health issues.

We also rely on these tribal consultation sessions to gain insight on tribal priorities and gauge needs on pressing health and human services issues in tribal communities. Some of the most pronounced areas of concerns expressed at these sessions surround methamphetamine use, suicide and access to Federal grants.

SAMHSA's proposed FY 2008 budget reflects these concerns. Our mission in Indian Country, and around the country, has been more focused and more clear with the release of our FY 2008 proposed budget.

SAMHSA Administrator, Dr. Terry Cline, has completed testimony on the FY 2008 SAMHSA budget and there are a few highlights I would like to share about the $3.2 billion proposal.

We continue to invest available resources in priority areas like screening, brief intervention, referral and treatment, criminal and juvenile justice and drug courts, access to recovery, substance abuse prevention, children's mental health services, suicide and school violence prevention, HIV/AIDS, and mental health system transformation. This information is available on our website.

I want you to recognize two priorities, and that is our screening, brief intervention program and our treatment drug courts. They have received increases for this budget year and tribes are eligible to apply for both.

Currently, the Cook Inlet Tribal Council in Anchorage operates an SBIRT program. In FY 2008, approximately $25 million is proposed for new SBIRT grants to increase screening. This objective is to wed primary care and substance abuse and mental health together so that we can identify problems early.

Approximately $32 million is proposed to fund 75 treatment drug court grants. Again, tribes and tribal organizations are encouraged to apply for both of these important initiatives.

With respect to suicide prevention, SAMHSA's FY 2008 budget includes $3 million for youth suicide prevention which will expand on a long-term commitment to tribal youth through the Native Aspirations project.

The Native Aspirations initiative is a five-year project that is operated though a contract with Kauffman and Associates, a Native American business located in Spokane, Washington.

SAMHSA consulted with tribes through the contractor, and to date, 24 tribal communities are participating in the Native Aspirations project, including the Crow Nation. With continued input from tribal leaders, we expect to expand this initiative in future years to include additional tribal sites.

Our Access to Recovery program, or ATR program, permits states and tribal organizations to provide clinical substance abuse treatment as well as recovery support services through a voucher-based system.

The ability to provide recovery support services is key to this grant, and it allows culturally appropriate and traditional healing practices to be reimbursed through the grant. Currently, the California Rural Indian Health Board was one of our first ATR grantees and it continues to serve as an example. For our second round of ATR grants, up to $98 million is available to fund approximately 18 new ATR grants in FY 2007, and we expect that more than one tribe will be awarded a grant in this new addition.

Since the recognition of a growing methamphetamine problem nationwide, SAMHSA has continued to put a strong emphasis on prevention.

In FY 2006, SAMHSA awarded ten methamphetamine prevention grants of approximately $350,000 each for up to 3 years. The grant program is to support expansion of methamphetamine prevention, intervention and/or infrastructure development.

Of the ten grants awarded, two were to tribes, the Cherokee Nation of Oklahoma and the Native American Rehabilitation Association of the Northwest. The grant program is designed to address the growing problem of methamphetamine abuse and addiction by assisting localities to expand prevention interventions that are effective and evidence-based, and to increase capacity through infrastructure development.

In addition, SAMHSA is a part of the HHS Indian Country Methamphetamine Initiative along with the Office of Minority Health and the National Institutes of Health.

Through this project, approximately $1.2 million was awarded to the American Association of Indian Physicians and its partners, to address the outreach and education of Native American communities on methamphetamine abuse.

Five tribes are included in this project, the Winnebago Tribe, which has been funded as a preventionsite, the Navajo Nation and the Northern Arapaho Tribe, which are intervention and treatment sites, and the Crow Tribe and Choctaw Nation which are treatment and recovery sites.

The Montana–Wyoming Tribal Leaders Council has a SAMHSA suicide prevention grant, and as a grantee, they are implementing the Planting of Seeds of Hope Project.

In many ways, this Council has led the way in developing new collaborations between all of the tribes in Montana and Wyoming, along with the states, in order to share resources, ideas, and truly work together on suicide prevention activities.

These new collaborations are building hope across the tribes and the states to overcome what once seemed an overwhelming and impossible problem to solve alone. These partnerships are leading the country in developing new strategies for saving the lives of our youth, and together they are spreading the word that suicide is a preventable tragedy.

To continue to address the suicide clusters on Standing Rock, the tribe applied and was competitively awarded a youth suicide prevention and early intervention program grant in October, 2006.

This grant is bringing together community leaders to implement a comprehensive tribal youth suicide prevention and early intervention plan at Standing Rock that is identifying and increasing youth referrals to mental health services and programs, increasing protective factors, reducing risk factors for youth suicide, and improving access to intervention services. Additionally, SAMHSA is establishing a new tribal advisory committee and is accepting nominations for community members. Similar to other SAMHSA advisory committees, the purpose of the Tribal Advisory Committee is to assist SAMHSA in carrying out its mission in Indian Country.

Key to carrying out our agency mission in Indian Country is increasing awareness of and access to our grants. In response to comments at the 2006 HHS Tribal Consultation meetings and the HHS/ASPE published Barriers to American Indian/Alaska Native/Native American Access to DHHS Programs report, SAMHSA convened an internal workgroup to develop strategies to remove barriers in discretionary grant announcements.

Senator DORGAN. Mr. Clark, I'm going to have to ask you that you summarize, please.

Dr. CLARK. One of the most important things is we want to make sure that tribes have access to our funding. I think one of the things that we view in these requests for proposals is making sure that tribes are not precluded from participating as states or other organizations have. So I'm pleased to note that we have done this.

We're also having other strategies like the tribal policy academy on co-occurring disorders and that tribes are along in that effort so that we can deal with substance abuse and mental health problems of the tribes.

So changes are underway, and we are working collectively with tribal communities and tribal governments so that we can address mental health and substance abuse problems.

Thank you.

[The prepared statement of Dr. Clark follows:]

PREPARED STATEMENT OF H. WESTLEY CLARK, M.D., J.D., M.P.H., DIRECTOR, CENTER FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICE ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Dorgan and Members of the Committee, I am Dr. H. Westley Clark, Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration or commonly called SAMHSA. I bring greetings from Dr. Terry Cline, SAMHSA Administrator. I am pleased to have this oppor-

tunity to join you and share with you how SAMHSA is working to create healthier tribal communities. However, before I detail a few of SAMHSA's initiatives, I think it is important to underscore the extent of substance use and mental health problems experienced among American Indians and Alaska Natives.

American Indians and Alaska Natives suffer disproportionately from substance use disorders (defined by symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school, or home during the past year) compared with other racial/ethnic groups in the United States. According to combined data from the 2002–2005 National Survey on Drug Use and Health (NSDUH) conducted by SAMHSA, American Indian and Alaska Natives over the age of 12 were more likely than members of other racial/ethnic groups to have a past year alcohol use disorder (10.7 vs 7.6 percent). They were also more likely to have a past year illicit drug use disorder (5.0 vs 2.9 percent). Specifically, rates of past year marijuana, cocaine, and hallucinogen use disorders were higher among American Indians and Alaska Natives than among other racial/ethnic groups.

One factor that may be driving the disparity in substance use between American Indian/Alaska Native youth and other youth is a higher rate of substance use risk factors among American Indian and Alaska Native youth. For example, data from the 2002 and 2003 National Survey on Drug Use and Health show that American Indian/Alaska Native youth are more likely than youth of other racial/ethnic groups to perceive moderate to no risk of substance use and less likely to perceive strong parental disapproval of substance use.

With respect to mental health concerns among American Indian and Alaska Natives, between 1999 and 2004, suicide was the second leading cause of death among youth between the ages of 10 and 24, compared to the third leading cause of death among the youth population as a whole. Spirituality may play a protective role in reducing suicide attempts. Specifically, a study of American Indian tribal members living on or near their Northern Plains reservations between 1997 and 1999 showed that those with a high level of cultural spiritual orientation had a reduced prevalence of suicide compared with those with a low level of cultural spiritual orientation.

Our work at SAMHSA does not stand alone—it requires partnership and the passion of others in order to make the largest positive impact. For example, our partners at the Indian Health Service, the Department of Justice (DOJ) and the Bureau of Indian Affairs are instrumental in our success in assisting tribal communities in training and technical assistance. Our State partners are partnering with Tribes and Tribal communities to meet service needs. In addition, our grantees are hard at work in the field providing services. And, Tribal leaders across the country are expanding the dialogue with SAMHSA everyday. All are examples of the type of collaborative efforts that create a wider reach than any single agency can provide alone.

One important tool to enhance collaboration are the Tribal Training and Technical Assistance Sessions that SAMHSA, the Department of Justice, Office of Justice Programs (DOJ/OJP) and the Department of the Interior (DOI), Bureau of Indian Affairs (BIA) have conducted this past year focusing on tribal priorities related to public safety and public health for families and communities. Four sessions were held in FY 2007. It should be noted that the fourth session included a 1-day Tribal Methamphetamine Summit hosted by the Office of National Drug Control Policy (ONDCP). These cross-agency sessions are designed so that Federal agency partners can share information on funding opportunities and agency initiatives with Tribes in one setting. Community challenges, best practices and lessons learned have been embedded into the session agendas to provide Tribes the opportunity to share their experiences and adapt strategies to their unique circumstances in their tribal communities. Also included on the agenda for these sessions are opportunities for Tribal leaders to consult with Federal officials on public safety, justice and public health issues. And, of course, we also rely on these Tribal Consultation Sessions to gain insight on Tribal priorities and gauge needs on pressing health and human services issues in tribal communities. Some of the most pronounced areas of concerns expressed at these sessions surround methamphetamine use, suicide and access to Federal grants.

SAMHSA's proposed FY 2008 Budget reflects those concerns. Our mission in Indian Country and around the country has become much more focused and more clear with the release of the FY 2008 proposed budget. SAMHSA Administrator Dr. Terry Cline has completed testimony on the FY 2008 SAMHSA budget and there are a few highlights I would like to share about the $3.2 billion proposed for SAMHSA.

We are continuing to invest available resources in program priority areas such as: Screening, Brief Intervention, Referral and Treatment (SBIRT); Criminal/Juvenile Justice and Drug Courts; Access to Recovery; Substance Abuse Prevention; Children's Mental Health Services; Suicide and School Violence Prevention; HIV/AIDS; and Mental Health System Transformation.. A comprehensive list of our grants can be found on our website: *www.samhsa.gov/grants/*.

I want to draw your attention to a few of these priorities briefly. Two of these priorities—the SBIRT program and the Treatment Drug Courts—have received increases this budget year and tribes are eligible to apply for both. Currently, the Cook Inlet Tribal Council in Anchorage, Alaska operates an SBIRT grant. For FY 2008, approximately $25 million is proposed for new SBIRT grants to increase screening, brief interventions, and referral to treatment in general medical and community health care settings. Approximately $32 million is proposed to fund about 75 Treatment Drug Court grants. Tribes and Tribal Organizations are encouraged to apply for both of these important initiatives.

With respect to suicide prevention, SAMHSA's FY 2008 Budget includes $3 million for youth suicide prevention which will expand on a long-term commitment to tribal youth through the Native Aspirations project. The Native Aspirations initiative is a 5-year project that is operated through a contract with Kauffman and Associates, Inc. (KAI)—a Native American business located in Spokane, Washington. SAMHSA consulted with Tribes through the contractor and to date 24 tribal communities are participating in the Native Aspirations project. With continued input from Tribal leaders, we expect to expand this project in future years to include additional tribal sites.

I don't want to just talk about proposed grant opportunities, but also current ones as well. One grant program I want to highlight is SAMHSA's Targeted Capacity Expansion Grants (TCE) program. In May 2007, SAMHSA announced $10.2 million in TCE Grants to expand or enhance a community's ability to provide a comprehensive, integrated, and community-based response to a targeted, well-documented substance abuse treatment capacity problem and/or improve the quality and intensity of services. Applications were accepted under four Categories: (1) Native American/Alaska Native/Asian American/Pacific Islander Populations; (2) E–Therapy; (3) Grassroots Partnerships; and (4) Other Populations or Emerging Substance Abuse Issues. Tribes were eligible to apply under all four categories and SAMHSA expects to award up to 16 grants in 2007, with an average grant amount of $500,000 per year for up to 3 years.

Another program priority area is SAMHSA's Access to Recovery (ATR) program. The ATR program permits grantees (*i.e.,* States and Tribal Organizations) to provide clinical substance abuse treatment as well as recovery support services through a voucher-based system. The ability to provide recovery support services is a key issue of this grant program because it allows clients to pursue and maintain their recovery through many different and personal pathways, including traditional healing practices. The California Rural Indian Health Board was one of the first ATR grantees and it continues to serve as an example of what can be accomplished through tribal collaborations. For our second round of ATR grants, up to $98 million is available to fund approximately 18 new ATR grants in FY 2007 of which $25 million is expected to support treatment for clients using methamphetamine.

Since the recognition of a growing methamphetamine problem nationwide, SAMHSA has continued to put a strong emphasis on prevention. In FY 2006 SAMHSA awarded 10 Methamphetamine Prevention grants of approximately $350,000 each for up to 3 years The grant program is to support expansion of methamphetamine prevention, interventions and/or infrastructure development. Of the 10 grant awards 2 were to Tribes, the Cherokee Nation of Oklahoma and the Native American Rehabilitation Association of NW, Inc., of Portland, Oregon. The grant program is designed to address the growing problem of methamphetamine abuse and addiction by assisting localities to expand prevention interventions that are effective and evidence-based and/or to increase capacity through infrastructure development.

SAMHSA is a member of the Office of National Drug Control Policy, Executive Native American Law Enforcement Workgroup along with members from DOJ, Indian Health Services, DOI, Tribal Police, and the Federal Bureau of Investigation. This workgroup is designed to coordinate and address the multidimensional aspect of methamphetamine use in Indian Country. In addition, SAMHSA is part of the HHS Indian Country Methamphetamine Initiative (ICMI) along with the Office of Minority Health and the National Institutes of Health. Through this project, nearly $1.2 million was awarded to the American Association of Indian Physicians (AAIP) and its partners to address the outreach and education needs of Native American communities on methamphetamine abuse. The partners are developing a culturally

appropriate national information and outreach campaign on methamphetamine use in Indian Country. They are also developing a methamphetamine abuse education kit, documenting and evaluating promising practices in education on methamphetamine use, and creating methamphetamine awareness multi-disciplinary education teams. Five Tribes are included in this project—the Winnebago Tribe, which has been funded as a preventionsite, the Navajo Nation and the Northern Arapaho Tribe, which are intervention and treatment sites, and the Crow Tribe and Choctaw Nation which are treatment and recovery sites.

The Montana–Wyoming Tribal Leaders Council has received a SAMHSA suicide prevention grant and as a grantee they are implementing the "Planting of Seeds of Hope Project." In many ways, this Council has led the way in developing new collaborations between all of the Tribes in Montana and Wyoming, along with the States, in order to share resources, ideas, and truly work together on Suicide Prevention activities. These new collaborations are building hope across the Tribes and the States to overcome what once seemed an overwhelming and impossible problem to solve alone. These partnerships are leading the country in developing new strategies for saving the lives of our youth and together they are spreading the word that suicide is a preventable tragedy.

In the Aberdeen Area, SAMHSA continues to work closely with the Standing Rock Sioux Tribe to respond to an outbreak of suicide clusters on their reservation. In 2005, through a SAMHSA Emergency Response Grant (SERG), SAMHSA staff and the One Sky Center staff began working with the Tribe to design and implement a suicide prevention program at Standing Rock. Based on SAMHSA's recommendation, tribal leadership mandated that the program must be Addiction and Dependency certified by the State of North Dakota. A Bismarck-based consultant from SAMHSA's Disaster Technical Assistance Center (DTAC) has assisted the Tribe with this process. The Tribe has funded two additional behavioral health staff positions to provide case management services and arrange for treatment and ancillary services for at-risk clients, which is making a difference. The strategic suicide prevention plan that was developed and implemented at Standing Rock is being considered as a model by other Indian reservations and the Indian Health Service. Although the SERG grant funding ended in December 2006, the Tribe was competitively awarded a Youth Suicide Prevention and Early Intervention Program grant in October 2006. This new grant is bringing together community leaders to implement a comprehensive tribal youth suicide prevention and early intervention plan at Standing Rock that is identifying and increasing youth referrals to mental health services and programs, increasing protective factors, reducing risk factors for youth suicide, and improving access to intervention services.

SAMHSA is also working with the Office of National Drug Control Policy, the Office of Justice Programs/Bureau of Justice Assistance within the Department of Justice and with the National Alliance for Model State Drug Laws on regional planning events to identify common issues and concerns among States that may require interstate resolutions or a Federal focus to address methamphetamine use. Through this partnership, three regional planning events were conducted in FY 2007. Attendance included representatives of substance abuse programs, law enforcement agencies, the criminal justice system, community coalitions and counties, cities and local municipalities. The goal was the identification of best practices that will be replicated in other States.

In response to the inescapable link between addiction, mental illness, and crime, SAMHSA is coordinating across Federal agencies through our participation on the Native American Law Enforcement Task Force. When prevention and treatment services are targeted to adult and juvenile offenders the benefits are three-fold. First, if we prevent addiction, drug related crime will decrease. Second, if we intervene early and get the appropriate treatment services in place, recidivism rates drop. And third, as SAMHSA increases recovery support services, reentry success rates climb and public safety is increased. It just makes sense for SAMHSA to strengthen partnerships with the law enforcement communities both in Indian Country and around the country. We have reached out to police organizations, correctional organizations, as well as the National District Attorneys Association to open the paths to collaboration. And, we will continue working closely with DOJ as well.

As you may know, the Department of Health and Human Services (HHS) revised its Tribal Consultation Policy in March 2005. Members of the Tribal–Federal Team contributed to developing the necessary recommendations. In early 2006, SAMHSA used the HHS document as a basis to create a starting point for revising the SAMHSA policy. We shared that document with tribes at each of the Regional sessions to solicit comments. During that process, we asked for volunteers interested in serving on a workgroup to assist with further review and revision of the Tribal

Consultation Policy. In June of 2006, a Technical Team workgroup was formed. The first meeting of the workgroup produced a second draft of the SAMHSA Tribal Consultation Policy which was reviewed and comments as well as resulting edits were incorporated in the final Tribal Consultation Policy. SAMHSA's goal was to have a signed Tribal Consultation Policy by early 2007 and I'm very proud to say we have accomplished that. Additionally, SAMHSA is establishing a new Tribal Advisory Committee and is accepting nominations for committee members. Similar to other SAMHSA advisory committees, the purpose of the Tribal Advisory Committee is to assist SAMHSA in carrying out its mission in Indian Country.

Key to carrying out our Agency mission in Indian Country is increasing awareness of and access to our grants. In response to comments at the 2006 HHS Tribal Consultation Meetings and the HHS/ASPE published "Barriers to American Indian/Alaska Native/Native American Access to DHHS Programs" report (April 2006) SAMHSA convened an internal workgroup to develop strategies to remove barriers in discretionary grant announcements. As a result, in August 2006 a Tribal Grants Review Team—with members from four Tribes/tribal organizations—reviewed nine previously published SAMHSA Requests for Proposals (RFAs). Their findings and recommendations were provided to SAMHSA grants and policy officials, some of which have already been incorporated into FY 2007 SAMHSA RFAs.

In addition to increasing the voice of Tribes and Tribal Organizations through the various avenues mentioned, SAMHSA is also committed to increasing technical assistance to our tribal partners on improving services. For instance, through SAMHSA's Addiction Technology Transfer Centers (ATTCs), SAMHSA is planning one or more special projects to provide technical assistance on treatment-related issues through partnerships with Regional Indian Health Boards. We are very excited about this new partnership and expect to have it underway in early FY 2008. Also, SAMHSA's Center for Substance Abuse Prevention will be awarding a contract for a Native American Technical Assistance Resource Center that will provide targeted technical assistance to current Tribal Strategic Prevention Framework State Incentive Grants grantees and prospective grant applicants.

I also want to mention that recently we participated in the IHS–SAMHSA 5th Annual National Behavioral Health Conference held June 11–14 in Albuquerque, New Mexico. This annual conference is an important training and networking opportunity for American Indians and Alaska Natives working in the behavioral health fields with the Indian Health Service.

Similarly, I'm pleased to announce that plans are underway at SAMHSA for a Tribal Policy Academy on Co-Occurring Substance Abuse and Mental Health Disorders in September 2007. The purpose of this Academy is to improve and expand access to effective, culturally relevant, and appropriate prevention and treatment services and supports for individuals with and at-risk for co-occurring substance use and mental disorders. The Academy will bring together Tribal Teams of officials with policymaking influence in conjunction with nationally recognized faculty and facilitators who will assist the Teams to develop an Action Plan for expanding access and improving co-occurring treatment and prevention services in their communities. The Academy will also help to identify promising practices in Tribal communities that may assist other Tribes to address co-occurring disorders in new and innovative ways.

Changes are underway—changes that will result in improved coordination of SAMHSA services to tribal communities. Ultimately the result will be healthier tribal communities—communities where lives are full and where native language, culture and traditions including native healing approaches can flourish. SAMHSA continues to look forward in assisting each of you in any way we can. Thank you.

Senator DORGAN. Dr. Clark, thank you very much.

Senator TESTER.

Senator TESTER. Thank you, Mr. Chairman. I have a few questions here, first for Dr. North, who is the Chief Medical Officer of the Indian Health Service.

Early this year, we asked your representative about the adequacy of the budget for this year for Indian Health. The response we got was, it's pretty good, we can meet most of the needs. Yet, when we talk with folks in Indian Country, we get a very different answer.

Do you think the budget request was sufficient to meet the needs?

Dr. NORTH. The budget in direct care, in all the facilities, maintenance, is about $3.2 billion. In addition to that, we have increased our third-party revenue this year substantially. It's now about three-quarters of a billion dollars.

We think with the tribal contract, the 638 health centers and hospitals, that we may be bringing in a billion dollars in third-party revenue this year in addition to the appropriated funds.

Senator TESTER. So do you think that it was sufficient to meet the needs?

Dr. NORTH. There are always needs that can be served in Indian Country.

Senator TESTER. Okay. Well, interestingly enough, I think this story could be repeated with any of the six other reservations in this state. As we were driving down from the airport with Chairman Venne today, I said, Carl, when did Indian Health services run out? He said I think it was about the first of June here in Crow. That indicates to me that the program is underfunded.

What does that indicate to you?

Dr. NORTH. I would like to ask the Area Director to comment specifically on the contract health services funding in the local service unit and the area.

Senator TESTER. Do you want to defer to Mr. Conway at this time? Do you understand the question Mr. Conway?

Mr. CONWAY. I believe so. Senator Tester, my thoughts on that is that we've heard stories, Carl Venne has told us stories about contract care. I think that whole issue centered around contract care is it probably not funded at the adequate level to provide all health care needs. What does that cost? Sometimes the cost share dollars may be another source to help cover those types of costs.

Senator TESTER. Are you allowed to make recommendations up the ladder for additional dollars, whether it's contract health care or some other item?

Mr. CONWAY. I'm allowed to make recommendations to Dr. Grim, who is our boss.

Senator TESTER. Okay. How do you feel those recommendations have been accepted, received, I should say?

Mr. CONWAY. I think generally the recommendations have been well received. I think that at meetings of the Area Directors there are problems in other areas also that are talked about need, where it goes from there.

Senator TESTER. How do you characterize the working relationship that you maintain with the tribal governments, how do you characterize that? Is it cooperative, productive, adversarial, how do you classify that?

Mr. CONWAY. I think generally for the most part the working relationship that we maintain with the tribes is cooperative. I think there's some issues that are always going to come up which may be adversarial. I think working through the Montana–Wyoming tribal leaders, and them being in Billings, being able to just walk up the street and discuss issues, I think it's been a real bonus.

Senator TESTER. So what issues are adversarial? What avenues do you use for reconciliation? Do you just say this is the way it is, too bad, or is there a process you go through?

Mr. CONWAY. The process that I go through actually is to sit down across the table with tribal leaders and talk it over, just sit down and discuss the issue.

Senator TESTER. Okay. Other than dollars, is there anything we can do in Congress to make your job easier?

Mr. CONWAY. I think some of the things you can do is look at some of the administrative requirements that we have, and perhaps, some HR things possibly, being able to offer somebody a job, those types of things.

Senator TESTER. The last question, do you take any administrative things off the top regarding what goes out?

Mr. CONWAY. No, my understanding is funding for the Area Office, this has been funding before I got there, the cost of living and things like that.

Senator TESTER. Thank you, Mr. Conway.

Mr. North, when I talk to folks in Indian County, they talk about the fact they can't get health care at certain times of the year unless they are life or limb, a loss of limb is involved.

How do you suggest that we move away from a system that waits until the injury or the health problem disaster, and encourages more preventive maintenance or adaptive maintenance?

Dr. NORTH. We have a program in health promotion, disease prevention that's nationwide. We think it's better to prevent these conditions and ask for treatment later whether it's direct or through contract care.

This area has a very high rate of contract health emergency funding, which is a reinsurance program in contract care, indicating to me that there are probably many opportunities to prevent illness in an early stage or altogether.

Senator TESTER. Do you work through Mr. Conway or through the tribe directly to encourage prevention programs in this case?

Dr. NORTH. Yes, we have a nationwide program. One of our Director's three initiatives is health promotion and disease prevention.

We're working closely with CMS on that also, and we have some favorable rates now, Medicare like rates with hospitals all over the country which helps save our contract health care dollars.

Senator TESTER. Thank you.

Before I go to Dr. Clark, I just want to make a comment, when we asked about the adequacy of the budget, Senator Dorgan was there and the Indian Affairs Committee, and they talked about that budget being adequate, when, in fact, we know when we go out in the field, it's not adequate.

I think we're wasting a lot of time, I think the budget is just flat not adequate because it hasn't been a priority.

Things would change a lot, from my perspective, if you guys would walk up to your bosses, or to the Secretary, and say, we need more dollars because we've got people dying out there unless we get more dollars for health care.

There's a lot of things out there that are really important, and we can go down the list from housing to water to roads, but if you're sick, you're not going to care, and if you have the opportunity to get people to help you if you're that sick, it's just going to cost more and more money for health preventatives.

With that, I do have a couple of questions for Dr. Clark.

A couple things, Dr. Clark. In your testimony, when you talked about early intervention and drug use and suicide, in particular in Indian Country, are you seeing any impacts of that early intervention, are you seeing suicide rates becoming static or going down, and the same thing with drug use?

Dr. CLARK. One of the most important things from our point of view is working with tribes and tribal organizations to deliver the services. So, as a service delivery organization, we had opened our portfolio up to tribes and tribal organizations, and as result of economics, monitored the performance of the tribe and tribal organizations as we do for every other provider, and we're seeing that more people are being provided services to.

So from the economic point of view, it's simply a matter of saying that I can cure the problem. We believe that working with tribes and tribal organizations with our resources, we are having a positive impact. Senator Tester: Okay. That's good. That's positive. We need to continue along that line.

What can we in Congress do to really attack some of the root causes of moving toward drug addiction or suicide?

Dr. CLARK. Well, of course, making sure that we have an adequate work force, making sure that there's adequate collaboration between agencies so that this partnership between IHS, the Bureau of Indian Health Affairs, and the tribes, can work together so that we can target our interventions in such a way to produce satisfactory results.

Senator TESTER. Okay. One last question, Dr. North, I do have one more question for you, and thank you, Dr. Clark.

You talked about a manpower program that 7,000 students have utilized, is that total or is that in the last year? The number really doesn't matter as much as the next question I'm going to ask, and that is, do you monitor the number of the folks that utilize this manpower program that actually come back into Indian Country and provide service?

Dr. NORTH. Yes, we do. That's 7,000 students since 1977, which is the year I joined the Indian Health Service 30 years ago.

Senator TESTER. And how many of them come back to Indian Country?

Dr. NORTH. We have more information on that, that's a complex answer. If you'd like, I could provide that for the record.

Senator TESTER. I would like more information on that, and also try to find out what's going to encourage them to come back to their homes.

With that, thank you very much, Mr. Chairman.

Senator DORGAN. Senator Tester, thank you very much.

Let me ask a couple of questions of Dr. North and Mr. Conway.

I want to ask about contract health care because Chairman Venne indicated this morning, that I believe at this point, on this reservation in the Crow Nation, they are out of contract health care dollars.

Chairman Venne, you are out of contract health care dollars at this point in the fiscal year and probably ran out somewhere in June or July; is that correct?

Chairman VENNE. That's correct.

Senator DORGAN. If that's the case, what that means is that if you are here in the Crow Nation and have a problem, a medical problem for which there is not treatment here, perhaps you need a specialist of some type, they're not going to pay for that specialist unless there is a life or limb at stake, you've got to lose a limb or lose your life; is that correct, Dr. North?

Dr. NORTH. And also special senses, hearing and eyesight would be included in priority one and child birth.

Senator DORGAN. If that is the case, if we're out of contract health care here now, the Fiscal Year ends at the end of September, of course, I've had a tribal chairman say they were out of contract health care funds in January. Former Chairman Tex Hall used to say on that reservation everybody understood don't get sick after June because there's no contract health care money.

If that's the case, isn't it a fact, then, that we are rationing health care to Native Americans?

Dr. NORTH. The Indian Health Service is the payer of last resort when it comes to referrals and notification of emergency care. All other alternate resources must be used first, like Medicare, Medicaid, private insurance, workmen's compensation, Veterans Administration benefits and county indigent programs and state indigent programs where they exist.

So, we're not the only payor of health care for Native Americans. There are several other options.

Senator DORGAN. Dr. North, you are absolutely correct about that, there are other payors in certain circumstances, but you, the Indian Health Service, represented by this government, is responsible. I mean, you do have a commitment. Others may or may not have a commitment, but we do know that the Indian Health Service does have a commitment.

Senator Tester was asking the question the right way, I think. We have these hearings in Washington, D.C. or in Montana or elsewhere, and we ask questions, and what we always get is, you know what, things are pretty good, we're doing the best we can. We've made a couple percent improvement here or there, but it seems to me the following:

Dr. Grim has admitted under my pretty intense questioning a couple of times, that the amount of health service that is required for American Indians is being covered to the tune of about 60 percent. That means 40 percent of the health service that is needed is not available. That means there's rationing of health care available.

And I think it ought to be on the front page headlines of every newspaper, because I think it's scandalous, and what I don't understand is how we finally get people to speak up on this.

I'm not trying to badger you, but Senator Tester made a point and I made a point to Dr. Grim when he was just re-nominated. We said why don't you risk your job, if necessary, to speak out. Risk your job, if necessary, to speak out.

The fact is, you've got some awfully good people working in Indian Health Service, in Public Health Service. I admire them, some terrific, committed, dedicated people. God bless them for doing it.

But the fact is, they're doing it without the resources they need, and we have to find a way to deal with that. And the only way that

we're going to do it is to get the Indian Health Service to stop saying things are pretty good and to start telling us exactly what's happening. Now, Dr. North, you or Mr. Conway can respond, but Mr. Conway, isn't it a fact that here on the Crow Nation if they're out of contract health care money at this point, that somebody can be pretty sick but it may not be life or limb and they're going to be told we're sorry, just wait, you're going to have to wait?, not we're sorry about the pain, but the pain is yours, not ours, we don't have the money, you wait.

Isn't that what happens? Am I wrong about that, or isn't that what's happening?

Dr. NORTH. We have to live with the reality of medical care daily. I've done that for 30 years as a physician in the Indian Health Service with my patients, and I think——

Senator DORGAN. I can't hear you, I'm sorry.

Dr. NORTH. I've been a family doctor for 30 years in the Indian Health Service, and I understand what you're saying, sir. We struggle to find the best resources for our patients, the best referral sources and the best methods to diagnose, treat and cure, and it takes creativity at times, sir.

Senator DORGAN. Well, are you frustrated?

Dr. NORTH. I find this struggle to be a good struggle and one worth fighting.

Senator DORGAN. All right. Well, let me ask this additional question.

I assume that somewhere at the bottom of this structure, there are dedicated Indian Health Service employees who are saying we don't have enough resources, we need more. We're the ones that are seeing the patients that we can't take care of, so we need the additional resources. We need the additional equipment. We need the additional facilities, and that goes up the line someplace.

My understanding is that the tribes are even asked to comment and to work and to make recommendations.

Is there a circumstance where the tribes are involved in discussions up the line when, for example, the Indian Health Service goes to the Secretary and the Secretary goes to the Office of Management and Budget, or is it a circumstance where when it leaves at this level, the Indian Health Service, at that point there's no more consultation, it's just the Office of Management and Budget and perhaps the Secretary and somebody else makes the decision with no consultation with tribes at that level?

Dr. NORTH. We take pride in tribal consultation at every level of the Indian Health Service. About 70 percent of our employees are Native American and are community members in many cases, and are family members of the tribal leaders and often tribal leaders themselves, so we feel like we work very closely with the communities and we have good two-way communications with tribal leaders.

Senator DORGAN. I should have mentioned, it's the Secretary of Health and Human Services, on other issues it's the Secretary of the Interior on Indian funding issues.

But Mr. Conway, let me ask you that question about someone who is ill here on the Crow Nation Reservation, and is probably not going to die, but is in substantial pain, needs to go to a specialist

somewhere else because the service isn't available here, tell me what happens in that case.

Mr. CONWAY. Maybe what would happen in that case, they will be deferred until the next year when we have some money. I think our job is probably the issue of asking for us to appropriate more money.

I think in my area, I think Chairman Venne receives 50 percent of the Health Service funding. I think we know that, at least in this area, we have service units that are funded at 58, 56 percent are being funded, all the way up to probably 76 or 78 percent.

And I think what we have to conclude from that, if they're funded at that level, there must be some needs out there that we need to continue to work on.

Senator DORGAN. And isn't that another way of saying that health care is being rationed to American Indians, really?

Mr. CONWAY. Yes, it's a way of saying that we do not have 100 percent of the funding. If we're keeping track of every service unit in the country, what the level they're being funded at is, we have other areas probably in the Dakotas that are probably funded at 40 percent level of needed funds.

Senator DORGAN. All I can tell you is I think most Americans, most Americans, if they've got a provider, health insurance, some other type of system, VA, they get sick, they want to go to a doctor, and if they're in pain they want to get it fixed, they want to get that pain resolved.

It appears to me, and I say this from having visited many Indian reservations and talked to a lot of patients, it appears to me we're in a situation where we don't allocate enough funding so that, for example, here you're out of contract health care money, and the person that needs that help is going to be told you just live with the pain because your need is going to be deferred.

I'm not saying you don't do all you can do, that's my point. My point isn't that the three of you don't do all that you can do. My point is we don't have anybody in the system that comes to us and pounds on the table and says publicly, in front of everybody, here's what's happening and we need to fix it.

What happens is they come to these hearings and they say, we're doing the best we can. Well, you know what, if it's 40 percent health care that's not available to people that need it, that's not good enough. The best we can is not good enough.

And so, I really want to work with Chairman Venne and Senator Tester, with you, with some dedicated people in the Indian Health Service and regional officials, but we need, we really need to see some evidence of frustration and anger, saying this isn't working and it needs to be fixed. That's what we need from you.

Dr. Clark, I've not asked you a question, but you know that I have held multiple hearings on the issue of teen suicide and, you know, where there are young people who feel that it is hopeless and they are helpless.

I've been to the reservations where it's happened. And the fact is, mental health services were not available. They just were not available. And it's true that we're making some strides, but we're not anywhere near where we need to be. And I hope that you and others in the administration will begin speaking out as well.

Methamphetamine addiction is a devastating addiction, and we can't treat that by putting somebody in a treatment program for 2 weeks, because that doesn't work. This is long-term and difficult and expensive, but it's the only way we can solve these problems.

I'm not going to ask you any questions, except I thank you for your testimony. I want to get to the other witnesses, the tribal witnesses.

Senator Tester has another question.

Senator TESTER. One point real quick. I would hope that this panel would stay around for the next panel group.

One of the things I would like to inserted in the record, Chairman Venne passed along to me.

In this region, it is not only underfunded, it's 48 million in the red on contract care here right now. That means when we're talking about Crow, Fort Belknap, Fort Peck, Rocky Boy, Salish and Northern Cheyenne, they're all in the same boat.

Right now on this reservation 28 positions are not filled in this hospital, 28. That's just not good, so I just wanted that put in the record.

Senator DORGAN. And before I let you go, one final point, I believe, and I believe, Dr. North, in your testimony you reiterate, I believe there is a trust responsibility that the Federal Government has for Indian health care. This isn't an option. This isn't a case where we say, well, on an optional basis we'll provide health care.

I believe there is a trust responsibility. If that trust responsibility exists, and I think most all of us believe it exists by custom and by law, then we are far short of meeting the needs and keeping our promise, and that's the point of it all.

Let me release you by saying, you are representatives of a lot of dedicated health professionals, I understand that. I don't ever want to diminish some Indian Health Service doctor, Public Health Service physician or others working in these kinds of circumstances. I don't ever want to diminish what they do. God bless them for doing it.

But we as a country, and we as health care professionals, we in the Congress, starting with the President's budget, have to own up to our responsibility now, not later.

So, thank you very much for testifying.

Next I'd like to call to the witness table Dr. Joe McDonald, who is the President of the Salish Kootenai College, Ms. Ada White, the Health Service Director of the Crow Tribe, Mr. Jonathan Windy Boy, the Chairman of the Subcommittee on Health Care, Montana–Wyoming Tribal Leaders Council, if you will come forward when I call your name. Also, Mr. Moke Eaglefeathers, who is the President of the National Council of Urban Indian Health Board, and Director of North American Indian Alliance.

Just let me mention briefly that Dr. Joe McDonald is accompanied by Ms. Marjorie Bear Don't Walk, the Director of the Indian Health Board of Billings.

Others on the panel are accompanying Ms. Stacy Bohlen, Executive Director of the National Indian Health Board. We have Jace Killsback, Billings Area Representative of the National Indian Health Board, Council member of the Northern Cheyenne Tribe,

and Dr. Joseph Erpelding, an orthopedic surgeon from Billings, Montana.

We have many of you testifying on the second panel. I want to tell you that your entire testimony will be made a part of the record. And I wish that you would summarize for us, and at some point, if you're unable to summarize, you may hear me bang the gavel, gently for you, of course.

I also want to tell you before we call on this panel, that we will ask any other testimony from any member of this audience or anyone listening, any testimony can be submitted by you or you can do it by fax or you can do it through the Internet or you can call the Indian Affairs Committee in the U.S. Senate, Washington, D.C.

We will make your formal testimony a part of the record even though you have not been called as witnesses, but you will have the opportunity to make statements and provide statements to this Committee. And that opportunity will exist for 2 weeks following today, and it will be open to you to submit such testimony.

Dr. Erpelding has surgery at 3 o'clock today, I understand, so because of your surgery schedule, we want to call on you first.

So, Dr. Erpelding, why don't you proceed? And again, I would ask all the witnesses to speak directly into the microphone so that all in this gymnasium will be able to share in your comments.

Dr. ERPELDING. Chairman, Senator and distinguished guests, thank you for allowing me this opportunity.

About a year ago, I was getting frustrated with the trend that I've seen practicing here for 11 years, that it's just gotten to the point where I searched out to try and look for some solutions outside of the current system, and I think Stacy is going to talk about that.

But, in essence, the trend has been a gradual decline in access and an increase in severity and diversity of disease, and I can share some specific numbers that illustrate that.

What I've been told is that IHS funding is currently at 54 percent of need, and the reason I don't know, but the result is that I cannot take care of patients that come in and need care, and it's very frustrating.

Access is limited by deferral of service. Patients wait anywhere from 2 weeks to a year to be seen in a clinic. I've had a patient wait 6 years to get a total joint replacement, 6 years.

Senator DORGAN. Six years for what?

Dr. ERPELDING. For a total joint replacement.

Orthopedic care is the most common deferred service. There frequently is no wait list. The surgery list that we had here at Crow 3 years ago was lost. We had about 60 patients on that list. The list got lost; those patients have to come back in, be seen, be evaluated and get back on the list. So, we've got some areas that we need to work on.

The deferral of service has consequences. I looked at the total joint and back patients that were waiting for surgery, 60 percent of them were on opiates, 60 percent. That's their way of coping with pain. If they can't get the surgery, they need something.

Last year we shut down the OR here for 2 months because we ran out of money, and I couldn't come down and do surgery here. I come down here and do surgery. There's also a decrease in em-

ployment and an increase in secondary disease due to lack of access.

I can give you some numbers; total joint patients the last 5 years, my non–Indian health service patients, the average age is 63½. The Indian Health Service patients, the average age was 54.2.

Why? I would submit some of this reflects a lack of access. It reflects a lack of health opportunities earlier in the onset of arthritis, and it's seen many years later. But a nine-year difference in average age for total joint replacement, that is sad.

When I looked at 20 patients that had ACL reconstructions, 20 that were non-IHS and 20 that were Indian Country patients, 95 percent of those that were Indian Country patients had a torn cartilage. That leads to an increase in arthritis. Only 10 percent of those who were non-IHS, had torn cartilage.

Why? The average wait for a non-IHS patient was 2 months. The average wait for an Indian County patient, 13 months. We can't keep doing this.

I've brought some solutions to the state. I was the President of the Orthopedic Society in the state. I've asked us to focus on health disparity education, medical and nonmedical. People need to know about this. They need to know that there's a disparity and how can we help.

We need to improve the cultural competency of those of us involved. I've got a surgery scheduled this Friday, it's during Crow Fair for heaven's sake. People wait a year to go to the Fair, and unfortunately, I tried to change it, could not, but that's cultural recognition, that I shouldn't be offering surgery on a week that is very important to this Nation.

Additionally, there's prevention principles that we need to focus on. But most important, I listened to Michael Porter, who is a Harvard professor and strategist a couple days ago at a leadership conference, and he said American people respond and make things happen. He also said we need to provide value. When we look for increase in funding, we need to provide value when we do that.

One of the areas that came up when I chatted with the Billings Area Office, is they need an infusion in business minds. It's difficult to do third-party collections if they don't understand how to do it. The private sector knows how to do it. This is an area where we can garner additional funds without a lot of increase in cost.

The others areas that I'm concerned about is we measure things, but the measurements aren't accurate, so it's garbage in, garbage out. We need to measure access for diagnosis, not just well, they're going to see a specialist, but do they get a diagnosis. And then we need to measure access for treatment better.

I plead with those of you that have the ability to improve the funding for health opportunity initiatives in Indian Country, and I thank you for the opportunity to talk.

Senator DORGAN. Dr. Erpelding, thank you very much. Dr. Erpelding, as I indicated, has surgery scheduled today and so we took his testimony first.

Thank you very much, and thank you for submitting testimony and giving us a different perspective, your perspective as an orthopedic surgeon on some very important issues. If you need to leave

at this point, we will understand. Let me next call on Stacy Bohlen, and Stacy Bohlen is the Executive Director of the National Indian Health Board.

Stacy, you may proceed.

Ms. BOHLEN. Thank you.

On behalf of the National Indian Health Board, Mr. Chairman and Senator Tester, thank you for allowing the National Indian Health Board to be here today. Dr. Erpelding was here as a witness for the National Indian Health Board, and as you said, I am the Executive Director.

I'm a member of the Sioux St. Marie Tribe of Chippewa Indians in Michigan, and I am actually accompanying Mr. Jace Killsback, who is a councilman for Northern Cheyenne, and he is also a Board member of the National Indian Health Board, so I'm going to turn this over to him, if you don't mind, sir.

Senator DORGAN. All right.

STATEMENT OF JACE KILLSBACK, BILLINGS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD, COUNCIL MEMBER OF THE NORTHERN CHEYENNE TRIBE; ACCOMPANIED BY STACY BOHLEN, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD AND DR. JOSEPH ERPELDING, ORTHOPEDIC SURGEON, BILLINGS, MONTANA

Mr. KILLSBACK. First of all, greetings Chairman Dorgan, Senator Tester and esteemed members of the Senate Indian Affairs Committee.

As Stacy mentioned, my name is Jace Killsback, a member of the Northern Cheyenne Tribal Council, and also a Board member representing the Billings Area for the National Indian Health Board.

Stacy will providing me with some technical assistance.

On behalf of the National Indian Health Board, it is an honor and a pleasure to offer this testimony on health care issues in Montana and nationally.

Our testimony today will focus on contract health service policy and practices and the consequences of poor funding and poor surveillance impacts on American Indians in Montana.

During our discussion, we will focus on the lack of orthopedic care in Montana, and how contract health services or CHS funding implementation have created this crisis in Montana.

We especially acknowledge the leadership of Senator Tester in organizing and holding this hearing on these critical issues.

So please allow me to express again my gratitude of the tribes for the work the committee has done in advancement of the reauthorization of the Health Care Improvement Act.

And we're especially thankful for the leadership that Senator Dorgan has provided and his tendency to bring this legislation to a successful conclusion to be enacted this year.

This bill will not only advance without the vigilance of the tribes, but also Congressional leaders like Senator Dorgan, and we hope that you will continue to be a champion of this effort.

We also would like to acknowledge the work of Senator Baucus and his assurance from the Senate Finance Committee that they will mark up the bill September 12. We look forward to seeing this bill progress of community consideration for the Senate floor.

A snapshot of the health care status of American Indians and Alaska Natives, they have a lower life expectancy and higher disease burden than all other Americans. Roughly 13 percent of American Indians and Alaska Native deaths occur for those under the age of 25. This is three times the rate of the U.S. population.

Our youths are more likely to commit suicide at 70 percent in Indian Country. These are involved with alcohol. We haven't found the effects of methamphetamine abuse.

American Indians have a life expectancy rate 6 years less than any other group in the United States, and rates for heart disease are twice the rate for Americans, and this continues to increase while the rate among the general public is decreasing.

The Center for Disease Control reported earlier this year that for the first time in 75 years of cancer disease surveillance, the rates of cancer in the U.S. are decreasing. This is true for all groups except for American Indians, for whom cancer rates are continuing to increase.

Disproportionate quality, poor education, cultural differences, and the absence of adequate health care and delivery are why these disparities continue to exist. The true tragedy is that most of these illnesses which American Indians suffer from are completely preventable.

It's also because the funding for Indian health care on a per capita basis is half of what Federal prisoners receive.

For the proud nations of people who fought for their freedom to protect their way of life and negotiated honestly for a few considerations like health care and education for their people in exchange for the land they had given up with their lives, surely Congress can do better.

You guys are pretty familiar with the statutory provisions for health care for American Indians, which again, is under the Snyder Act of 1921 and Health Care Improvement Act.

There are two types of services, direct services that are provided to IHS at our tribal hospitals and clinics, and our contract health services which are provided by the private sector facilities, and providers are based on referrals from IHS from the tribal CHS program.

CHS services are utilized when a direct care facility is not available, the direct care facility is not capable of providing the required emergent or specialty care, or is not capable of providing the care due to medical care workload.

CHS authorizes, subject to the availability of alternate resources, such as Medicaid, Medicare and private health insurance. Due to the limit of CHS funding, CHS regulations require that services must be preapproved at the local CHS program and determined to be medically indicated within medical priorities.

If the services are provided in an emergency situation, notification must be made to the local CHS program within 72 hours. The majority of CHS services are authorized for priority medical, emergent or acutely urgent care services.

These services are defined in the CHS manual as services that are necessary to prevent the immediate death or serious impairment of the health of an individual.

Other medical priorities include priority two for Indian health care, and priority three, secondary health care issues. Priority four, prompt tertiary and extended health care services such as rehabilitation.

For those services that are within the medical priorities but are considered elective or not emergent or not authorized for pain due to lack of CHS funding, are considered deferred services.

In Fiscal Year 2006, the IHS received over 150,000 requests for services that were deferred. If they had been approved and paid, they would represent $176 million from the CHS. The data on these numbers for deferred services is not consistent among the IHS areas and is probably under reported.

Because the general deferred services are never authorized and never paid for, there is little incentive for an Indian patient to request IHS programs to pay for their services.

As an example, the Northwest Portland Indian Area Health Board has estimated that due to lack of data on deferred services, that they have estimated there are probably 300 million of unmet needs for CHS in their area alone.

Senator DORGAN. I'm afraid I'm going to have to ask you to summarize the remainder of your statement in order that we might get all of the statements in from others.

Mr. KILLSBACK. Here in Montana, we represent the large land-based tribes, and we are the most desperate, the most needy of the neediest. Our communities are rural, and a lot of times we see economic development being pushed on our tribes, and the notion is here, we can't have economic development without healthy communities.

The payor of last resort is something that, again, reflects a perception in Indian Country of the culture of IHS. We have patients that go in and are not being treated until there is appropriate funding, and so what you have is a creation of an addiction, painkillers.

This has also allowed for some issues in the communities for black market drug trade of prescription drugs that isn't being addressed also.

The culture of IHS in the continuing fighting for funding has the Indians playing the numbers game. Some numbers that are interesting, consider we have 30-year-olds walking around like 50-year-olds on our reservation.

Because of the deferments also, we are not keeping accurate records so we don't have the appropriate data even for diagnosis, and how can we get the proper amount of funding for treatment if we don't have the proper number for diagnosis or referrals.

I just want to wrap it up by saying that the reimbursement issue that was brought up earlier, it's not IHS that's improving the third-party reimbursements, it's tribes improving third-party reimbursements, and yet, those reimbursements are still being utilized against us in the budget process when it comes to the IHS budget formulation.

Thank you for allowing us to testify.

[The prepared statement of Mr. Killsback and Dr. Erpelding follows:]

PREPARED STATEMENT OF JACE KILLSBACK, BILLINGS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD, COUNCIL MEMBER, NORTHERN CHEYENNE TRIBE AND DR. JOSEPH ERPELDING, ORTHOPEDIC SURGEON, BILLINGS, MONTANA

"The most basic human right must be the right to enjoy decent health. Certainly any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians."

H.R. Rep. No. 94-1026, pt. 1, at 13 (1976)
Indian Health Care Improvement Act of 1976

Introduction

Chairman Dorgan, Senator Tester and distinguished members of the Senate Indian Affairs Committee, I am Jace Killsback, a member of the Council for the Northern Cheyenne Tribe in Lame Deer, MT and a Board Member of the National Indian Health Board and I am joined by Dr. Joseph Erpelding, an orthopaedic surgeon from Billings, MT who will also testify today. Our technical assistant is Stacy Bohlen, Executive Director of the National Indian Health Board (NIHB). On behalf of the National Indian Health Board, it is an honor and pleasure to offer the NIHB's testimony on Indian health care issues in Montana and nationally. Our testimony today will focus on contract health services policy and practices and the consequences of poor funding and surveillance impacts American Indians in Montana. During our discussion we will focus on the lack of orthopaedic care in Montana and how the Contract Health Service, or CHS, funding and implementation have created a crisis for Indians in Montana.

We especially acknowledge the leadership of Senator Tester in organizing and holding this hearing on these critical issues.

First, please allow me to express the gratitude of the Tribes for the work the Committee has done to advance the reauthorization of the Indian Health Care Improvement Act. We are especially thankful for the leadership of Senator Dorgan in his tenacity to bring this legislation to a successful conclusion: enactment this year. This bill will not advance without the vigilance of the Tribes and congressional leaders like Senator Dorgan and we hope you will continue to champion this effort. We also would like to acknowledge the work of Senator Baucus for his assurances that the Senate Finance Committee will mark up the bill on September 12. We look forward to seeing the bill progress out of his Committee for consideration on the Senate Floor.

National Indian Health Board

Established in 1972, NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care delivery to American Indians and Alaska Natives, as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their Area. NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.

Snapshot of the Health Status of American Indians and Alaska Natives

American Indians and Alaska Natives have a lower life expectancy and higher disease burden than all other Americans. Approximately 13 per cent of AI/AN deaths occur among those under the age of 25; a rate three times that of the total U.S. population. Our youth are more than twice as likely to commit suicide, and nearly 70 per cent of all suicidal act in Indian Country involve alcohol. We are 670 percent more likely to die from alcoholism, 650 per cent more likely to die from tuberculosis and 204 per cent more likely suffer accidental death. American Indians can expect to live at least 6 years less than members of any other group. Rates for cardiovascular disease are twice the rates of other Americans and continue to increase, while rates among the general population are decreasing. The Centers for Disease Control reported earlier this year that in for the first time in 75 years of Cancer disease surveillance the rates of Cancer in the US are

decreasing; this is true for all groups EXCEPT American Indians, for whom Cancer rates continue to increase. Disproportionate poverty, poor education, cultural differences, and the absence of adequate health service delivery are why these disparities continue to exist.

The true tragedy is that most of the illnesses from which American Indians suffer are completely preventable.

It has also been documented that funding for American Indian health care, on a per capita basis, is half of that received by federal prisoners. For proud nations of people who fought valiantly for their freedom and negotiated honestly for a few considerations, like health care for their people, in exchange for their land and their lives – surely Congress can do better.

Let us examine one of the programs of the Indian Health Service that is at the heart of these issues.

Background: Contract Health Services

The provision of Federal health services to Indians is based on a special relationship between Indian tribes and the U.S. Government first set forth in the 1830s by the U.S. Supreme Court under Chief Justice John Marshall. Numerous treaties, statutes, constitutional provisions, and international law have reconfirmed this relationship. In exchange for over 400 million acres of land, the Federal government promised to provide health services to Indian people. The Indian Health Service (IHS), within the Department of Health and Human Services, is the Federal agency with the primary responsible for the delivery of health care to American Indians and Alaska Natives (AI/ANs).

The statutory basis for the provision of health services to AI/ANs is the Snyder Act of 1921 (25 U.S.C.13) and the Indian Health Care Improvement Act (IHCIA), Pub. L. 94-437, as amended (25 U.S.C. 1601, et seq.). The IHS and Tribes provide health care through two types of services: 1.) direct care services that are provided in IHS or tribally operated hospitals and clinics; and 2.) contract health services (CHS) that are provided by private or public sector facilities or providers based on referrals from the IHS or tribal CHS program. CHS services are utilized when a direct care facility is not available, the direct care facility is not capable of providing the required emergent or specialty care, or is not capable of providing the care to medical care workload. CHS services are authorized subject to the availability of alternate resources, such as Medicare, Medicaid, or private health insurance.

While the IHCIA makes references to the CHS program, for example, the establishment of a Catastrophic Health Emergency Fund (separate funding source for the payment for high cost CHS claims), the underlying basis for the CHS program is the Snyder Act. Relying on the general provision of the Snyder Act authorizing appropriations for the "relief of distress and conservation of health of Indians", the IHS established the CHS program by regulations published in 1978. These regulations, revised in 1990 to clarify the IHS Payor of Last Resort Rule, continue as the effective regulations for the operation of the IHS CHS program today. [Footnote: In 1987, the IHS published final regulations revising the eligibility criteria for direct and contract health services to members of Federally-recognized Tribes residing in Health Service Delivery Areas. These regulations were intended to make the eligibility criteria for direct and contract health services the same. However, these regulations remain subject to a Congressional moratorium prohibiting implementation until such time as the IHS conducts a study and submits a report to Congress on the impact of the 1987 final rule. As of this date, a report has not been submitted to Congress.]

The basic eligibility criteria for both direct care and contract health services requires that the person being served is of "Indian descent belonging to the Indian community served by the local facilities and program." For eligibility for direct care services, the IHS has adopted an "open door" policy and does not require residency in the particular Indian community where services are being sought as long as the person is a member or descendent of a Federally-recognized tribe. However, eligibility for CHS requires residency in a Contract Health Service Delivery Area (CHSDA), a geographic area defined by regulation or in statute, but in general, includes the reservation and the counties contiguous to that reservation.

Due to limited CHS funding, CHS regulations require that the services must be pre-approved by the local CHS program and determined to be medically indicated and within medical priorities. If the services are provided in an emergency situation, notification must be made to the local CHS program within 72 hours. The majority of CHS services are authorized for "Priority Level 1: Emergent or Acutely Urgent Care Services." These services are defined in the IHS CHS manual as "services that are necessary to prevent the immediate death or serious impairment of the health of the individual . . . . that if left untreated, would result in uncertain but potentially grave outcomes." Examples of such services include:

- Emergency room care for emergent/urgent medical conditions, surgical conditions, or acute trauma
- Emergency inpatient care for emergent/urgent medical conditions, surgical conditions, or acute injury
- Renal dialysis, acute and chronic
- Emergency psychiatric care involving suicidal persons or those who are a
- serious threat to themselves or others
- Services and procedures necessary for the evaluation of potentially life threatening illnesses or conditions
- Obstetrical deliveries and acute perinatal care

- Neonatal care

Or in simpler terms, the following services, while not inclusive, are services identified by the IHS considered to be emergent or acutely urgent:

Airway obstruction
Abscess
Amputation, traumatic
Anaphylaxis
Asthma, acute

Burns

Cholecystitis, acute
Coma
Concussion
Congestive heart failure, decompensated

Dehydration, severe
Delirium tremens
Diabetic ketoacidosis
Drowning, near

Embolism, cerebral or peripheral
Encephalitis
Epididymitis, acute
Epiglottitis
Eye diseases, acute
Eye injuries

Flail chest
Fractures

Glomerulonephritis, acute
Gunshot wounds

Head injury
Heat exhaustion and prostration
Hemoptysis
Hemorrhage
Hepatic encephalopathy
Hernia, strangulated or ruptured
Hypocalcaemia
Hypertension, crisis or emergency

Lacerations

Meningitis
Menorrhagia, profuse
Migraine, acute attacks
Musculoskeletal trauma, acute
Myocardial ischemia, acute

Obstetrical emergencies
Pancreatitus
Pelvic inflammatory disease
Peritonitis
Pneumonia, acute
Pneumothorax
Poisoning
Premature infant

Pulmonary embolism
Pulmonary edema
Puncture or stab wounds

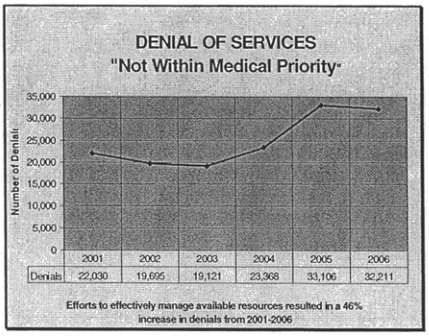
Rape, alleged, examination
Renal lithiasis, acute
Renal failure, acute
Respiratory failure

Sepsis
Shock
Spinal column injuries
Suicide attempt

Urinary retention, obstruction

Other medical priorities include: Priority II: Preventive Care Services (e.g., routine prenatal care, mammograms); Priority III: Primary Secondary Care Services (e.g., specialty consultations); and Priority

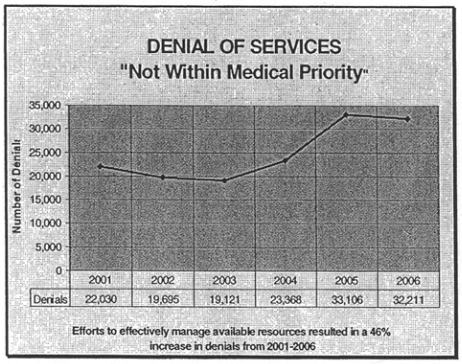
IV: Chronic Tertiary and Extended Care Services (e.g. rehabilitation care, highly specialized medical procedures). For those services that are within medical priorities but are considered "elective" -- not emergent, and are not authorized for payment due to a lack of CHS funding, are considered "deferred" services. In FY 2006, the IHS received 159,000 requests for services that were "deferred" and if they had been approved and paid, would represent $176 million in CHS dollars. The data on the number of deferred services is not consistent among the IHS Areas and is probably under reported. Because in general deferred services are never authorized and paid for, there is little incentive for Indian patients to request the CHS programs to pay for the services. The Northwest Portland Indian Health Board has estimated that due to the lack of data of deferred services, they have estimated that there is probably $300 million of unmet CHS needs in their Area alone, consisting of three States and 43 Tribes. The IHS should abandon this practice of "deferring" services that they know they will not ultimately pay for and simply deny the claims. By denying the claims formally, the IHS would have better data that accurately reflects the unmet CHS needs. And in fact, the following table (produced from the IHS website), shows that in order to manage the limited IHS CHS funds, there has been a 40% increase in the number of denial of services from 2001- 2006.



The lack of CHS funding is exacerbated by the lack of adequate IHS direct care facilities. Many of the facilities were built in the 1930s and are not able to house the necessary equipment and staff to provide

many of the services that are referred out under the CHS program – many of the services could be provided directly by IHS or Tribes if there were up to date hospitals and clinics. The IHS Crow Hospital is an exception, built in the 1990s with modern equipment and adequate space to provide necessary services directly. However, closure of existing emergency rooms, such as that at the Wagner Hospital in South Dakota puts a burden on limited CHS dollars. Indian patients will not have "after hour" care and will have to rely on the community hospital in Yankton.

Finally, authorization of CHS payment is subject to the exhaustion of any available alternate resources. Some Tribal Leaders object to the IHS Payor of Last Resort Rule because AI/ANs should not have to apply for other alternate resources, such as Medicaid, as a condition of receiving health services from the IHS – health care is a responsibility of the U.S. government



Unfortunately, the IHS is a discretionary program, with limited CHS dollars, and until it becomes an entitlement program, is dependent on the availability of other government programs, Medicare, Medicaid or the Veteran's Administration to supplement the CHS program.

It is worthy of note that the often-quoted "Don't get sick after June 1st" statement stems from the time of year that CHS funding is depleted annually. The NIHB Board has embraced the creation of a foundation called "The June First Fund," which would offer Indian people a place to go for funding to access emergency and chronic health care financing that would otherwise be depleted by June 1st. This program is in its infancy and organizational structures are currently under consideration. While NIHB wholly supports sovereignty and recognizes the obligation of the federal government to provide adequate health care services to Indian people, it also recognizes that many Indian people die each year, have amputations that could be avoided and suffer needlessly - all because the federal obligation to provide health care services is not met.

Montana and Wyoming Perspective

Each year the Tribes participate in an HHS Department-wide budget consultation process. Through this process, the Tribes work on an Area basis, to determine their priorities for the coming year. In 2007, the Montana/Wyoming Tribal Chairman's Council determined that they would advance only one priority: increased funding for Contract Health Services. This unprecedented decision highlights the magnitude of the importance of this program to the tribes in Montana and Wyoming.

The lack of stability and access to contract health services has created a culture of hopelessness for the members of Montana's tribes. After experiencing years of long waiting lines, deferred or denied services and no follow-up care for long-documented ailments, a culture of hopelessness has evolved. What this means for many tribal members is that they will no longer seek the health care they need because they do not believe that their needs will be met. In addition, many Tribal members express fear of doctors using who have not been trained in Tribal community laws and customs and the Tribes look forward to working with IHS to address this very solvable obstacle to health care. In short, it has become the common

understanding among tribal people that you don't bother going to get health care for problems that mainstream Americans would consider extremely serious because in our experience the needed care is not available. Problems with orthopedic and other injuries being addressed with self-care, patients neglecting to see an optometrist because eye glasses are not available, cuts and abrasions are just some of the health care issues for which Tribal members are likely not to seek care. On the reservation, word of mouth on about health care access spreads throughout the community. For example, a patient with an ankle injury goes to the clinic to get an x-ray and is told that there is no x-ray machine available. The individual asks for help because they want to heal enough to play basketball the following week – or their injury will prevent them from working. He is offered ibuprofen for the injury and then wraps his own ankle at home. After this experience it is unlikely the individual will seek additional health care. In addition, it is unlikely that those who know about his experience will believe that they will receive better care than he did, and so are unlikely to seek care when they need it.

One of the real challenges Tribes face, and with which it needs assistance, is ensuring IHS is keeping access records that can be used to measure incidents of unmet health care needs, progress over time with meeting these needs and how many patients never return for health care. This is critical data because it provides a baseline for defining health care access issues and instructs Tribes and the organizations that represent and support them with tracking progress, requesting appropriate funding to address demonstrated need and with measuring progress. This type of surveillance is inconsistent across the nation and is lacking in the Billings Area. For example, under the Contract Health Services program if a tribal member seeks care and the care is deferred – what is the outcome of the deferral? The IHS Areas are not required to keep track of these deferrals; therefore, it is not possible to ascertain how many patients did not receive care, the diagnosis for which care was deferred, whether care was eventually provided and what should be done to attempt to secure alternative care for these patients. All of this data is essential to demonstrating any measurable improvement in Indian health care. Without it, how can we know what is to be done to help Indian people and address their health care needs?

Congress can require that this data is kept nationally and we request that Congress does so.

The Special Diabetes Program for Indians provides an excellent model for the value of surveillance. Through this program, the incidence of Diabetes among American Indians initially increased. This was due to the new commitment of resources for surveillance. Similar programs should be developed for services provided through Contract Health Services.

We will discuss the obstacles faced by Montana's tribal members seeking orthopaedic care to demonstrate the consequences lack of access to needed specialty care through CHS means.

Orthopaedic Health Care in Montana

It came to the attention of the NIHB that orthopaedic health care for American Indians in Montana was among the worst, if not the worst, in the nation. As a result, NIHB began examining methods through which it might serve as a conduit to get needed orthopaedic care to the Tribes in Montana. NIHB's Native American Orthopaedic Initiative began late last year with meetings between NIHB, IHS and the American Academy of Orthopaedic Surgeons. NIHB immediately followed these meetings were a meeting with Tribal Leaders in Montana, along with the Executive Director of the Wyoming/Montana Tribal Chairman's Council, the IHS Area Director and Area Medical Director, Dr. Joseph Erpelding, a Billings-based, private practice orthopaedic surgeon with many years of experience with the CHS system and with serving Indian people and the Billings Area Tribal Epicenter. The purpose of this meeting was to ensure that the program is something the Tribes would embrace and that IHS would support. The meeting was a success. NIHB then followed up with the AAOS as an invited speaker before its Diversity Advisory Board. The Diversity Advisory Board listened to NIHB's proposal to work with the Academy to identify orthopaedic surgeons who would commit to providing voluntary orthopaedic health care in Montana. The result, to date, is that a member of the Diversity Advisory Committee will attend the NIHB National Consumer Conference, which takes place in

September in Portland, Oregon, and meet with the NIHB Board of Directors to discuss the proposal. Let us be clear that it is the lack of adequate funding for CHS that lead NIHB to undertake this initiative. As with the June First Fund, NIHB recognizes that it is the obligation of the federal government to provide adequate health care to Indian people; however, while we will continue to vigorously work to advance the health care of all American Indians and Alaska Natives, it is no longer possible to wait while Indian people suffer. We are very hopeful that this "doctors within borders" discussion with the American Academy of Orthopaedic Surgeons will blossom into a successful, humanitarian project and create a national model that will offer hope to all American Indians and Alaska Natives.

As a sworn witness in this field hearing, Dr. Erpelding will discuss his data, experiences and recommendations regarding the orthopaedic health disparities among American Indians in Montana. He will provide an overview of the trends he sees in orthopaedic health care for Montana's Indian population, the consequences of delayed orthopaedic health care, such as pain killer addiction (>60%), secondary diseases that result from inactivity due to untreated musculoskeletal injuries and the consequences of a decrease in health care opportunities for Indian People. In addition to the physical consequences of poor care, it is critical to note that orthopaedic injury often leads to decreased employment and employability. Finally, he will offer suggestions for solving these difficult problems.

Appropriations and Budget Recommendation: Keep IHS Funding Separate from Medicare and Medicaid Revenues

Considering Medicare and Medicaid collections as part of the IHS budget is in direct violation of the Indian Health Care Improvement Act.

The Indian Health Service FY 2008 Budget Request – Congressional Justification includes specific amounts of Medicare and Medicaid collections (total of $625,193,000) as part of its total FY 2008 President's Request of $4.1 billion. The budget justification clearly takes into consideration the Medicare and Medicaid estimates from prior years in determining the budget justifications for the next fiscal year. The consideration of Medicare and Medicaid collections is in direct violation of the Indian Health Care Improvement Act. In 1976, Congress gave the IHS specific authority to bill for and receive Medicare and Medicaid reimbursement for services provided to Medicare and Medicaid-eligible American Indians and Alaska Natives. As part of this authority, Congress did not intend for Medicare and Medicaid collections to replace existing IHS appropriations; rather, it was meant as a supplement to IHS appropriations to meet Medicare and Medicaid accreditation and compliance standards.

This is clearly stated in the law. For example, 25 U.S.C. 1641 (a) states that "any payments received by a hospital or skilled nursing facility of the Service (e.g., IHS) (whether operated by the Service or by an Indian tribe or tribal organization pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A. 405f, et seq.] for services provided to Indians eligible for benefits under title XVIII of the Social Security Act [42 U.S.C.A. 1395, et seq.]) shall not be considered in determining appropriations for health care and services to Indians.

25 U.S.C. 1642 (b) states "any payments received by such facility for services provided to Indians eligible for benefits under title XIX of the Social Security Act [42 U.S.C.A. 1396, et seq.] shall not be considered in determining appropriations for the provision of health care and services to Indians."

Therefore, we request that Congress consider these facts when making decisions about budget resolutions and appropriations for Indian health care.

By making the request for $625 million additional dollars, the Administration clearly stated that this is part of what the IHS needs to fulfill its responsibilities. We agree.

Removing the Medicare and Medicaid revenues from the IHS budget request while maintaining their requested amount would lead to the correct assumption that IHS needs an additional $625 million. Indian County would certainly like to see these additional funds invested in Contract Health Services and ensuring that facilities are adequate to providing this care.

Closing

Thank you, again, for holding this field hearing on Indian health care issues. Please work with the National Indian Health Board and the Tribes to:

- Achieve passage of the Indian Health Care Improvement Act during this Congress;
- Ensure that the Contract Health Services system is adequate to meet the needs of our People. Specifically, please ensure that program funding and practice meet;
- Ensure that IHS keeps accurate and detailed records about deferred and denied CHS services with Congressional oversight;
- Ensure that this IHS surveillance is uniform nationally;
- Support Tribal efforts to promote cultural competency among health care providers;
- Support private efforts, like the June First Fund and the Native American Orthopaedic Initiative.
- Continue to listen to the Tribes.

Thank you.

Senator DORGAN. Mr. Killsback, thank you very much. I have read ahead of you in your testimony and you have provided, I think, some very important data and statistics on these issues. We appreciate that very much.

I'm sorry to ask you to summarize at the end, but we have so many witnesses and I want to make sure all of them have an opportunity, but I want to thank you for putting together about 12 pages of some very useful information about Wyoming, Montana, about some of the data that we are seeking, so thank you very much.

And Ms. Bohlen, thank you very much for bringing Mr. Killsback and Dr. Erpelding with you as well.

Dr. Joe McDonald is with us and we will hear next from Dr. Joe McDonald, President of the Salish Kootenai College.

Dr. McDonald, thank you very much, and as I indicated to others, you may summarize and your entire statement will be made a part of the permanent record.

DR. JOSEPH F. MCDONALD, PRESIDENT, SALISH KOOTENAI COLLEGE

Dr. MCDONALD. Honorable Jon Tester and Mr. Chairman, my name is Joe McDonald, I'm the President of the Salish Kootenai College. It's really an honor to appear before you today and provide this testimony. I thank you very much.

And I extend a special thanks to Chairman Venne and the Crow Tribe for hosting this field hearing and nice lunch and the nice facility you have here and the excitement of the celebration that's about to begin.

I can't say enough about the need for recruitment of American Indian people into the medical provider professions, ranging all the way from CNAs to medical doctors.

It's difficult to recruit these people into our rural areas and get them to stay. And I think if we could recruit members of tribes and have the tribal colleges provide the training, that they would come and they would stay, and we would not have the shortage that we have on our reservations. I think they would provide consistent service.

At Salish Kootenai College, we have been offering nursing for about 18 years now, and we've had 400 and some nurses graduate, 200 and some have been American Indian nurses. Our passing grade on the Implex has been over 90 percent.

They told us when we started that, you know, Indians couldn't pass that test. They said, Joe, after all, they have to take this test. Well, we do take it and we do it well.

The doctors say that our nurses are very good. You go to the hospitals in our western Montana, they say, Joe, you've really got some great nurses there. And so the Indian people can do this, and they can do it well.

We have nurses working here at the Crow Hospital, as we have at all the IHS facilities, Indian Health Care facilities in Montana and much throughout Indian Country.

When we started our program in 1989, our research showed that there was one American Indian in nurses training in Montana that year. This year, just this year, we'll have 46 American Indian students in our classes in Salish Kootenai this fall.

So given a chance, the American Indian students, they will enter the field, they will take on the challenge of becoming a nurse.

We also have a dental assisting technology program. We hoped it could grow into a dental hygiene program, but it hasn't to this stage, but they do take the licensure to be certified dental assistants and they're working throughout the southwest. We have some even in Alaska and in dental clinics around our reservations.

There's a need to have more of these programs, licensure programs in many medical fields, such as dental hygiene, occupational therapy, all the different x-ray programs, the medical records technology, all of them. There's a tremendous need for that.

We in the tribal colleges could do that well if we just had the resources. We can do the training, and we can do the recruiting if we have the resources.

Health care in Montana is one of the fastest growing areas of employment. It's one of the biggest employers in Ronan, and provides one other opportunity for Indians to get employment.

In order to do the recruitment, our K–12 students need to be encouraged to think about these health care programs, and appropriate classroom instruction is needed and counseling is needed to build confidence and competence so that the Indian students at the sixth grade level, seventh grade level decide that I'm going to be a nurse or I'm going to be a doctor or I'm going to be a x-ray technician, or whatever it might be, because they can do that.

We need to build a pipeline, a pipeline in Indian Country that will go from kindergarten all the way through the chosen profession.

Once students are recruited in the program, they need help to overcome a lot of barriers and problems that they encounter.

Finance is certainly a problem, individual finance is a problem. Many of the students come that need help in basic skills, college skills. They need to complete prerequisites before entering the nursing program. A lot of times they burn up a lot of their Pell grant eligibility getting ready to enter into the nursing program.

Once they enter the nursing program, the study demands are enormous and they need confidence building, they need a pat on the back, they need a push and support.

The graduating nurse must be very skilled and very confident, and we can't cut any slack with them because they have to be good and they have to be very good.

The costs of the college for the health care provider training are much greater than the average other programs that we offer. At Salish Kootenai College we really struggle to find the fiscal resources and the instruction staff to maintain the nursing program.

Every year as we get into the budgeting, part of the program is on the chopping block. We have not done it; we have been struggling with being able to meet those needs.

Our salaries are not adequate. It's tough to recruit them with the salaries we pay. We have an opportunity right now to recruit an American Indian nurse that's been completing her doctorate degree. We'd like to have her come back, but I'm not sure that we could negotiate or get through that.

So, I believe that Indian students can be recruited and retained if given the opportunity, that retention of the student depends on adequate funding for the college to provide the program.

I think the solution is to continue to adequately fund the Tribal College Act, and I know that you've been a leader in that, and if we could just get our funding equal to the state allocation averages for 2 and 4-year mainstream colleges, we would be doing well.

I'm pleased to hear that the legislation, THE PATH, has been introduced, because I think that's going to be a big help. I'm also pleased to hear that the Indian Health Care Improvement Act, Improvement Reauthorization Act is going to be marked up.

We have suggested some amendments to it. I understand many of them have been included. I've included that in my testimony that we have suggested it, so I really do thank you for that.

So, Mr. Chairman and Senator Tester, we thank you for inviting us and for considering any of our suggestions in the amendments.

In closing, I want to extend my sincere thank you for your commitment and hard work in support of our nation's tribal colleges and Indian tribes.

I think that both of you are true role models for lawmakers, and I really appreciate it.

Thank you very much for taking this time.

[The prepared statement of Dr. McDonald follows:]

PREPARED STATEMENT OF JOSEPH F. MCDONALD, PRESIDENT, SALISH KOOTENAI COLLEGE

Honorable Senators John Tester and Byron Dorgan,

It is an honor to appear before you and offer this testimony. Thank you very much. I also extend my thanks to the Crow Tribe for hosting this field hearing.

There is a need to recruit American Indian students into the various medical provider professions ranging from LPN's to medical doctors. It is difficult to recruit skilled medical professionals to work in our rurally isolated Indian communities. The most efficient way is to recruit, and train American Indian medical staff. They are more willing to serve on their reservations and will provide consistent service to their communities.

At Salish Kootenai College we started a nursing program in 1989. Thus far we have graduated 432 nurses, 202 are American Indian nurses. Our passage rate of NCLEX certification examination has averaged over 90 percent. Our American Indian nurses that have graduated from Salish Kootenai College serve the hospital here at Crow Agency as well as the hospitals on the Blackfeet Indian Reservation, the Fort Belknap Indian Reservation, the health service agencies on each reservation, private hospitals, nursing homes, and home health agencies throughout Montana.

When we started our nursing program in 1989 there was only one identified American Indian student in nursing programs in Montana. This fall we will have 46 American Indian students in our nursing education program. We will also have 41 non-Indian students.

We also have a training program for dental assisting technology. Graduates of the program are eligible to take the Licensure Examination and become certified dental assistants. Our graduates work in Indian dental clinics throughout "Indian Country" and Alaska. Some go on to become dental hygienists.

There is a need to have educational programs that lead to licensure in other medical fields such as dental hygiene, occupational therapy, x-ray technicians, laboratory technicians, medical records technology, and many others.

Health care is one of the fastest growing areas for employment in Montana. It provides a great opportunity for employment for American Indian people.

Our K–12 students on our Reservations need to be encouraged to think of working in the health care field. Appropriate classroom instruction and counseling is needed to build confidence, competence, and desire to pursue a career in the health care field.

Once students are recruited into the program, they require help to overcome the many barriers and problems they encounter. Individual finance is a problem. In addition to family maintenance, students have the cost of going from Pablo to Missoula or Kalispell for their hospital practicum. Tutoring is needed, and counseling services are a necessity.

Many of the Indian students that come need help in basic college skills and need to complete prerequisites before entering the nursing programs. Once they enter the nursing program, the study demands are enormous. The graduating nurse must be very skilled and competent.

Costs to the college for health care provider training are much greater than for most training in fields of study.

At Salish Kootenai College we really struggle to find the fiscal resources and the instructional staff to maintain our nursing education programs. We are competing poorly for faculty salaries and our turn over rate of nursing instructors is much higher than for the rest of our college.

In summary, American Indian students can be recruited and retained in health care professions such as nursing. Retention depends on adequate funding for the student and adequate funding for the college providing the program. Continuing to increase the funding of the Tribal College Act would be a great help and would get tribal colleges funding equal to the state allocation averages for 2 and 4 year mainstream institutions.

The passage of the legislation, S. 1779 entitled *THE PATH* will help greatly also. It is an Act that will help prepare an American Indian health workforce, improve health and wellness of students and their families, and combat substance abuse. It has been introduced by you two Senators and I thank you for it. And I speak for all of our colleges in extending thanks to you.

Passage of the Indian Health Care Improvement Reauthorization Act of 2007 will provide valuable assistance to our tribal colleges. We have asked for some amendments in the legislation. The amendments address: (1) delivery of health training programs; (2) recruitment and retention of Native American nurses in our associate and bachelor degree programs; (3) scholarship payback options that would allow payback to include teaching in a tribal college nursing program; and (4) addition of a provision that would authorize TCU-based social work and psychology degree programs.

The specific amendments are as follows:

"SEC. 104(b)(1) INDIAN HEALTH PROFESSIONS SCHOLARSHIPS, ACTIVE DUTY SERVICE OBLIGATION—OBLIGATION MET"

Add a subsection (D) to read "In a teaching capacity in a tribal college nursing (or related health profession) program."

"SEC. 113. INDIAN RECRUITMENT AND RETENTION PROGRAM."

Add a subsection (c) to read: "Tribal college health education programs shall be accorded priority for funding pursuant to this section."

"SEC. 115(d) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM, PREFERENCES FOR GRANT RECIPIENTS"—

Add a subsection (5) to read: "Programs conducted by tribal colleges."

"SEC. 115(f) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM, ACTIVE DUTY SERVICE OBLIGATION"—

Add a subsection (5) to read: "teaching in a tribal college nursing program."

"SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES. (a) GRANTS TO ESTABLISH PROGRAMS—(1) IN GENERAL—

It is essential to recognize that several tribal colleges, including Salish Kootenai College, are accredited as 4-year institutions of higher education by regional accrediting associations, rather than classified or accredited as "community colleges." Construed to its logical extreme, Salish Kootenai College could arguably be considered ineligible for a training grant under this section, notwithstanding that it is a community college in the more global sense. We do not think this is Congress' intent. We therefore recommend modifying the first sentence of this subsection to read:

> "The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges or tribal colleges for the purpose of assisting such colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on or near a reservation or in an Indian Health Program."

We further recommend that this language change be reflected in subsection "118(a)(2) AMOUNT OF GRANTS,"—which should also increase the minimum annual grant award, as follows:

> "The amount of any grant awarded to a community or tribal college under paragraph (1) for the first year in which such a grant is provided to the community or tribal college shall not exceed $250,000."

The rationale for the increase of the first-year ceiling level from $100,000 to $250,000 rests with the fact that it is virtually impossible to adequately or credibly initiate a health career-training program with $100,000. This low amount is a set-up for failure from the beginning and accordingly needs to be increased.

Also, the term "or tribal college" should be inserted after the phrase "accredited and accessible community colleges" or "community college" in Sections 118(b)(1), (2), and Section 118(c).

Under Section 118(b)(2)(C)(i), strike the word "advanced" before the phrase "baccalaureate or graduate", as it is redundant, confusing, and unnecessary.

As to Section 118(a) and (b), we urge that language be added to the effect "Priority for the award of funds under this subsection shall be accorded to accredited tribal colleges with nursing programs."

Finally, for purposes of consistency, we recommend that the title of Section 118 be changed to read: "HEALTH TRAINING PROGRAMS OF COMMUNITY OR TRIBAL COLLEGES."

"SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS"

We recommend that tribal college social work and psychology programs be added to this section. In the case of Salish Kootenai College, our former substance abuse program has been incorporated in our new social work program. This appears to be the trend. The same holds true for psychology programs, which have essentially incorporated former stand-alone substance abuse curricula under the psychology rubric.

"SEC. 126 (c) TIME PERIOD OF ASSISTANCE; RENEWAL"

A 1-year period is simply too short of a timeframe to administer or renew an academic program. Accrediting agencies require a minimum of a 3-year timeframe for approval of any new program. These types of programs are two or 4-year programs, *i.e.,* multi-year. Program and student learning outcomes (and academic planning and assessment, and budgeting) are accordingly based on multi-year timeframes, usually 3–5 years. In short, a 1-year life period is wholly unrealistic from all relevant perspectives.

Mr. Chairman, we thank you for considering our concerns regarding these much needed amendments to the Indian Health Care Improvement Act. We respectfully ask you to include this letter in the record of the Committee's mark-up of S. 1057.

In closing, please accept my sincere thank you for your longstanding commitment, hard work, and support of our Nation's tribal colleges and Indian tribes. You are a true role model for lawmakers, and we will forever appreciate your service. My kindest regards.

Thank you for taking the time to hear about health care for American Indians.

Senator DORGAN. Dr. McDonald, thank you very much.

Let me mention, as I prepare to recognize Ada White, that THE PATH legislation that you referred to is legislation that Senator Tester and I have jointly introduced in July.

Senator Tester has added a great deal with this idea to the opportunities in education, and I am proud to be a partner with him and we intend to push it. And I think it's a testament to Senator Tester's concern and aggressiveness on these issues. So thank you very much for mentioning that.

Next we will hear from Ms. Ada White, the Health Service Director of the Crow Tribe.

Ms. White, if you will pull the microphone very, very close, and you may summarize and your statement will be part of the record.

STATEMENT OF ADA M. WHITE, HEALTH SERVICE DIRECTOR, CROW TRIBE

Ms. WHITE. Good afternoon, distinguished members of the U.S. Senate. I am welcoming you to Crow Country, and I thank you for this great opportunity to provide testimony on behalf of the Crow Tribal health concerns.

As stated earlier, my name is Ada White. Like many people in this room, I have devoted most of my life to working for the Crow Tribe. I can find a lot of value in the fact that we've had a lot of development, and I've been with the tribe for over 36, 37 years.

I share this information because I want to illustrate my passion and commitment to the health and welfare of the Crow people. Throughout my years of being involved, I have always worked to strengthen tribal sovereignty, to further tribal self-determination,

and to remain vigilant in helping enforce other Federal trust responsibilities.

Senator Dorgan and Senator Tester, and other members of the Indian Affairs Committee, I commend your commitment to Indian Country. I commend your vigilance in watching what's happening on Capitol Hill, protecting our interests.

In particular, I am certainly indebted to your work in working for the reauthorization of the Indian Health Care Improvement Act, working on a special diabetes initiative, and also keeping in the forefront that it is the responsibility of the Federal Government to honor trust agreements, trust responsibilities as it relates to health care.

Unfortunately, this is a challenge that we must continually work on, and that is to dispel the myth that scheduled ordinance provision of Indian health care is optional. And as we have heard from a speaker alluded to earlier, health care is a must; money is a must to develop health care.

And as stated by my colleague from the Fort Peck Reservation, James Melbourne, he and I spoke, he says the issue of entitlement versus discretionary funding must be addressed by Congress.

Health care provider for the Federal Government, as stated earlier, is based on the various acts and treaties, and for the Crow Tribe, it's the 1868 Treaty at Fort Laramie, the 1904 Crow Tribe Federal agreement and the 1920 Crow Allotment Act.

Despite all this, today we are facing that fact that Indian Health Service is appropriating less than half of the necessary funding to provide basic medical services for the Crow people.

I bring to your attention, and I've attached it to my testimony, a recent article entitled "Cardiovascular Risk Factors in Montana—American Indians With or Without Diabetes."

The rationing of health care for American Indians described in the recent Institute of Medicine report on racial and ethnic disparities, emphasizes the lack of resources for preventive care in this population. And certainly we know that we get a lot of lip service on prevention, but when it comes to providing money for the actual provision of those activities, we have no funds.

I am now going to direct my comments to the health care as it is, as we experience it here on the Crow Reservation. And I know that in the audience, Crow people are listening to how I cover this topic.

You have been inundated with statistics. I can see them coming out of your ears. I know that's all you hear in Washington, D.C. Today, I am going to present some real information as to what it means for Crow people to receive health care.

And before I do, I know that my comments and my observations may be perceived by some as bashing of Indian Health Service people, however, I want to take this time to commend the highly committed, the deeply compassionate and under appreciated health care professionals who serve our community.

However, I must be honest about dire conditions that exist here on Crow Reservation so that we may work together to address the problems. And as alluded to earlier, these problems are apparent in all of the reservations within the Billings Area.

I direct your attention to a meeting held in Billings, Montana August 2, 2006, wherein Dr. Charles Grim, the Director of the Indian Health Service, was asked for improved health services. Dr. Grim responded, quote, "Indian Health Service, people are the services." So what does that do when you look at Indian health care, that means we look at people providing those services within the IHS system.

As has been shared, in June of 2006, the Crow service unit fiscal deficit was approximately 4.3 million. At a meeting yesterday, I was told that the deficit is 12.3 for this year. I asked at that time, have you resolved that 4.3 deficit, and no, it has not.

That just illustrates the accumulation of the deficits that have gone on here at the Crow service unit historically.

I remember several years ago, I asked a question to the acting Service Unit Director about personnel and project costs. Again, I quote, "67 percent of the local budget was applied to personnel salaries."

I remember a comment that our esteemed chairman asked Dr. Charles Grim in Billings. He said, "If there are no funds for pay raises, why give it?" Dr. Charles Grim at the time responded that he got that money from third-party reimbursements. And we know that third-party reimbursements is a collection activity that sometimes is realized, most often not.

Again, at the same meeting in Billings, Montana on August 7, 2006, Billings Area IHS Director Pete Conway stated, quote, "As the dollar get's tighter, there is a need to find ways to cut in other areas." The implications of this statement are evidenced in many areas.

For example, one, according to Indian Health Service, there has been a 46 percent increase in denials from Indian Health Service for services through the contract health service program from 2001 to 2006. In an article in the *Great Falls Tribune,* IHS stated that it's an effort to budget the funds available efficiently.

Two, the deferred contract health service list increases daily. For those waiting in excess of several years and living in constant pain, there is often prolonged use of pain medication that cause a host of other medical problems, which may too go unaddressed due to the lack of funding.

As people like to say, "if it ain't broke, don't fix it." In this case, CHS is beyond repair. We pose a challenge for the decisionmakers in IHS to explore other options. If the CHS system is not working, come forth with something else that will.

Third point, prescriptions originating from contract health care referrals are not filled locally. Over the counter medications are not provided locally. Certain drugs have been eliminated. The result is that financially strapped individuals are unable to purchase needed medications that have been prescribed for them.

Many of us in here are working, but there are many Crow people living out there that have very little money to purchase over the counter medications. A member of the Crow legislative body brought to my attention the fact that his wife cannot get the arthritis medication that she had been receiving for treatment prior years.

I go on to point four, access to proper health care is inadequate, and in many cases, is denied. I know every Crow person in this room listening to this testimony can provide examples of the deficiency and lack of health care, and I encourage those persons to share their stories with members of the Senate Committee.

I will personally at this point share with you two cases involving members of my family. Additionally, I will be providing several more copies of letters that have been provided for me.

Senator DORGAN. Ms. White, I want you to share both of those cases, and then following that, I need to have you summarize because we have to have the other testimony.

Ms. WHITE. Thank you. Thank you.

Senator DORGAN. But why don't you share both of those cases.

Ms. WHITE. First, you have here a very cute little girl in her native outfit, that was very hard work, good to see, but difficult. People say there is a thousand words in pictures. I show this picture of my 5-year-old granddaughter. This was taken at the Lodge Grass Pow-Wow last July. My granddaughter left us, she died short of a year ago.

From May, 2006 to August of 2006, numerous visits were made to the clinic at Crow. During this time, Ta'shon (phonetic) was treated for depression. During one of her clinic visits, Ta'shon's grandfather pointed out the bulbous condition on her fingertips and toes, which is indicative of a lack of oxygen.

In June, 2006, I spoke with Ta'shon's doctor and asked the doctor to eliminate cancer and leukemia. On August 7, 2006, my granddaughter was rushed from the Crow clinic to St. Vincent Hospital in Billings due to a collapsed lung.

She was airlifted to Denver. After being there 5 days, we were told that she had a tumor that was untreatable and incurable. She died on September 1st.

The point is, if she had been diagnosed earlier, could some of that have been prevented? I believe she spent the last 2 years of her life in unmedicated pain. One premature death of a child who suffered excruciating pain is too much for the conscience.

Case two, Ta'shon's great-grandmother, Ada Rides the Horse was brought to the Crow Emergency Room, waited 3 hours, taken by her daughter to the Hardin Clinic, transferred from the Hardin Clinic to St. V's, she died in the Emergency Room from a ruptured aneurism.

The RN who was working at the Crow Emergency Room says later to Ada's daughter, I'm sorry, if I would have known, I would have taken your mother right in.

Those are the two stories I'd like to share. There are other points here. We have received a lot of information. We compliment you, the support that you have given us.

Pryor people, Lodge Grass people are concerned about the continual discussions about the possibility of closing those clinics, and again, the same financial considerations exist. People do not have the money to come to Crow.

Again, you will get all the information, and I present this to the Committee.

Thank you very much.

[The prepared statement of Ms. White follows:]

PREPARED STATEMENT OF ADA M. WHITE, HEALTH SERVICE DIRECTOR, CROW TRIBE

To the august Members of the U.S. Senate, serving on the Senate Select Committee of Indian Affairs, welcome to Crow Country. On behalf of the Crow Tribal Members, I thank you for this opportunity to provide Crow Tribal Health concerns to this esteemed Body.

My name is Ada White, I am a member of the Crow Tribe, and currently employed by the Crow Tribe as the Director of the Crow tribal Health Department. Previously, some 17 years ago, I worked in Tribal Health, as the Director of the Community Health representatives Program for nineteen years. I briefly worked for Indian Health Service for 18 months, and returned to Crow Tribal Employment in the Administrative Department (Finance, Social Services and Administrative Officer) for 10 years. I then became employed by the Little Big Horn College as the Grants and Contracts Officer for 3 years, and have been back with the Crow Tribe, at the Health Department for an additional 4 years. I share my employment history for the sole purpose in validating the commitment and involvement I've had in the various aspects of Tribal Health development. Throughout these years, the maintenance and protection of the Federal Trust Responsibility; the strengthening of Tribal Sovereignty, and the enhancement of Tribal self-determination have been dominant in my endeavors.

Senator Dorgan, Senator Tester and other members of the Senate Committee on Indian Affairs, I commend your vigilance, in assuring the Indian Tribes of this Country that Indian Health Care is a Federal Trust Responsibility.

However, as Tribal Groups continue to work with the Federal Government, this Trust Responsibility must be promulgated and enforced. According to my Colleague (James Melborne) from the Ft. Peck Reservation, "the issue of entitlement versus discretionary funding must be addressed by Congress."

On July 3, 2007, an article in the Great Falls Tribune stated, "access to and the availability of health care for the First Americans of this Nation was a trust contract in the Constitution in 1787." Certainly, Members of the Crow Tribe firmly believe health care is assured in the Ft. Laramie Treaty of 1855.

We are also cognizant of this Great Nation's growing pains in affording basic human rights to its citizenry: the need for the Civil Rights Act; the need for the Voting Rights Act (there is a pending case here in Big Horn County, filed by the Citizens Equal Rights Alliance a right winged group alleging "denying non-tribal members an opportunity to participate effectively in the political process on an equal basis with other members of the electorate. ."); the list can go on and on. To those associated with the current Administration in Washington, D.C. alleging "race based" considerations, I strongly urge their perusal of printed materials and studies which document racism in the delivery of health care; race based discrepancies in health care and funding restrictions prohibiting resource parity.

I quote from an article, CARDIOVASCULAR RISK FACTORS IN MONTANA AMERICAN INDIANS WITH AND WITHOUT DIABETES, "Yet the rationing of health care for American Indians described in the recent Institute Of Medicine Report on Racial and Ethnic Disparities emphasizes the lack of resources for preventive care in this population." A dichotomy is self-evident wherein a major study indicates a lack of funding for preventive care, and Indian Health is emphasizing Health Promotion and Disease Prevention. Or, most likely it's the "catch up" syndrome.

Honorable Senators Dorgan and Tester, we know you are monitoring this race based phenomena very closely, and you have voiced your displeasure, and for this we are most grateful.

I will now proceed in localizing my observations to the Crow Tribal Health Care concerns. Let me emphasize, that my observations and comments are not to be interrupted as "Indian Health Service Bashings." I know we have many Health Professionals highly committed, deeply compassionate and under recognized for their services.

HEALTH CARE MEANS ACCESSING HEALTH RESOURCES. HEALTH CARE MEANS THE PROVISION OF HEALTH SERVICES. BEING HEALTHY MEANS A CONDITION OF WELLNESS, OR FEELING WELL.

At a meeting in Billings, Montana, August 2, 2006, Dr. Charles Grimm, the Director of Indian Health Service was asked about the prospect for improved health services, and his response was, "Indian Health Service people are the services." So this leads one to focus attention on "the people."

THE CURRENT STATE, RELATIVE TO HEALTH CARE, OF THE CROW INDIAN HEALTH SERVICE HOSPITAL AND CLINICS HAS EXCEEDED THE CRISIS MODE. What is being provided by Indian Health Service is woefully inadequate and can be classified as scandalous, unconscionable.

Approximately 3 years ago, the Acting CEO of the Crow Service Unit stated that "67 percent" of the local budget was applied to personnel salaries.

June 2006, Indian Health Service indicated the Crow Service Unit fiscal deficit was approximately 4.3 million.

August 2, 2006 at a meeting in Billings, Montana, Mr. Pete Conway, the Director of the Billings Area Indian Health Service stated: "As the dollar gets tighter, there is a need to finds ways to cut in other areas." What implications does this comment bear locally, Consider:

1. According to Indian Health Service, there has been a 46 percent increase in denials from Indian Health Service for services through the Contract Health Service Program from 2001 to 2006. It's an effort to budget the funds available, $520.5 million in Fiscal Year 2006 efficiently" (Great Falls Tribune Article, July 3, 2007).

2. The deferred Contract Health Service surgical list increases daily. For those waiting in excess of several years, and experiencing continual pain, prolonged usage of pain medication leaves other undesirable results.

3.Prescriptions originating from Contract Health Care referrals are not filled locally. Over the Counter Medications are not provided locally.

Financially strapped individuals are unable to purchase needed medications. Is this a National policy for all Indian Health Service Facilities?

4. Access to proper health care is inadequate or in some cases denied. Each Crow Person in this room, listening to this testimony, can provide examples of unanticipated results of this concern. I personally share with you the following two cases.

Case One: My 5 year old granddaughter, Ta'Shon Rain Little light, died September 1, 2206. From May of 2006 to August 7, 2006, numerous visits were made to the Crow Clinic for services. During this time, Ta'Shon was being treated for depression. During one of the Clinic Visits, Ta'Shons Grandfather pointed out the bulbous condition of her finger tips and toes. This condition is indicative of a lack of oxygen. June 2006, I spoke with Ta'shons Doctor and I asked the Doctor to eliminate cancer and leukemia. August 7, 2006, My Granddaughter was rushed from the Crow Clinic to St. Vincent Hospital in Billings, Montana for a collapsed lung. The next day Ta'Shon was air lifted to the Denver Children's Hospital, where she was diagnosed with an untreatable, incurable form of cancer. The question remains, what if this tumor was detected earlier, would it have made a difference? Our baby lived with unmedicated pain, the last 3 months of her life. Even one premature death is too much.

Case Two: June 2003, Ta'Shons Great Grandmother, Ada Rides Horse visited the Crow Emergency Room for stomach pain. After a wait of 3 hours, her daughter transported her to the Hardin Hospital (12 miles NW of Crow) for care. Ada Rides Horse was admitted, and then transferred to the St. Vincent Hospital in Billings, where she died in the Emergency Room from a ruptured aneurysm. The ordeal did not end here. The RN who was working in the Crow Emergency Room later approached Ada Rides Horse' daughter and said: "I'm sorry, if I were clairvoyant, I would have taken your mother right in."

5. The excessive waiting time for services (Out Patient Clinic, ER, Pharmacy) needs to be addressed. Throughout the years, the local facility has tried to modify some of the national trends and adapt them for local operations, but rather that producing a positive result, the bureaucratic stratum increases. Case at hand is having a walk in clinic; add walk in clinic plus a speciality clinic; add walk in clinic, speciality clinic, plus prescheduled appointments with specified providers. Tuesday, August 8, 2007, I waited 3 hours at the Out Patient Clinic, then I was called to the ER for care. The waiting continues, patients become angry, and providers become defensive.

The problem in waiting, and not having enough providers on a given day could be addressed by having some of the professional health administrators, including the Commissioned Officers Corp provide some "hands on" care. Again, I am reminded of Dr. Grimm's Statement that Our health care is the "Indian Health Service People."

I inquired about the list of Medical Professionals posted on the wall in the Crow Waiting Room, and the ER Nurse stated that "½ of them have left." This may be so, however, three of the current Physician's are employed part-time (Wilson, L.

Byron, Upchurch). This certainly affects the level of care, and may also affect the recruitment process, because it ties up 1.5 positions.

Our distinquished Crow Tribal Chairman, Mr. Carl Venne asked Dr. Charles Grimm, the Director of Indian Health Service, "if no additional funding is provided for pay raises, why give it?" Dr. Grimm responded, "We make up for this with third party reimbursements." What impact does the fluctuations in third party collections have on this reasoning? Futhermore, a pay and time audit may be necessary to fully understand the issues surrounding employee pay. What we do know is that the salary and benefits for Commissioned Officer Corp Members runs much higher than it does for a Civil Service Employee.

There are several other concerns that impact the level of resources, which impacts the level of care.

1. It has been reported to the Crow tribal Health Board that non-beneficiaries receive treatment at the Crow facility. The concern becomes one in determining whether reimbursements are received for these services?

2. Vacant positions need to be advertised and filled according to established procedures and Federal requirements; in lieu of filling these positions, contracts are awarded for services. Is there a sizable cost savings in this procedure? Recently there was controversy in the way the Director of Nursing position was filled, and then "unfilled." Actions of this sort impact the morale of the service Unit, which in turn impacts the kind of service Crow People receive.

Certainly, we applaud the efforts of this Senate Committee on Indian Affairs and their passionate support in pursing the: reauthorization of the Indian Health Care Improvement Act; recognizing the effects of Diabetes and addressing the Special Diabetes initiative. Yet the need for quality health care, which resonated in the past, and continues today, is an ever present challenge. How does the equalization in health care occur? As long as we have a dual health care system (the haves and the have not's); as long as socioeconomic disparities are apparent, there is going to be a continual need for this Committee Senators.

The provision of Dialysis is a health concern, and Indian Health Service can no longer bury its head in the sand, hoping this issue will dissipate. We need one funding source for this, available for all Tribes. Diabetes is the fifth (out of ten) ranked health problem for the Crow Reservation.

We need to continually fund the Epidemiology Center serving the Billings Area Tribes. The data collected will be made available to and will be utilized by the specific Tribes.

Funds need to be identified and made available for HPV immunizations. A recent article in the Billings Gazette identified the Crow reservation as having the highest reported cases of HPV infections. Approximately 50 percent of the Crow Tribal enrollment is under the age of 30. This is the age group with pronounced sexual activity.

Long term planning and resource identification needs to be addressed for the problems associated with aging, especially for the "baby boomers." It is anticipated that Cancer and Diabetes will have an increased prevalence in this group. Expanded care for this age group includes: nursing home care; assisted living; independent living services (including home monitoring and health tracking measures); ophthalmology; prosthetics; mental health.

Senators, the Crow People have a rich heritage. There is a bit of ethnocentrism, for Crow Speakers still abound, traditional and cultural practices are adhered to. It is this identity has been the cohesiveness quality that has kept the Crow Tribe distinct among other groups.

Again, thank you for this opportunity to share the Health Concerns of the Crow People.

Senator DORGAN. Ms. White, thank you very much, and thank you for your powerful statement, and we grieve for your loss of that beautiful young girl.

Let me also thank you for 17 years of work in Indian health care. That's great dedication. We appreciate your being here and we will read very carefully the testimony you have presented as well.

State Representative Jonathan Windy Boy. Representative Windy Boy, thank you very much for coming. Let me ask if you would summarize.

I think following your testimony, we will hear from Mr. Moke Eaglefeathers as well. So if you would summarize, we would appreciate it very much.

We thank you for your service and thank you for being here, Representative.

STATEMENT OF HON. JONATHAN WINDY BOY, COUNCIL MEMBER, CHIPPEWA CREE TRIBE BUSINESS COMMITTEE; MONTANA REPRESENTATIVE, HOUSE DISTRICT 32

Mr. WINDY BOY. Thank you Chairman Dorgan and Senator Tester for having this hearing.

For the record, my name is Jonathan Windy Boy. I'm a member of the Chippewa Cree Tribal Council, and also State Legislator representing House District 32, Chairman of the Rocky Boy Health Board, and also been appointed Chairman of the National Caucus of Native American State Legislators Committee on Health.

I'm going to kind of zip through my testimony here because you can probably get a copy of it and highlight it.

The situation today is the under-funding of Indian health care and American Indian health disparities. Under-funding of Indian health care for some time now in the United States is not under the true meaning of health services for American Indian people.

The medical inflationary rate over the past 10 years sat at 11 percent. The average increase for IHS accounts over the same period has been only 4 percent so that those numbers are kind of off a little bit from each other on the true need.

In FY 1984, IHS services account received 777 million; in FY 1993, the budget totaled 1.5 million. Still 13 years later in 2006, the budget for health services was 2.7 billion, when to keep pace with inflation and population growth, this figure should be more like 7.2 billion.

American Indians die at higher rates than other Americans from tuberculosis at 600 percent higher; alcoholism, 510 percent higher; motor vehicle crashes, 229 percent higher; diabetes, 18 percent higher; unintentional injuries, 152 percent higher; homicides, 61 percent higher.

There are many challenges in the existing health care budget, and one of the things that you have heard earlier from some of the Federal Government is that Medicaid third-party reimbursements has been accounted for.

And I think the misnomer with that, I feel is that should not be included in IHS funding, because that is pretty much a given for the tribes and the states at 100 percent last year. So I think that should be excluded from the IHS budget.

You know, Mr. Chairman, Senator, aside from all of these facts and figures and all of that, I want to go back to a real life happening at home. I have an aunt that's 77 years old. For several years now she's been diagnosed as a diabetic. She travels to Great Falls Monday, Wednesday and Friday for dialysis. That's 120 miles from Rocky Boy to Great Falls.

I have some of my constituents at home that go to dialysis three times a week to Billings, and that's 250 miles one way.

So if you take those figures, you're looking at 1500 miles a week to Billings, approximately 720 miles to Great Falls and back.

If you can imagine the same situation with Fort Peck having to come to Billings, which is approximately 300 miles one way, and if a diabetic has to go through the dialysis that's needed just to stay alive, the remoteness that we have is one of the factors that tribes in Montana are up against.

Fort Belknap is in a similar situation. They're about 200 miles from Billings, round-trip 400, multiply that times three, 1200 miles. Great Falls is about 160 miles one way. So the remoteness is really a factor that hasn't really been placed into call here.

One of the things when you're talking about contract health services, right now in the middle of July, we have over 360-some thousand dollars short in my contract health services budget, and I still have 3 months to go. And if I'm going to be only having to provide life or limb for those members, I'm going to be in a real stickler here very shortly.

One of the things too, you know, about recently with the contract health dollars, there's something that isn't talked about. You know, when a person who has an emergency to them which does not fall under the regulations of IHS regulations, then that individual will go to the Emergency Room. In my case, we go to Havre or Great Falls.

If they don't fit under those standards, qualifications to receive contract health service dollars, then those bills are going to accrue and accrue and accrue, and finally those hospitals are going to send them to the credit bureau and that's a reality. And I'm even on that credit bureau for health services.

One of the things too, you know, it was kind of ironic to hear that a dentist from Helena that testified in Senator Baucus' hearing on CHIP a couple months ago, provided testimony, and why it was ironic to me is because he said that there was a child who needed surgery, orthodontic surgery, a child from Box Elder, and that's, come to find out that's one of my grandkids. And if they had waited a couple more days, that child would have died from that.

So, you know, the levels of what the Feds and everybody else tells you, that everything's fine and dandy, you know, that's a bunch of hogwash.

Every time as a tribal leader, we go to D.C., we go to HHS, we go to different departments. The one thing that they tell us, is okay, you go back to the states, we've funneled more money into the states that you're eligible for. We have grants that the tribes are eligible for.

If you know the granting process, there's 560-some tribes across the country, and if we have to complete, the ones with the best grant writers are going to get the money. So that's another thing that we're up against as tribal leaders as well.

And also, too, on Medicaid, we talk about Medicaid and the barriers that we see. One of the things that we see on my local level is, I'll give you an example of an elderly couple. Right away that elderly couple, on any reservation, when they see a brand-new, spanking new car come driving up the driveway, a non-native guy looking like Jon Tester—in jest, Jon—but anyway, right away they're going to be cautious.

They're going to take a couple of steps back because they're not going to trust. Trust is a real thing that we're up against as far

as one of the barriers. And I think in order to make the Medicaid eligibility process, we need to train our home to be in that process.

So again, I want to thank you for having this hearing, and thank you for letting me be a part of your panel, and I'll be open for questions.

Thank you.

[The prepared statement of Representative Windy Boy follows:]

PREPARED STATEMENT OF HON. JONATHAN WINDY BOY, COUNCIL MEMBER, CHIPPEWA CREE TRIBE BUSINESS COMMITTEE; MONTANA REPRESENTATIVE, HOUSE DISTRICT 32

Good afternoon, Chairman Dorgan and Senator Tester. My name is Jonathan Windy Boy. I am an enrolled member of the Chippewa Cree Tribe of Rocky Boy's Reservation and a citizen of the beautiful State of Montana. I have the honor to serve as a council member for the Chippewa Cree Tribe Business Committee. I also serve as a Representative in the Montana State Legislature, House District 32. I serve as the Chairman of the Rocky Boy Health Board, the governing body for the Chippewa Cree Health Center. I also serve as the chair of the Montana Wyoming Tribal Leaders Council—Subcommittee on Health and I was recently appointed the interim Chairman of the National Caucus of Native American State Legislators'—Subcommittee on Health. I appreciate this opportunity to address the healthcare issues of the Montana Tribes. I would like to thank the Committee for the opportunity to testify at this "Field Hearing on Indian Healthcare."

Before I begin this testimony, I would like to reaffirm the foundation of the provision of health services in relationship to the sovereign status of Tribes.

"No right is more sacred to a nation, to a people, than the right to freely determine its social, economic, political and cultural future without external interference. The fullest expression of this right occurs when a nation freely governs itself."

The Late Joseph B. DeLaCruz, Former President, Quinault Nation, 1972–1993.

The Foundation: Tribal Sovereignty and the Provision of Health Services

The overarching principle of Tribal sovereignty is that Tribes are and have always been sovereign nations, Tribes pre-existed the Federal Union and draw our right from our original status as sovereigns before European arrival.

The provision of health services to Tribes is a direct result of treaties and executive orders entered into between the United States and Tribes. This Federal trust responsibility forms the basis of providing health care to Tribal people. This relationship has been reaffirmed by numerous court decisions, Presidential proclamations, and Congressional laws.

The Situation Today: Underfunding of Indian Healthcare and American Indian/Alaska Native Health Disparities

Underfunding of Indian Healthcare

For some time now, the United States has not funded the true need of health services for AI/AN people. The medical inflationary rate over the past 10 years has averaged 11 percent. The average increase for the Indian Health Service (IHS) health services accounts over this same period has been only 4 percent. This means that IHS/Tribal/Urban Indian (I/T/U) health programs are forced to absorb the mandatory costs of inflation, population growth, and pay cost increases by cutting health care services. There simply is no other way for the I/T/U to absorb these costs. The basis for calculating inflation used by government agencies is not consistent with that used by the private sector. OMB uses an increase ranging from 2–4 percent each year to compensate for inflation, when the medical inflationary rates range between 7–13 percent. This discrepancy has seriously diminished the purchasing power of Tribal health programs because medical salaries, pharmaceuticals, medical equipment, and facilities maintenance cost Tribes the same as they do the private sector.

In FY 1984, the IHS health services account received $777 million. In FY 1993, the budget totaled $1.5 billion. Still, thirteen years later, in FY 2006 the budget for health services was $2.7 billion, when, to keep pace with inflation and population growth, this figure should be more than $7.2 billion. This short fall has compounded year after year resulting in a chronically under-funded health system that cannot meet the needs of its people.

As the Federal Government develops models that aim to reduce or eliminate racial and ethnic disparities (*i.e.,* "Closing the Gap") a balance needs to be made between the Federal deficit model (comparison to All U.S. Races) and a positive development model. Otherwise health policy (and the subsequent allocation of funding toward Indian healthcare) will be determined on the basis of Tribes being a marginalized minority and not as sovereign nations with distinct treaty rights, which have been negotiated with the "*full faith and honor of the United States of America*."

American Indian/Alaska Native Health Disparities

American Indians have long experienced lower health status when compared with other Americans. Disproportionate poverty, discrimination in the delivery of health services and cultural differences has contributed to the lower life expectancy and disproportionate disease burden suffered by American Indians. American Indians born today have a life expectancy that s 2.4 years less than the US All Races.

American Indians die at higher rates than other Americans from:

- Tuberculosis—600 percent higher
- Alcoholism—510 percent higher
- Motor Vehicle Crashes—229 percent higher
- Diabetes—18 percent higher
- Unintentional injuries—152 percent higher
- Homicide—61 percent higher

Some of these health disparities are historic. Alcoholism continues to be a serious challenge to American Indian health. Since its introduction to Tribal people early in this Nation's history, alcohol has done more to destroy Indian individuals, families and Tribal communities than any disease. Today in 2007, Tribal people are dying at a rate 510 percent HIGHER than other Americans from alcoholism. The overall impact of these health disparities has made us "at-risk" communities, weakened and vulnerable. In fact, as reported in a Denver, Colorado newspaper, the Wind River Reservation in Wyoming was targeted by Mexican drug cartels because of their history with alcoholism. The drug dealers figured that the Tribal community (already inundated in alcohol addiction) would be easy to infiltrate for drug distribution. Their business plan included marrying into the Tribe, giving free samples to get people addicted and then get them to distribute to support their addiction. This is an approach that is being implemented throughout Indian Country.

Given the significant health disparities that Tribal people suffer, funding for Indian healthcare should be given the highest priority within the Federal Government. Many of the diseases that Tribal people suffer from are completely preventable and/or treatable with adequate resources and funding.

The Challenges: Access to Medicaid Services, Medicaid and Medicare Reimbursements, Recruitment and Retention of Health Providers

Access to Medicaid Services

The IHS budget cannot provide the health services needed thus Tribes must depend upon alternate health resources, such as, Medicaid for critically needed healthcare for our people. The Indian health system is funded at less than 60 percent of need and is heavily dependent upon Medicaid. Understanding this, accessing Medicaid is an important health issue.

The barriers to accessing Medicaid have been identified by Tribes through out the years. Though there has been some positive movement, many of those identified barriers still remain. The most critical of those identified is the application and eligibility determination process. This is the first gate and if a Tribal member cannot get through the first gate—access to needed healthcare is denied. The application and eligibility determination barriers are often protocols developed to "cost contain" or manage the National Medicaid budget. Unfortunately, Tribal people often cannot afford to jump through the "hoops" of a budget management protocol and the denial of access to care can be disastrous for the individual Tribal member and their family.

In FY 2004, the Chippewa Cree Tribe and the Confederated Salish & Kootenai Tribes partnered with the State of Montana and CMS/Region VIII to begin discussion on how to alleviate the barriers to accessing Medicaid for the Montana Tribes. In May 2007, the Chippewa Cree Tribe signed an agreement with the Governor of Montana and the State of Montana to contract Medicaid Eligibility Determination. Having the ability and authorization to determine Medicaid eligibility onsite at our Tribal healthcare center will facilitate access to care for eligible Indian users that are eligible Medicaid users. Getting access to healthcare through Medicaid to those eligible Montana citizens (whether Indian or non-Indian) as soon as possible bene-

fits the recipient and the State of Montana. A healthy state community is one where its citizens can fully participate in education, employment and economic development.

Medicaid and Medicare Reimbursement

Thirty-one years ago, in 1976, in response to the health conditions in Indian Country, Congress provided the IHS and Tribes with the authority to bill for and receive Medicaid and Medicare reimbursements for services provided to American Indian beneficiaries. Today, Medicaid and Medicare reimbursements provide a critical source of supplemental funding for the underfunded IHS and Tribal healthcare delivery service programs.

Originally Congress did not intend for Medicaid revenue to "offset" the strained Indian Healthcare budget but to supplement it. Today, the IHS and Tribes are expected to bill and collect for Medicaid to replace IHS appropriations. In the FY 2008 budget Request Congressional Justification includes specific amounts of Medicaid and Medicare collections (total of $625,193,000) as part of its total FY 2008 President's request of $4.1 billion. Members of the Committee, we need this situation remedied in order to realize an appropriate level of funding for Indian healthcare.

The Indian health system is funded at less than 60 percent of need and is heavily dependent upon Medicaid payments. States receive 100 percent FMAP for Medicaid services provided in an IHS or Tribal facility. These facilities have a limited capability to provide all needed direct care. Any health care not provided by the facility is referred to a private or public provider. The state must then provide the regular state Medicaid match for that eligible Indian user/eligible Medicaid user. Thus states are given an incentive to limit the benefits that American Indians referred to outside providers would receive under the state Medicaid plan.

A current issue relating to both Medicaid and Medicare is the imposition of increased cost sharing or premiums. States may charge a co-payment for medical services or drugs. The rationale for charging co-payments is to achieve a more appropriate utilization of Medicaid covered services. First of all American Indian participation is very low and the imposition of a co-pay has a negative effect as many American Indians cannot afford even a modest co-pay (and why would they if they can receive services from IHS without a co-pay). This could prevent them from enrolling in Medicaid or Medicare, which could deprive the chronically underfunded IHS or Tribal facility critical Medicaid revenue.

Imposing a co-payment has not changed the utilization of American Indian Medicaid or Medicare beneficiaries because IHS and Tribes do not charge co-pays to their beneficiaries. Instead co-pay amounts are cost shifted to the Indian health programs, causing a further reduction to services they can provide.

Recruitment and Retention of Health Providers

The recruitment and retention of health providers has been a barrier to effective healthcare delivery for Montana Tribes. As in most rural areas of this Nation, Montana Tribes are challenged with providing a continuity of care, because of a high turnover of healthcare providers. Montana Tribes are located in geographically isolated areas (only Alaska has a remoteness designation more severe than Montana). Montana is considered a "frontier" area with a population of less than 6 people per square mile.

It is a challenge to recruit health providers that will commit to a long term, interact and invest in the Tribal Community and work to understand and respect the Tribal culture and traditions. These attributes for health providers are imperative to the effective provision of healthcare for our Tribal communities. Ideally, most Tribes want a Tribal member as their healthcare provider, knowing that a Tribal member would have the maximum investment for their community.

Chairman Dorgan and Senator Tester, it will take the commitment of the Administration, the U.S. Congress, the State of Montana, and the Montana Tribes to insure that the issues I have presented are addressed and accomplished by reauthorizing the Indian Healthcare Improvement Act. The provisions of the IHCIA will insure that Montana Tribes will have access to building the healthy Montana Tribal communities where healthcare is more than a promise but a reality for every man, women and child. I thank you for this opportunity to provide testimony.

Senator DORGAN. Representative Windy Boy, thank you very much. Thanks for your service in the state legislature, and thank you for coming today to testify.

Our final witness is Mr. Moke Eaglefeathers, President of the National Council of Urban Indian Health and Director of North American Indian Alliance.

He is accompanied by Ms. Marjorie Bear Don't Walk, Director of the Indian Health Board of Billings.

I might mention that we had a meeting in Washington D.C. a while back and Mr. Eaglefeathers was there as well.

So, let me ask you to proceed for the final bit of testimony, and let me see if we can get a microphone over to you.

Mr. Eaglefeathers, why don't you proceed. Once again, if you would please summarize, your entire statement will be made a part of the permanent record.

MELBERT "MOKE" EAGLEFEATHERS, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH; DIRECTOR, NORTH AMERICAN INDIAN ALLIANCE; ACCOMPANIED BY MARJORIE BEAR DON'T WALK, DIRECTOR, INDIAN HEALTH BOARD, BILLINGS, MT

Mr. EAGLEFEATHERS. It is an honor for me to be here on behalf of the National Council of Urban Indian Health, which is a 36-member organization, and 120,000 urban Indian patients that are served annually.

I would like to take this opportunity to thank you, and the opportunity to provide the testimony and address an assessment of the Indian Health Care Improvement Act.

My name is Melbert Eaglefeathers. You know me as "Moke". I am the Executive Director of the North American Indian Alliance here in Montana. I also serve as the President of the National Council of Urban Indian Health. I am a Northern Cheyenne enrolled member here in Montana.

I am honored to serve as a representative of the urban Indian population. Thank you for providing me the opportunity to testify in support of the reauthorized Indian Health Improvement Act.

Urban Indian Health program has spent the last year regrouping and solidifying relationships with local and national tribal leaders. One thing Salish Kootenai was to work on tribal relationships, I've spent many hours in tribal leaders' offices and meetings discussing health concerns. To understand this issue is to look at our next generation for our health care issue.

At this time, I would like to turn to my colleague, Marjorie Bear Don't Walk, to talk about the Montana program.

Thank you.

Senator DORGAN. Thank you very much.

Ms. Bear Don't Walk, why don't you proceed?

Ms. BEAR DON'T WALK. Good afternoon, Chairman Dorgan, Senator Tester.

I would like to say that the Urban Indian Health program, we need more money. At the present time 67 percent of Indian people live off the reservation and they receive 1 percent of the Indian Health Service budget. By saying that, I would also like to say, that we do not receive any funds for contract care.

So, for all of the people who are having problems getting contract care money, we have none. So our problem with contract care is that if you are ill and you need contract care, you can forget it.

The other problem that we have is we need more dollars, period. One percent of the budget provides the minimal health care, which is very insulting to any Indian person, let alone a hurting Indian person who is not eligible for contract care anywhere.

In Billings, there are about 10,000 Indians, about half of them are Crows and they are eligible for contract care. About a fourth of them are Northern Cheyenne, and they are ineligible for contract care, even though it is the Crow/Northern Cheyenne hospital. All of the others, and the largest number are Sioux and Chippewas, are not eligible for contract care.

I am a member of the Confederated Salish and Kootenai Tribe. Forty-one years ago, when I was young and foolish, I married a Crow Indian.

[General laughter.]

Senator DORGAN. All right, you're done testifying.

[General laughter.]

Proceed, I'm sorry.

Ms. BEAR DON'T WALK. His name is Urban Bear Don't Walk, and I have worked in urban health in excess of 20 years. So, it is kind of interesting for the definitions of Indian people, of reservation and urban Indians, when urban Indian, the name Urban came from a fifth century pope who urbanized Europe.

So we have been branded with the term "Urban Indians". And I hear very often that urban Indians have more opportunity for health care. That truly is bull. The Indians who have opportunities in urban areas are the Indian Health Service workers who have insurance.

Almost all of the other Indians that I know of, unless they work for the Federal Government, do not have insurance. So if you're working two jobs or three jobs and you have children and you need health care, you've got to make a choice, you can use Indian Health or someplace else.

I have felt that we need to advocate for all Indian people, that we are all considered as the people who were here when Columbus landed.

The Federal Government has done a lot to divide us all, and I would like to see that stop. And we have continued, as Indian people, to divide ourselves also, and I think that we need to stop that also.

We, as Indian people, are here in the area of a large number and my children, while they are Salish and Crow, are enrolled as Crow Natives.

So I would like to ask the Senate to give more money to urban Indians for health care, and I would like to see the health care of urban Indians to be as valuable as anybody else's health care.

I would like to see Indians, the money appropriated per capita for people in the United States, I would like to see where Indian people are no longer at the bottom of that list.

I thank you very much.

[The prepared statements of Mr. Eaglefeathers and Ms. Bear Don't Walk follow:]

PREPARED STATEMENT OF MELBERT "MOKE" EAGLEFEATHERS, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH; DIRECTOR, NORTH AMERICAN INDIAN ALLIANCE

On behalf of the National Council of Urban Indian Health, its 36 member organizations and the 120,000 urban individual Indian patients that our members serve annually, I would like to thank you for this opportunity to provide testimony addressing the reauthorization of the Indian Health Care Improvement Act.

My name is Melbert Eaglefeathers and I am the Executive Director of the North American Indian Alliance in Butte Montana, I also serve as the President of the National Council of Urban Indian Health (NCUIH). I am honored to serve as a representative of the urban Indian population on health related matters before Congress and our peers. Thank you for providing the opportunity to testify in support of legislation to amend and reauthorize IHCIA

I would also like to take this opportunity to thank the Senate Committee on Indian Affairs for your unwavering support of the 34 Urban Indian Programs in the face of an administrations budget that zeroed the program out of the IHS budget. Our programs are an excellent investment for the United States and for all of Indian Country.

Urban Indian Health programs have spent the last year regrouping and solidifying our relationships with local and national Tribal leaders. One of my primary goals as the President of NCUIH was to work on Urban Tribal relationship building. I have spent many hours in Tribal leader's offices and at meetings discussing our common concerns and working to bridge a historical divide with one theme in mind "One Culture Two Worlds".

Below I have outlined some of the issues raised by the Administration about the Urban Indian Health Program in the Indian Health Care Improvement Act and the NCUIH response. Congress has continually refuted the assertions made by the Administration relying on its Constitutional authority to legislate on Indian Affairs.

Department of Justice (DOJ) White Paper Questioning Constitutionality of Urban Indians.

Towards the end of the 109th Congress, the Indian Health Care Improvement Act reauthorization legislation appeared to be well on its way to passage. However, passage was thwarted in the eleventh hour by the release of an undated and unsigned memorandum entitled "Department of Justice White Paper" that created confusion and led to delays that prevented passage. In the "White Paper" (and in testimony before this Committee in the 110th Congress), the U.S. Department of Justice argued that the definition of "urban Indian" in the Indian Health Care Improvement Act reauthorization legislation, which closely tracks current law (25 U.S.C. Section 1603), as well as the definition used in the No Child Left Behind Act (Section 7151), runs a significant risk of being ruled unconstitutional by a Federal court since it encompasses more than just members of federally recognized tribes. In a two-paragraph analysis, the "White Paper," relying principally on two Supreme Court cases (*Adarand Constructors, Inc. v Pena; Rice v. Cayetano),* argued that where Congress has authorized services for Indians who are not members of Federally recognized tribes, such services would likely be regarded as a racial classification, rather than a political classification, and would not meet the constitutional "strict scrutiny" standard applied to racial classifications. In making this argument, the "White Paper" was arguing for a sharp curtailment of Congress' authority to legislate in the area of Indian affairs, an authority which has long been deemed by the Supreme Court as "broad," "plenary and exclusive." *United States v. Lara*, 124 S. Ct. 1628, 1633 (2004). In the unlikely event that the "White Paper's" reasoning were ever to be adopted by the courts, many longstanding Federal Indian laws would be ruled unconstitutional.

Contrary to the White Paper's position, Congress' plenary authority in Indian affairs allows Congress to recognize tribes for some purposes and not for others – which it has done in dozens of laws -- and to provide benefits to the members of tribes and their descendants, whether those tribes are federally recognized, state recognized or had their recognition terminated. The broad reach of Congress' authority is founded in the Indian Commerce Clause of the Constitution (Art I, Section 8, cl. 3) and other constitutional, common law and international conventions and has been repeatedly affirmed by the Supreme Court. Congress' authority in this area has been deemed political in nature and not generally subject to Court review.[1] Many federal laws address non-federally recognized Indian entities and have withstood court challenge, including challenges that cite the *Adarand* case relied upon in the "White Paper."

In Part I of this testimony, I will focus on the Federal obligation to urban Indians in the health care area, which provides a sufficient policy basis for Congress to authorize

[1] "Plenary authority over the tribal relation of the Indians has been exercised by Congress from the beginning, and the power has always been deemed a political one, not subject to be controlled by the judicial department of the government." *Lone Wolf v. Hitchcock*, 187 U.S. at 565 (1903)

programs to "urban Indians" as that term is defined in current law, as well as in the Indian Health Care Improvement Act reauthorization legislation. In Part II of this memorandum, I address the question of whether urban Indian health programs duplicate services already being offered in urban areas - they do not - which is why they are so critical to the urban Indian community.

I. THE FEDERAL OBLIGATION TO URBAN INDIANS IN THE HEALTH CARE AREA

The Congress has long recognized that its obligation to provide health care for Indians, includes providing health care off the reservation.

> "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation.* Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there.*"

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).[2] Congress has "a responsibility to assist" urban Indians in achieving

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[2] "The American Indian has demonstrated all too clearly, despite his recent movement to urban centers, that he is not content to be absorbed in the mainstream of society and become another urban poverty statistic. He has demonstrated the strength and fiber of strong cultural and social ties by maintaining an Indian identity in many of the Nation's largest metropolitan centers. Yet, at the same time, he aspires to the same goal of all citizens—a life of decency and self-sufficiency. The Committee believes that the Congress has an opportunity and a responsibility to assist him in achieving this goal. It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."

"The Committee is committed to rectifying these errors in Federal policy relating to health care through the provisions of title V of H.R. 2525. Building on the experience of previous Congressionally-approved urban Indian health prospects and the new provisions of title V, urban Indians should be able to begin exercising maximum self-determination and local control in establishing their own health programs."

Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652 at p. 2754.

"a life of decency and self-sufficiency" and has acknowledged that "[i]t is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs which failed to provide the Indian with an improved lifestyle on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities." House Report No. 94-1026 on Pub. Law 94-437, p. 116 (April 9, 1976).

Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided: [3]

> "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the *American Indian people*, to meet the national goal of providing the highest possible health status to Indians *and urban Indians* and to provide all resources necessary to effect that policy"

25 U.S.C. Section 1602(a)(emphasis added). In so doing, Congress has articulated a policy encompassing a broad spectrum of "American Indian people." Similarly, in the Snyder Act, which for many years was the principal legislation authorizing health care services for American Indians, Congress broadly stated its commitment by providing that funds shall be expended " for the benefit, care and assistance of the Indians *throughout* the United States for the following purposes: . . . For relief of distress and conservation of health." 25 U.S.C. Section 13 (emphasis added).

The Supreme Court and lower Federal courts have held that the Federal government's obligations to Indians extends beyond reservation boundaries. "The overriding duty of our Federal Government to deal fairly with Indians *wherever located* has been recognized by this Court on many occasions." *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); and *Board of County Comm'rs v. Seber*, 318 U.S. 705 (1943). In other areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian housing rather than dismantle it where it exists. The Court generally agrees." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987).

The Federal courts have also stated that there is a trust responsibility for individual Indians, including urban Indians. "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members living collectively or individually, on or off the reservation.*" *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*,

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[3] As originally conceived, the purpose of the Indian Health Care Improvement Act was to extend IHS services to Indians who live in urban centers. Very quickly, the proposal evolved into a general effort to upgrade the IHS. See, *A Political History of the Indian Health Service*, Bergman, Grossman, Erdrich, Todd and Forquera, The Milbank Quarterly, Vol. 77, No. 4, 1999.

675 F. Supp. 497, 535 (D. Minn. 1987)(emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising *that it can extend to Indians individually*, as well as collectively, *and off the reservation*, as well as on it." *St. Paul Intertribal Housing Board v. Reynolds*, 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

> "As the history of the trust doctrine shows, the doctrine is not static and sharply delineated, but rather is a flexible doctrine which has changed and adapted to meet the changing needs of the Indian community. This is to be expected in the development of any guardian-ward relationship. *The increasing urbanization of American Indians has created new problems for Indian tribes and tribal members.* One of the most acute is the need for adequate urban housing. Both Congress and Minnesota Legislature have recognized this. The Board's program, as adopted by the Agency, is an Indian created and supported approach to Indian housing problems. *This court must conclude that the [urban Indian housing] program falls within the scope of the trust doctrine . . . .*"
>
> Id. At 1414-1415 (emphasis added).

This Federal government's responsibility to urban Indians is rooted in basic principles of Federal Indian law. The United States has entered into hundreds of treaties with tribes from 1787 to 1871. In almost all of these treaties, the Indians gave up land in exchange for promises. These promises included a guarantee that the United States would create a permanent reservation for Indian tribes and would protect the safety and well-being of tribal members. The Supreme Court has held that such promises created a trust relationship between the United States and Indians resembling that of a ward to a guardian. See *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). As a result, the Federal government owes a duty of loyalty to Indians. In interpreting treaties and statutes, the U.S. Supreme Court has established "canons of construction" that provide that: (1) ambiguities must be resolved in favor of the Indians; (2) Indian treaties and statutes must be interpreted as the Indians would have understood them; and (3) Indian treaties and statutes must be construed liberally in favor of the Indians. See *Felix S. Cohen's Handbook of Federal Indian Law*, (1982 ed.) p. 221-225. Congress, in applying its plenary (full and complete) power over Indian affairs, consistent with the trust responsibility and as interpreted pursuant to the canons of construction, has enacted legislation addressing the needs of off-reservation Indians.

The urban Indian is an Indian who has become physically separated from his or her traditional lands and people, generally due to Federal policies. Some of these federal policies were designed to force assimilation and to break-down tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed

miserably. The result of this "course of dealing," however, is the same - a Federal obligation to urban Indians.[4]

- **The Federal Relocation of Indians.** The BIA's Relocation program originated in the early 1950s as a response to adverse weather and economic conditions on the Navajo reservation. A limited program was initiated to relieve the crisis by finding jobs for Navajos who wanted to work off the reservation as little or no job opportunities existed on the reservation. Shortly afterward, the BIA converted its Navajo program into a full-fledged Bureau of Indian Affairs program applicable to many Indian tribes. Solving reservation economic problems by relocating Indians off of their tribal lands is roughly the equivalent of the Federal government, during the Depression, sending Americans overseas to find work – something the Federal government would never have done. All told, between 1953-1961, over 160,000 Indians were relocated to cities, where they quickly joined the ranks of the urban poor.[5] Today, the children, grandchildren and great-grandchildren of the 160,000 Indians relocated by the BIA are still in the cities.

- **Failure of Federal Efforts to Economically Develop the Reservations.** The second major reason Indians have moved to the city is the near total failure of Federal programs to promote economic development on Indian lands, coupled with the ongoing success of the Federal efforts in the 1800's to undermine the economic way of life of Indian peoples, locking nearly all Indians into hopeless poverty which still plagues most reservations today. The long history of treaty-breaking by the Federal government is an important part of this tale. As a result, out of desperation, a number of Indians have left their homelands to go to the cities in search of work, even without the dubious benefit of the BIA's relocation program. Generally, these Indians were no better equipped to handle life in the city than the BIA relocatees and quickly joined the ranks of the urban poor. Congress has noted the correlation between the failure of Federal economic policies and the swelling of the ranks of urban Indians: "It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His [urban

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[4] The unique legal relationship of the United States with Indian tribes and people is defined not only in the Constitution of the United States, treaties, statutes, Executive orders, and court decisions, but also in the "course of dealing" of the United States with Indians. As the Supreme Court noted in a major Indian law case, "[f]rom their very weakness and helplessness, so largely due to the *course of dealing* of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection and with it the power." *United States v. Kagama* (1886) (emphasis added).

[5] "Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, p. 2747.

Indians] difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."[6]

- **Termination of Tribes.** In 1953, Congress adopted a policy of terminating the Federal relationship with Indian tribes. Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, executive orders, and through the "course of dealing" with Tribes, to protect their interests. Many tribes were coerced to accept termination in order to receive money from settlements for claims against the United States for misappropriation of tribal land, water or mineral rights in violation of treaties. The results of termination were devastating: having lost Federal support, and without tribal sovereign authority over an established land basis, and with tribal members no longer eligible for Federal programs and IHS services, the Tribes collapsed. Some members remained in the area of their old reservations; many went to the cities, where they, too, joined the ranks of the urban poor.

- **Indian Patriotism -- World War I and World War II.** Many Indians served the United States in time of war[7] and, subsequently, were stationed in or near urban centers. At the end of their service to the United States, seeing the poor economic conditions on their reservations (resulting from the Federal war on Indians), many chose not to go back. The fact that they chose to stay in an urban area did not make them any less Indian, nor did it reduce the Federal government's obligation to them.

- **The General Allotment Act.** The General Allotment Act ("Dawes Act") had two principal goals: (1) by allocating communal tribal land to individual Indians it would breakdown the authority of the tribal governments while encouraging the assimilation of Indians as farmers into mainstream American culture; and (2) it provided for unalloted land (two-thirds of the Indian land base) to be transferred to non-Indians. The General Allotment Act succeeded at transferring the majority of Indian land to non-Indians and further disrupting tribal culture. Some Indians who received allotments became U.S. Citizens and, after losing their lands, moved into nearby cities and towns.

- **Non-Indian Adoption of Indian Children.** The common practice for many years of placing Indian children up for adoption into non-Indian families has created another group of Indians in urban areas who, because of the racial bias of the courts, have lost their core cultural connection with their tribal people and homelands. Many of the adopted Indians have successfully sought to restore those connections, but because of their upbringing are likely to remain in urban areas.

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[6] Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652,at p. 2754.

[7] It is in part because of their gallant service in World War I that the U.S. Congress granted U.S. citizenship as a group to American Indians in 1924.

- **Federal Indian Boarding Schools.** The Federal program of taking Indian children and educating them away from their reservations in boarding schools where they were prohibited from speaking their native language and otherwise subject to harsh treatment, created a group of Indians who struggled to fit back into the reservation environment. Eventually, some moved to the cities. The boarding school philosophy of "Kill the Indian, Save the Man" epitomizes the thinking behind this approach and the racist Federal effort to assimilate American Indians which, as a result, led to a number of Indians moving to urban areas.

- **The Fracturing of the Indian Nations.** The result of these, and other Federal Indian policies, has been the fracturing of Indian tribes and the creation, in the urban setting, of highly diverse Indian communities with members who fall into one or more of the following categories: Federal relocatees; economic hardship refugees; members of Federally recognized tribes, terminated tribes, and state recognized tribes.

Thank you for the opportunity to testify before you today I truly believe we Indian Country will benefit for this hearing today.

PREPARED STATEMENT OF MARJORIE BEAR DON'T WALK, EXECUTIVE DIRECTOR, INDIAN HEALTH BOARD, BILLINGS, MT

On behalf of the Indian Health Board of Billings and our Indian patients I would like to thank you for this opportunity to provide testimony addressing the reauthorization of the Indian Health Care Improvement Act.

My name is Marjorie Bear Don't Walk and I am the Executive Director of the Indian Health Board of Billings in Billings Montana. I am honored to serve as a representative of the urban Indian population on health related matters before Congress and our peers. Thank you for providing the opportunity to testify in support of legislation to amend and reauthorize IHCIA

This is also a great opportunity to thank the Senate Committee on Indian Affairs for your continued support of the Urban Indian Program when we were zeroed out of the Administrations budget. Our programs are an excellent investment for the United States and for all of Indian Country.

Below I will address some of the concerns on duplication of services that have been used as justification by the Administration in the proposals to zero out funding to the 34 Urban Indian Health Programs that serve 120,000 individual patients annually.

THE URBAN INDIAN HEALTH PROGRAMS DO NOT DUPLICATE OTHER FEDERAL PROGRAMS.

The issue of whether the Urban Indian Health Programs duplicate other services was front and center in the Congress in 2006 because the President had proposed zeroing out the program in the FY 2007 budget, as he has proposed for FY 2008. Congress overwhelmingly rejected the President's proposal, staunchly defending the value of the program. Notably, the National Association of Community Health Centers wrote the President to let him know that contrary to the position taken by Office of Management and Budget, CHCs would not be able to effectively duplicate the Urban Indian Health Program.

Disease knows no boundaries. As one Federal court has noted, the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." *United States v. Raszkiewicz*, 169 F.3d 459, 465 (7th Cir. 1999). With the

2000 census showing that well over half of the Indian population now resides in urban areas, the health problems associated strongly with the Indian population as a whole can only be successfully combated if there is significant funding directed at the urban Indian population, as well as the reservation population.

For similar reasons, urban Indians suffer from the same severe health care problems common to reservation Indians. According to research undertaken by the Urban Indian Health Institute, urban Indians suffer higher mortality rates "due to accidents (38% higher than the general population rate), chronic liver disease and cirrhosis (126% higher), and diabetes (54% higher). Alcohol-related deaths in general were 178% higher than the rate for all races combined." The rate of Sudden Infant Death Syndrome was 157% higher when compared to the rate for all children combined. Nearly one in four Indians residing in areas served by Urban Indian Health Organizations live in poverty and nearly half live below 200% of the Federal poverty level. These rates are substantially higher than the rates for the general (all races combined) population (i.e., 14% below 100% FPL and 30% below 200% FPL). [1]

Urban Indian health programs provide unique and non-duplicable assistance to urban Indians who face extraordinary barriers to accessing mainstream health care. What Urban Indian health programs offer cannot be effectively replaced by the HRSA's Health Centers program which, even according the President's FY 2007 budget could only address the needs of an additional 25,000 Native Americans, at a loss of the nearly 150,000 Native Americans served by Urban Indian health programs.

- **Urban Indian health programs overcome cultural barriers.** Many Native Americans are reluctant to go to health care providers who are unfamiliar with and insensitive to Native cultures. Some Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of some Indians. Urban Indian programs not only enjoy the confidence of their clients, but also play a vital role in educating other health care providers in the community to the unique needs and cultural conditions of the urban Indian population.

- **Urban Indian health programs save costs and improve medical care by getting urban Indians to seek medical attention earlier.** Without Urban Indian programs, many urban Indians would not seek or otherwise would dangerously delay seeking proper medical care. Such a delay in seeking treatment can easily result in a disease or condition reaching an advanced stage where treatment is more costly and the probability of survival or correction is lower. Urban Indian programs reduce the number of emergency room visits and otherwise raise the standard of care for a marginal additional cost to the system.

- **Urban Indian health programs are better positioned to identify health issues particular to the Native community.** Urban Indian programs are experienced in those health issues, whether physical or mental, that are prominent in the Native community. They are able to diagnose more quickly and more accurately the needs of the patient, as well as more readily point a patient to the appropriate medical resource to address his or her condition.

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[1] *Id.*

Indian Health Board of Billings, Inc.

1127 Alderson Avenue
Billings, Montana 59102

August 15, 2007

Good Afternoon Chairman Dorgan and Senator Tester.

I am Marjorie Bear Don't Walk, member of the Salish and Kootenai Tribe of western Montana. I married a member of the Crow Tribe, I have lived in this area for over 40 years. I have been the administrator of the Indian Health Board of Billings, and Urban Indian Health Care Program, on two different occasions for a period of over 20 years.

I thank you for the Senate Indian Affairs Committees approval of the Indian Health Care Improvement Reauthorization Act of 2007.

I am pleased to be attending this field hearing on needs and concerns regarding health care services in Indian Country.

I watched the SCHIP debates and was impressed with the success of congress to keep on the health care task for children.

I am hoping that the same process will result in the success of the Indian Health Improvement Reauthorization Act of 2007.

If you look at a map of Indian Country when Columbus landed in 1492, and a map of Indian Country today, it is astounding. The Indian Country land base has changed from all the land, to less than 10%.

More astounding is the change in the definition of American Indian people. American Indians were all the people who were here in American when Columbus landed in 1492.

Since 1492, the definition of American Indians has changed each time a treaty obligation, a moral obligation, and/or an obligation of decency is required.

Today, all of the descendents of the American Indian people that lived in American when Columbus landed in 1492 are divided in to categories.

When Columbus landed in 1492 American Indians did not live on reservations.

Now the federal government has divided the American Indians so that they try to only recognize those American Indian descendents that live on reservations.

American Indians lived on all the land in America, now those American Indians not living on 'reservations' are considered 'Urban Indians'.

The word Urban is the name of an Italian pope of the fifth century who urbanized Europe into cities.

We are all descendents of the American Indian people who were here when Columbus landed in 1492, we all live in what has always been Indian Country America.

The discrepancy of the health care funded allocated by congress for the different groups of Americans is an important issue that needs to be addressed.

Where is the equality in health care? American Indians are funded by congress, receiving the least per capita for health care than any group in America.

Everyone; the veterans, the federal prisoners, community health centers, and all groups of Americans, shouldn't all be funded at the same level?

Why are American Indians funded at the bottom of the health care scale?

All American Indian people live in Indian Country.

The majority of American Indian people live off reservations.

Why is IHS funded at the bottom of the funding levels, and Urban Indians, who are the majority of the American Indian population, funded at 1% of the IHS funding?

The Indian Health Service employees who oversee the health care for American Indians have health insurance.

IHS administrators and their employees DONOT have to use the Indian Health Service for health care.

Most Urban programs, Indian Tribes, and Indian organizations CANNOT afford health insurance.

Many IHS Area Office administrators do not have experience providing direct health care. American Indian people deserve the best health care possible, today, that is not happening.

American Indian Vets are not receiving adequate health care, by IHS or the V.A.

As American Indians face some of the more horrible health care problems, such a diabetes and cancer, I would like to see Congress improve the health care available to Indian people.

I am hoping that the Indian Health Care Improvement Act will improve the conditions that hinder American Indians from providing and receiving the best health care possible.

Senator DORGAN. Thank you very much for your testimony. Thanks to all of you for your testimony.

I know that you have told on occasion a North Dakota joke. We've told a Montana joke from time to time over on the North Dakota side of things, but I must tell you that coming to Montana today has been really impressive for me.

The number of people who have attended this hearing, your passion, the statements by the witnesses, that is impressive and a very powerful, strong statement.

You come here at a time when there is a Crow Fair, which I'm told, I've not attended it, but I'm told is widely attended and much anticipated. I hope all of you have a wonderful opportunity to participate in that.

Chairman Venne has been wonderful today to me and to Senator Tester, as well.

I'm going to have to leave in a little while, and I hope you will excuse me. I think you will when I tell you why.

I have to be on an airplane at the Billings airport, and the reason I have to be off an airplane about midnight tonight, is tomorrow morning I am taking my daughter to college as a freshman, and we're driving her to college for her first year of college. And so you understand, I hope, how important that is to me to be there and catch that airplane.

So I will take my leave in a few minutes and ask Senator Tester to continue chairing the remainder of this hearing.

I also want to say this, David Mullon, who I introduced earlier, is a member of our staff, has been a member of the staff as a Chief of Staff and now Chief of Staff to the minority, David is from the Cherokee Tribe in Oklahoma. David is right here.

Heidi Frechette, sitting over there, Heidi, would you stand up? Heidi is a counsel, an attorney on our staff in the Indian Affairs Committee, and she is from the Menominee Tribe in Wisconsin.

At the end of this hearing, both David and Heidi will also be here and available to spend time with those who have some issues you want to discuss personally with our staff. And I'd like you to feel free to seek them out if you would.

My understanding also is that Senator Tester will, following questioning of this panel, be taking some brief statements by other tribal officials who have come today and who have not been able to testify.

But if you will allow me to take my leave for the purpose I have described, I want to tomorrow morning be driving my young daughter to her first year in college, and so I want to catch that airplane out of Billings.

But again, let me say a heartfelt thanks, and to tell you this, with Senator Tester, myself, Senator Baucus, and so many others, we will work very, very hard.

This is not just some other time. This is the time for us to demand that these things get fixed, and I pledge to you that's what's going to happen. We're going to work and work and work, and we're going to get things fixed and make some progress.

So, let me with that turn it over to Senator Tester to chair the remainder of the hearing, and I thank you for your hospitality and your passion, and I say God bless to all of you.

Senator TESTER. Senator Dorgan, I just want to express my thanks to you, Senator Dorgan, as Chairman of the Indian Affairs Committee and a true leader in the U.S. Senate for the work that you have done, really working for, not only the folks in Indian Country, but everybody in the United States that needs help.

Thank you very much for your commitment and your public service to this country.

I do have a few questions, and we'll kind of jump around a little bit.

I'll start with Joe, if you've got a mike that works, Joe, in front of you.

First of all, Joe, my compliments to you on really a top rate organization. You've done a great job educating folks in Indian Country, and I hope you continue in that venue for many, many more years.

You talked a little bit about having tribal colleges do the training for everybody, not everybody, but as many people as possible that could deal with health care in Indian Country. And you had talked about in 1989 you had one nurse in the program and now you've got as many as 46.

Over the last few years, I'll ask you the same question I asked Dr. Moore, have you been able to track where any of these students have ended up at? Have you been able to determine whether these they stayed in Salish Kootenai Country. or have they gone to some other reservation somewhere else?

Dr. MCDONALD. Yes, pretty well. I could go to the nurse director. We have their pictures on the wall, and that way I could point at the nurse and she would tell me pretty much where they're at because it's very close, and we did keep track of them.

Senator TESTER. Did most of them stay in Indian Country?

Dr. MCDONALD. The American Indian nurses stayed, they most generally stayed. We just lost one to Portland. The Sisters of Providence made an offer to her she couldn't turn down.

Senator TESTER. Okay, good.

You talked about adequate funding for tribal colleges in order for you to be successful, in order for students being able to afford to go to your institution.

Just where are you at funding-wise as far funding for trial colleges if we're going to push this along, are you underfunded, are you adequately funded, where are you at?

Dr. MCDONALD. We're really underfunded for nursing. Nursing costs the college about $10,000 per student.

Senator TESTER. Okay.

Dr. MCDONALD. And our money we get on the Student Tribal College Act is about $5,000. We try to keep the tuition down for them, so we get about $7,500 of that $10,000.

Senator TESTER. Well, thank you. It's good to know that nursing is something that's going to require some additional resources.

Would you pass the mike down to Ada, if you're available for a few questions. I do have a few for you.

I asked, I think I asked Pete Conway about the working relationship between Indian Health and the tribes, so I'm going to ask you the same question.

I want to start with your perspective, and I hope it's the same, but I'm asking the question to find out. Is your working relationship that you maintain within your health service, would you classify it as productive, cooperative, adversarial overall?

Ms. WHITE. I think it's a work relationship that is fairly—there's a lot of mutual respect, a mutual coming together sharing ideas.

There are points that I raise and I make them very aware that my presence there is most often in an advocacy position. I may articulate, I may question in a manner that may be a little confrontational, or whatever, but it's a give and take, I believe a productive relationship.

Senator TESTER. Good, outstanding.

You are put in a very difficult position because you have to make health care decisions when they have more sick people than they have money. How do you do that? How do you deal with that?

Ms. WHITE. You're asking me how I make health care decisions in view of restrictive funds?

Senator TESTER. Correct.

Ms. WHITE. I try to put myself in the shoes of the medical providers, and I look at the doctors, some of them being extremely capable and competent, not being able to take care of what's presented to them.

Now, having explored that, sometimes I marvel, I wonder what goes through their heads, because on my side of the point, certainly we have very limited funds to operate on. Certainly we're not the direct service provider that IHS is, but I am sensitive to that issue, that there is a profound need for more funds.

Senator TESTER. Okay.

You talked about, and I just want to make sure that I heard what you said, you said that there is no money for prevention; did I hear that correctly?

Ms. WHITE. My comments had to be tailored somewhat from my original draft that I sent you. That's why I resubmitted those copies of the information I received.

I am a person that believes in the buck stops here. If I'm in a position to make a decision, I certainly do, and if I have to defer to higher-ups, I certainly do that.

However, in response to your question, what do we mean by prevention and promotion? It becomes a semantical game. I believe that the money is not there for people to do an adequate job in promoting health information, health concepts and in providing the opportunities for promotion to exist.

We're at a point where that is a novel idea. I do not see how we can emphasize promotion and prevention when basic care is not being provided. You have to be well to listen.

You have to have the information at an early age. You have to be educated to understand what some of the ideas are, and I think sometimes we get bogged down with lofty ideals.

Senator TESTER. That's a good point.

I'll just tell you that for both promotion and prevention, to my perspective, is one and the same because it's about education. But I hear what you're saying. Thank you very much, Ada.

Jonathan Windy Boy, I've got a question or two for you. Jonathan, good to see you again. I want to tell you that you being in the legislature, you understand that oftentimes we're put in positions where you've got X number of dollars and you need to spread it around between health care and infrastructure projects and education.

Sometimes I see this as being in the same boat, where you're pitting one tribe against another tribe for financial resources.

My question is, and they may already be doing it, so you'll have to enlighten me on this, how can Montana Indian Nations work together to promote and improve health care in Indian Country and not be in competition with one another?

Mr. WINDY BOY. Well, first of all, thank you, Mr. Tester. I think there is a number of ways that the tribes and the government can work together.

First of all, one of the things, to use an example of what we did most recently, in 2003, if you recall, there was the Medicaid redesign—or 2005, I'm sorry, the Medicaid redesign that came in effect. And what that allowed us to do is to demonstrate how to stretch the dollar for health care.

And what that basically did, it allowed the tribes and the state to do, is to think outside the box, basically. The result of that was to try to access existing resources that are available, and in this case, Medicaid, Medicare, was that vehicle.

Realizing that Federal dollars have been limited to the IHS accounts, there are other resources outside that, and CMS has definitely been a part of that.

Demonstrating part of that, Senator Tester, is that we have partnered with the state of Montana. Governor Schweitzer has come to the table and we have signed agreements. And I think that while the atmosphere is friendly, I think it's best that we take advantage of that to try to think outside the box.

And realizing that, like you mentioned, that the dollars are limited to make it stretch, but I think by doing that, we're going to make things better hopefully for everybody.

Senator TESTER. Okay, thank you.

I'll just say that the point that you made, and you made many good points, but one of the points that you made that I thought was particularly appropriate, especially for Montana, is the remoteness.

And, you know, people back in Washington, D.C. talk about rural areas. We're beyond rural, we're frontier. It's a huge issue when you talk about distance in this state to get quality health care. And it's something that when we talk to our folks back east that are administering the programs, the only way you can ever appreciate it is if you drive between Rocky Boy and Billings and back in the same day. That's one hell of a drive. So, you know, that's important.

I want to pass it down to Stacy and Jace, and I'll just ask a question, either one of you can answer it. Do you have a working mike?

Just curious how the needs of Montana tribes compare with other tribes in the Nation.

Mr. KILLSBACK. Well, like I mentioned before, the tribes in Montana are large land-based tribes with large populations, and our needs reflect those of the direct service tribes.

Another example is during the budget formulation process this year, the tribes got together and said the number one priority, instead of piecemealing prevention, different types of health care needs, we all came together at the table and said contract health service is the number one priority. And that's the message we need to take to D.C. when you do describe the needs.

Senator TESTER. So the major disparity between Montana tribes and other tribes in the U.S. is in contract health care?

Mr. KILLSBACK. I think it could be seen as a possibility because we are direct service tribes and we don't have the access to—well, the money is a big factor and that's why contract health is the number priority here as well.

So I believe our area and Aberdeen Area, those areas with a large population of urban areas, these populations are served, have similar issues concerning funding, have similar relations concerning health care, access to health care.

Ms. BOHLEN. Can I say something about that?

Senator TESTER. Yes, Stacy.

Ms. BOHLEN. Thank you, Senator Tester.

I think that one of the real challenges that Indian Country faces is the lack of reliable data on where the disparities specifically are, who's being treated, who's being turned away, what the outcome of a person being turned away is, where do they go from here, do they ever get care.

At the National Indian Health Board, we're trying to come up with programs, like we're trying to work with the American Academy of Orthopedic Surgeons to get a volunteer orthopedic program for the Indians in this state. And it's very difficult to start because we don't have the data about where everyone is, what the problems are.

I think that's something that Congress could really help with.

Senator TESTER. And as the good doctor, Joe Erpelding said, the data is probably not necessarily good data, and so we need to work on that.

I'm going to take just a few minutes here to have some other comment by elected officials, and I've got to get out of here by shortly after 3, so I'm in the same kind of boat.

What I'm going to do is this, if we could get a representative, if you want, if you can add to it, to talk about health care. I know there's a lot of other issues, but health care is it.

Go ahead, state your name for the record and what tribe you represent. You're going to have 2 minutes, and I've got to hold you strictly to it, otherwise I can't give everybody a chance to speak.

Go ahead.

STATEMENT OF DARRYL RED EAGLE, TRIBAL EXECUTIVE BOARD MEMBER, FORT PECK ASSINIBOINE SIOUX TRIBE

Mr. DARRYL RED EAGLE. Thank you, Senator Tester. My name is Darryl Red Eagle. I'm tribal executive Board member for the Fort Peck Assiniboine Sioux Tribe.

Senator TESTER. Sir, what I'll ask you to do is talk into that mike, summarize your statement, your written testimony. You will turn it in and it will be a part of the record. So summarize it very quickly. I'm sorry, but this is not something we normally do anyway.

Speak into that other mike, please.

Mr. RED EAGLE. The Fort Peck Tribes appreciate the committee having this hearing in Montana, and urge swift passage of this Act. If you have any questions, we will be glad to respond.

Thank you.

[The prepared statement of Mr. Red Eagle follows:]

PREPARED STATEMENT OF DARRYL RED EAGLE, TRIBAL EXECUTIVE BOARD MEMBER, FORT PECK ASSINIBOINE SIOUX TRIBE

Good afternoon Senator Byron Dorgan and Senator Jon Tester, and welcome to Montana. My name is Darryl Red Eagle, Tribal Executive Board member of the Fort Peck Tribes. I am pleased to appear before this hearing to present the concerns of my Tribes concerning reauthorization of the Indian Health Care Improvement Act, which hasn't been reauthorized since 1992. We appreciate the Committee's consideration on making this Act your highest legislative priority.

I am pleased to submit to your Committee some previous documents on behalf of the Fort Peck Tribes, namely;

the testimony of our Tribal Chairman, John Morales, Jr., from May of 2006 on the reauthorization of the Act.

written comments of our previous Chairman Caleb Shields to the Tribal Leaders Council in April of 2006

a memo from our tribal attorneys on a Strategic Plan to Implement a new vision on Indian Health Care, based on tribal resolution 546-2006-04

tribal resolution 546-2006-04 which states that improving health and health care as the number one priority of the Tribes.

The Tribal Executive Board of the Fort Peck Tribes considers this resolution a measure that requires drastic action that all tribes should promote and support because the health history of our people is critical and the lack of adequate health care is life threatening. The Tribes took this action to reflect the desperation that's required by us since all other

recommendations hasn't seemed to be effective in resolving the serious lack of funding for Indian Health Service. We request our position on resolution 546-2006-04 be given consideration on future hearings of the Committee.

Mr. Chairman, the reauthorization act is so critical and is a important step in elevating the health status of our people at Fort Peck because of the remoteness of our Reservation in northeast Montana, and because the services and quality of health care has resulted in our tribal members suffering at a much higher degree than the general population.

The Fort Peck Tribes appreciates the Committee having this Hearing in Montana and urges swift passage of the Act. If you have any questions I'd be glad to respond. Thank you.

TESTIMONY OF JOHN MORALES, JR., CHAIRMAN, ASSINIBOINE AND SIOUX TRIBES, FORT PECK RESERVATION

One of the greatest needs in Indian country is access to adequate health care for Indian people. While there has been some headway by the Indian Health Service in improving the health conditions of Indian people, a great deal remains to be done. The Indian infant mortality rate is still 150% greater than for non-Indian infants. Moreover, death from diseases such as: tuberculosis is 520 percent greater; by alcoholism 433 percent greater; by diabetes 188 percent greater; and by pneumonia and influenza 44 percent greater than in the non-Indian populations. Perhaps the most heartbreaking of statistics, is that suicides for Indians and Alaska Native is 2 ½ times higher than the national average. All of these statistics highlight the need to upgrade and improve the health care deliver system in Indian country.

This nation's trust responsibility to Indian tribes requires us to continue to provide comprehensive health care services to Indian people in order to elevate their health status to the highest level. Currently, fewer federal monies are spent on the health care of an Indian patient than a non-Indian patient receiving federal assistance. One way to address this severe shortfall is through the reauthorization of the Indian Health Care Improvement

Act. This Act sets the Nation's major health status goals and authorizes the major health care programs provided to Indian people throughout the country. This is why the Assiniboine and Sioux Tribes of the Fort Peck Reservation strongly support the reauthorization of the Indian Health Care Improvement Act and urge its swift passage.

In particular, the Fort Peck Tribes support the provisions in the legislation that allow Indian health care dollars to be used in a way that reflects the modern health care delivery system by allowing the IHS and tribal health care providers to utilize funds for home and community-based health care, including hospice care, rather than only for hospital based care. This is especially important in areas like, the Fort Peck Reservation, that do not have an Indian Health Service hospital. The Tribes and our Service Unit need to be able to place the resources where we can have the greatest impact on our patients and their families.

The legislation will also allow for the integration of mental health, substance abuse, domestic violence and child abuse programs for a coordinated behavioral health program. On the Fort Peck Reservation, we face a social service crisis as a result of the triangle that is mental health, drug and alcohol abuse, and violence and suicide. These community and social issues are obviously linked. Thus, the methodology for addressing this crisis must be linked. A more holistic

approach that allows for the various health and social services programs to be integrated is the best hope for tackling this enormous issue.

Finally, the legislation will enhance health care training and recruitment to diminish the chronic shortage of qualified health care providers. This is a vitally important issue to the Fort Peck Tribes, we have not had a fully staffed service unit for several years. Currently, we only have three physicians; four nurse practitioners, six registered nurses and three LPNs, to meet the needs of a service population of more than 9000. Moreover, the turnover in the Service Unit medical staff impacts the continuity of these patients. We attach with these comments an article from the Tribal newspaper about a patient who had to have surgery to remove a twenty-three pound tumor, which was misdiagnosed numerous times by service unit professionals. The Tribes believe this was a result of a lack of continuum of care for this patient. We must do more to attract and keep Indian health professionals.

Again, the Fort Peck Tribes strongly support the reauthorization of the Indian Health Care Improvement Act and urge its passage. Nevertheless, the Tribes have some concerns with the legislation and would urge that Congress consider making some changes to the bill.

Caleb Shields Presentation at the Montana Tribal Leaders Council Annual Health Conference, Billings, Montana April 6, 2006

Indian Health Care Improvement Act

1. **Summary of Indian Health Care Improvement Act reauthorization bill**

The Indian Health Care Improvement Act was first passed in 1976. Pub. L. No. 93-437, codified at 25 USC 1601 et seq. It was last comprehensively reauthorized in 1992 and has been reauthorized annually since then through the annual appropriations process. Comprehensive reauthorization bills have been proposed during the last few Congresses, but each year they have stalled. The main reason for this has been the Administration's unwillingness to accept certain parts of the bill. The current reauthorization bill is S. 1057 and it was introduced by Senator McCain. The Senate Indian Affairs Committee has approved the bill, but the full Senate has yet to consider it. There is also no companion bill in the House at this time. Congressman Young (R-Alaska) will be introducing the House companion bill in the next few days. It mirrors the Senate bill with a few exceptions that address certain remaining tribal concerns.

The Indian Health Care Improvement Act is a comprehensive piece of legislation that addresses the provision of health care services, billing and reimbursement for those services, the structure of the Indian Health Service, training and licensing of health

professionals, and many other areas. I want to focus today on one important section dealing with payment and reimbursement for health care services provided by IHS, tribal or urban Indian health care programs.

2. Third Party Reimbursement

Title IV of S. 1057 covers payment and reimbursement for health care services. Section 403 provides that the IHS, tribal health programs and urban Indian health programs have the right to recover the cost of health care services from any third party payor, such as Medicaid, HMOs or insurance companies. This section of the bill generally reflects current law. However, in the Senate bill, new language would be added to current law so that Indian health programs can only seek reimbursement for "reasonable" costs, which would give the Secretary a role in the reimbursement process that she does not have under current law. This change should be opposed by tribal leaders.

3. Payor of Last Resort

Section 407 of the bill provides that Indian health programs (this includes IHS, tribal or urban programs) are to be the "payor of last resort" for person eligible for services. This means that if an Indian who goes to an Indian health program for services is eligible for another type of health benefit – such as Medicare or Medicaid – these

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*NOT ADMITTED IN DC

MEMORANDUM NO. 136-06

August 10, 2006

To: **Fort Peck Tribal Executive Board**

From: **Sonosky, Chambers, Sachse, Endreson & Perry, LLP**

Subject: **Strategic Plan to implement new vision for Indian Health(144.22)**

We write in response to the Tribes' request to develop a strategic plan to implement Council Resolution 5462006-004. In this Resolution, the Tribes first proclaim improving the health and health care of your members as your top priority. Second, the Tribes request Congress to enact a waiver from the Medicare and Medicaid Third Party Reimbursement process and to transfer those funds back to the IHS budget for direct payments to tribes. Third, the Tribes ask Congress to identify the amount of federal income taxes that all Indians pay and to earmark those funds to fully fund the Indian Health Service. Finally, the Tribes seek a demonstration project or pilot project to initiate this program.

A. Seeking a waiver of the Medicare and Medicaid Third Party Reimbursement process.

We have discussed this proposal with a number of Indian health care professionals and Congressional staff. We have been told that there would be a significant and unified resistance to

enacting this kind of waiver in both Congress and by the Administration. However, there is now currently in the law provisions that allow the Tribes to directly bill Medicaid, Medicare and SCHIP. Also, the provisions of the Medicare, Medicaid and SCHIP Indian Health Care Improvement Act (S. 3524), which was approved by the Finance Committee this year, would ensure that the Tribal health care providers are reimbursed at the highest rate possible. Most significantly, this measure would exempt Indian people from any cost sharing requirement by State Medicaid programs. Thus, we would also encourage the Tribes to strongly support S.3524 and work with Congress to see that it is enacted. We would also be pleased to work with the Tribes if you want to explore the opportunity to carry out a program to directly bill for Medicaid, Medicare and SCHIP.

B. Amendments to the Internal Revenue Code to fully fund Indian Health Care.

The Tribes propose to amend the Internal Revenue Code to provide that income taxes that are remitted by Tribal members be directed to the Indian Health Service. Before formulating this proposal into legislative language, legal research must be done to determine whether the law permits the targeting of federal income taxes for a particular purpose. We are prepared to do this research if so directed by the Board. If we find that the law would permit this to occur, we believe an expert should be hired to determine how much money would be earmarked. In hiring an expert, the Tribes would have to be prepared to answer questions related to whose taxes would be targeted for this purpose and how the U.S. Treasury would identify whose taxes should be earmarked. However, because this kind of earmarking is unprecedented, we do not believe that Congress would embrace this approach, even if it were legal and we could determine how to appropriately identify whose taxes should be earmarked. Thus, we would encourage the Tribes to consider an alternative approach.

Our understanding from the Resolution is that the Tribes want to establish a mandatory and increasing stream of revenues that would provide mandatory and increasing funding for the Indian Health Service in perpetuity. This is called an entitlement and would require more money to come in to the federal treasury than is currently now coming in. The only way entitlements occur (e.g., Social Security, Medicaid, Medicare, SCHIP) is for Congress to enact a tax (i.e., the Social Security tax) to pay for them. For instance, in 1997, Congress enacted an increase in the federal tobacco tax to pay for the SCHIP Program and the mandatory tribal diabetes grant funding program that is now provided to tribes. *See* P.L. 105-33 (1997).

In considering a tax to address the health needs of Indian country, we identified a current federal tax on alcohol. 26 U.S.C. 5001-et seq. The consumption of alcohol has a real and substantial impact on Indian communities. At the same time, the industry has made a great deal of money from Indian communities. The idea that the industry would be a partner and part of the solution addressing these health costs is in our view reasonable. Thus, we would suggest that

rather than earmarking income taxes (which we believe is not something Congress would embrace), the Tribes should change your proposal to be one that would increase the excise tax on alcohol, to fund mandatory increased spending on the Indian Health Service.

While we believe that this is a solid policy proposal, as with any legislative initiative, it is also true that getting Congress to provide secure and full funding for the Indian Health Service will only occur in steps. Thus, we think the Tribes should also engage in a broader strategy, which includes supporting the reauthorization of the Indian Health Care Improvement Act, taking a leadership role in national Indian health care policy and working with other interested parties (American Medical Association, unions, the AARP) to gain support their support for Indian ~~health policy improvements. To be sure, any proposal to increase the tax on the alcohol will be~~ met with stiff resistance from the alcohol industry, hospitality industry, corn producers, consumer groups and anti-tax groups. The Tribe will have to anticipate opposition and work to minimize its impact.

1. Actively support the Indian Health Care Improvement Act Reauthorization

The first part of this strategy is to work with Congress and other Tribal organizations to enact the Indian Health Care Improvement Act Reauthorization. This legislation has been pending before Congress for seven years. This bill is the beginning of what the Tribes want accomplished because it increases the amount of funds paid into the IHS system. An enormous amount time and political capital has been put into getting this measure passed by Congress. The Senate is poised to take up the bill sometime this year. The House Resources Committee has also approved a version of the bill. What remains to be done is to get the House Energy and Commerce Committee and the House Ways and Means Committee to consider the bill.

The House Energy and Commerce Committee is the primary House committee of jurisdiction over health legislation and the House Ways and Means Committee is the primary House committee of jurisdiction over legislation that involves entitlement programs (Medicaid, Medicare and SCHIP). As we understand it, these Committees are concerned with how the bill would impact the entitlement programs to increase payments to tribal health providers and increase the federal costs for the Indian health system. The Tribes should be working actively with the National Indian Health Board, the Montana-Wyoming Tribal Leaders Council, and the National Congress of American Indians on efforts to pass this important legislation. If the Tribes wish to take a more active role, we would be pleased to facilitate your involvement with the Coalition for the Reauthorization of the Indian Health Care Improvement Act and to participate on your behalf if we are directed to do so.

In our view, Tribes have the necessary vision to serve as a leader in this first step of increasing funding for the Indian Health Service through your support of the reauthorization bill.

Without this first step, we do not believe Congress will consider broader proposals that would make even more substantial changes to the Indian health care system. Changes to health care legislation can be very complicated because they involve so many different programs. While not perfect, the reauthorization bill currently pending before Congress would achieve some of the objectives you seek. This is why taking an active role in supporting the bill is important. Furthermore, advancing competing legislation would place the Tribes in a difficult position with regard to other tribes and Indian organizations. On the other hand, if the Tribes become actively involved in the reauthorization effort, significant proposals such of the kind suggested in the Resolution may be incorporated into future reauthorizations. Again, we would be pleased to work with the Tribes to actively support the enactment of this important legislation.

2. Leadership Role in National Indian Health Policy Organizations

In order to garner support for creating an increased federal alcohol tax to fund Indian health care, the Tribes are going to have to take a leadership role in National and Regional Indian health care organizations and other health organizations. This includes serving on Boards, attending their meetings and actively participating in their legislative activities. Without these organizations' support for your proposal, it is unlikely to gain support in Congress.

3. Support from Non-tribal Organizations

In addition to Tribal organizations, the Tribes will have to work with other organizations that are involved in health policy and garner their strong support of this idea. These organizations include the American Dental Association, American Medical Association, health care unions, Kaiser Family Foundation, AARP, American Friends Society and the National Organization on Fetal Alcohol Syndrome. Often these organizations are critical to the success of any health policy legislation before Congress. This work will also be important to address the strong opposition this proposal will likely face from the various industries, anti-tax groups, certain Members of Congress and the Administration.

C. Conclusion

We commend the Tribes for making health care your top priority. We stand ready to assist you in your efforts.

Respectfully Submitted,

SONOSKY, CHAMBERS, SACHSE
ENDRESON & PERRY, LLP

By: Mary J. Pavel
Addie C. Rolnick

cc: Mr. Caleb Shields

5. **The Tribal Executive Board of the Fort Peck Assiniboine and Sioux Tribes proposes to seek the support of Indian tribes, regional and national Indian organizations, states and all supporters of Indian people of America to finally cure the health care injustice that exists in this great country of America.**

CERTIFICATION

I, the undersigned Secretary/Accountant of the Tribal Executive Board of the Assiniboine and Sioux Tribes of the Fort Peck Reservation, hereby certify that the Tribal Executive Board is composed of 12 voting members of whom 9 members constituting a quorum were present at a meeting duly called and convened this 28th day of April, 2006, that the foregoing resolution was duly adopted at such meeting by the affirmative vote of 7 for, 0 opposed, 0 not voting and 2 absent.

Secretary/Account

APPROVED;

Chairman/Vice Chairman
Fort Peck Tribes

Superintendent
Fort Peck Agency

Senator TESTER. Thank you very much. Next up?

STATEMENT OF CAROLE LANKFORD, VICE–CHAIR, SALISH KOOTENAI TRIBES; ACCOMPANIED BY KEVIN HOWLETT, HEALTH DIRECTOR, SALISH KOOTENAI TRIBES

Ms. LANKFORD. I am Carole Lankford, Vice-Chair of Salish Kootenai Tribes. I want to thank you for coming out and giving us this opportunity.

We are submitting written testimony and I would also like to give my tribal health director a chance to say a few words.

Senator TESTER. Thank you.

Mr. HOWLETT. Senator Tester, my name is Kevin Howlett, I'm the Health Director for the Salish Kootenai Tribes. I would just like to thank you for holding this hearing.

I think the issues that have been addressed have been certainly sincere, and I think that as you look across Indian Country, it isn't just Crow, it's every reservation that has these kinds of issues.

Things have got to change. People have got to think about this differently and we really have to move health care into the twenty-first century.

We will be submitting testimony, and thank you and Senator Dorgan for having us at this hearing.

Senator TESTER. Thank you, I appreciate it, and the problems are not exclusive to here, but all Indian Country.

Go ahead.

STATEMENT OF TRACY "CHING" KING, COUNCIL MEMBER, FORT BELKNAP INDIAN COMMUNITY, ASSINIBOINE TRIBE

Mr. KING. Good afternoon, Senator Tester, my name is Tracy "Ching" King, I'm the Assiniboine representative at large of Fort Belknap.

I want to personally thank you for looking into the matter of my daughter who is a combat vet of the Iraq war and the mistreatment she had with the Veterans Administration in Helena. I appreciate that.

But I'd also like to say that the Tribal Council believes they don't have a good relationship with Indian Health Service. If you look at the disparities of the funding, it's somewhere in the 60 percent range.

In the corporate world, Wall Street, there's like incentives built into some of the people in corporate America. Corporate America executives received $154.9 billion, billion. for incentives for the past 10 years.

And the top 20 executives in Wall Street, their salary is 260 million and up to $1.5 billion totaling $13 billion that corporate America gets.

170 years ago, my grandfather fought with Sitting Bull, my three grandfathers, and I come from a family of leaders and veterans. My daughter is a combat vet. My nephew is a combat vet, my brother, and I think we need to listen to our needs.

Thank you.

Senator TESTER. Appreciate your comments, appreciate your service and your family's service.

Next up?

STATEMENT OF JULIA DAVIS WHEELER, TRIBAL COUNCIL MEMBER, NEZ PERCE TRIBE

Ms. JULIA DAVIS WHEELER. Yes, good afternoon. Good afternoon everyone, my brothers and sisters that are here. My name is Julia Davis Wheeler, and I'm a Nez Perce Tribal Council woman from the Nez Perce Tribe in Idaho.

The Nez Perce Tribe is one of the 42 tribes in the northwest that count on contract support costs to take care of the majority of our major health needs. We do not have hospitals, even though in our treaties it's stated that we would have hospitals.

Nonetheless, having no hospitals, we need to have inpatient facilities. Regional centers of excellence would be a great help in helping those of our people that are suffering.

The Nez Perce Tribe is a self-governance tribe by choice of the General Council, not the Tribal Council, the General Council. This has been a good move, but this also comes with inadequate funding. I just returned from a self-governance meeting in Bellingham, Washington, and we talked about that issue.

The tribe has been working tirelessly with the issue of trying to recoup contract support costs that were formerly withheld for certain Fiscal Years. We're trying to get that money from the Indian Health Service.

Claims have been dated back to 2005. Two years later we received letter after letter stating that the $600,000 claim that we have put in has not been processed. This is a shame. This is a

shame and an atrocity to the people that are counting on contract health service.

I wanted to bring this to your attention, but I also wanted to echo what everyone has stated here.

But I want to end my comments with something that is very near and dear to me, as well as the descendants of chiefs here in this room.

Chief Joseph stated 120 years ago; I have heard talk and talk, but nothing is done. Good words do not last long until they amount to something. Good words do not give my people good health and stop them from dying. Good words will not give my people a home where they can live in peace and take care of themselves. I'm tired of talk that comes to nothing, it makes my heart sick. But I remember all the good words and all the broken promises. Too many misrepresentations have been made. Too many misunderstandings have come up between the white man about the Indians. There need be no trouble, treat all men alike, give them all an even chance to live and grow. All men were made by the same Great Spirit Chief. They are all brothers and the Earth is the mother of all people.

I end my speech with this from Chief Joseph. Thank you.

Senator TESTER. Thank you.

STATEMENT OF EUGENE LITTLE COYOTE, PRESIDENT NORTHERN CHEYENNE TRIBE

Mr. LITTLE COYOTE. Good afternoon. I'm Eugene Little Coyote, President, Northern Cheyenne Tribe.

I'll be very brief. Of course, the Northern Cheyenne Tribe strongly encourages and supports the reauthorization of the Indian Health Care Improvement Act.

We have three priorities we were going to mention today, diabetes and dialysis, methamphetamine prevention. We have a war on meth on the Northern Cheyenne, and I'd like to mention that Chairman Venne and the Northern Cheyenne Tribe have a interdepartmental coalition, Safe Trails Task Force. We're doing very well on that.

Third is contract health care. We need increased funding in all areas of Indian health care, and the Northern Cheyenne will submit a detailed written testimony on these.

Thank you.

[The prepared statement of Mr. Eugene Little Coyote follows:]

PREPARED STATEMENT OF EUGENE LITTLE COYOTE, PRESIDENT NORTHERN CHEYENNE TRIBE

Good afternoon, Chairman Dorgan and members of the Committee. I am Eugene Little Coyote, President of the Northern Cheyenne Tribe. The Northern Cheyenne Tribe operates community health programs under an Indian Self-Determination Contract. We work with the Billings Area Indian Health Service, which operates the Northern Cheyenne Community Health Center in Lame Deer. I am pleased to be here today and to offer testimony regarding the health needs of the Northern Cheyenne Tribe.

Let me begin by thanking you, Chairman Dorgan, and other members of the Committee for introducing earlier this year, S. 1200, to reauthorize the Indian Health Care Improvement Act. We fully support S. 1200 and urge its enactment this year. Like the Snyder Act, the Indian Health Care Improvement Act is the foundation for the Indian health program. Much work has been done throughout Indian country to produce S. 1200. Chairman Dorgan, your comments in introducing this bill show that you understand the deficiencies we operate under in the current Indian health system. To begin to address these deficiencies, we need your help in reauthorizing the Indian Health Care Improvement Act without further delay, and then supporting our programs by appropriating significant increases to fund the programs authorized by the Indian Health Care Improvement Act.

The Act contains many programs of value in Indian country. I want to mention just a few that are priorities for the Northern Cheyenne Tribe.

Diabetes Prevention and Treatment. Diabetes treatment and prevention are among our most significant health needs. Based on our most recent GPRA reports, the Diabetes Prevalence rate among our Northern Cheyenne user population is 12%. This 12% equates to 462 active users with a diagnosis of Type II Diabetes. While these numbers

are alarmingly high in themselves, our population as a whole is at risk because in general our population fits within the most significant risk factors for Diabetes.

Northern Cheyenne Tribal Health operates several programs that provide diabetes prevention services. We use the Special Diabetes Program for Indians grant funds for a number of community health education, exercise and nutrition programs. With the limited funds we have available, we try to balance the needs of our total population – for preventive programs and services -- with the acute needs of some tribal members for services needed to address diabetes complications, such as End Stage Renal Disease.

We have over 20 patients currently on dialysis; another approximately 50 patients indicated to be at or near in need of dialysis; and almost 150 patients showing early indications of renal disease. Our dialysis patients currently have to travel significant distances to receive dialysis. We used to have a dialysis center in Lame Deer just as until recently there was a dialysis center here at Crow Agency. Both centers have closed due to staffing, funding and related difficulties. This means that our tribal members in need of dialysis have to travel over two hours each way twice a day three times a week to get dialysis services. Being a dialysis patient is hard enough but the lack of local services takes our tribal members away from their families and communities for at least three very long, difficult days each week. Others have to go live in Billings or other places because they have complications, transportation difficulties, or other extenuating circumstances.

We are in the process of determining the feasibility of re-opening a dialysis center in Lame Deer. We know this initiative brings with it significant challenges but this is a service we need for our people in our community. We are evaluating whether we can build, equip and staff a dialysis center and make it sustainable on a long term basis. Our research shows that we are up against substantial staffing recruitment and retention obstacles, and of course, funding shortfalls. At the same time, dialysis is a service we need to continue to pursue in our local communities because of the hardships it places on our members to travel so far for this critical service.

We are appreciative of the Special Diabetes funding we have received in recent years and urge you to renew this program when it is up for reauthorization in 2008. We also request your support as we develop critically needed local services to address the complications associated with diabetes, such as dialysis.

Methamphetamine Abuse. Secondly, I want to address methamphetamine abuse. There is probably not a single family on the Northern Cheyenne Reservation that has not in some way been affected by methamphetamine use. Over the last year, we have had over 750 patient visits for reasons related to methamphetamine use or dependence. While I am told methamphetamine abuse is declining in the State of Montana, I believe it is increasing on reservations. We have seen a 65% increase in visits for methamphetamine abuse over the last three years.

On the Northern Cheyenne Reservation, we started a "War on Meth" several years ago. Through this initiative we have formed an interdepartmental coalition that develops and supports methamphetamine prevention and treatment programs. While the War on Meth has seen some success, our program directors are continuing to reevaluate current treatment options and to develop outpatient and other treatment programs targeting methamphetamine use. We are finding that to successfully address methamphetamine abuse, we need to involve the family as a whole in treatment, and we also need to provide substantial aftercare and other support. Treatment of Methamphetamine addiction is calling for new treatment strategies, and particularly for coordination with other community services, such as Law Enforcement. We need your support for increased funding for substance abuse and behavioral health to effectively address methamphetamine abuse.

Need for Increased Funding. This year, our Tribal Health program budget exceeds the amount of the current year's funding. We have operated this way for several years and have funded the deficit with carryover or other tribal funds. We currently project that we will deplete these carryover funds in the next year. The Tribal Health budget simply cannot keep pace with population growth and inflation. In addition to inflationary

increases, each year "rescissions" further reduce the funding amounts in our Indian Health Service contract. We ask the Committee to include bill language to protect our contract funding for direct services from budget rescissions.

Last, I want to mention the Contract Health Services ("CHS") program operated by the Indian Health Service out of the Northern Cheyenne Community Health Center. The proposed increases for CHS in the FY 2008 appropriation are not sufficient. We understand that our local service unit typically operates at a deficit of approximately $500,000.00 a year. And the service unit operates at a high level priority -- authorizing the use of CHS funds only for "loss of life or limb" priorities. As Chairman Dorgan recognized in his statement when he introduced S. 1200, under current appropriations the Indian Health Service is forced to ration care. I could give numerous examples of the effect of rationed care here in the Billings Area and on the Northern Cheyenne Reservation. I think you are familiar with these stories.

In closing, I thank you for the opportunity to be here today and for your consideration of my testimony on behalf of the Northern Cheyenne Tribe. I urge you to seek enactment of the Indian Health Care Improvement Act this year, and then increased funding for our programs to help us start to alleviate the disparate health status and conditions under which we currently operate.

I will be happy to answer any questions you may have.

Senator TESTER. Thank you very much, Eugene, appreciate it.

STATEMENT OF LEO STEWART, VICE-CHAIRMAN, CONFEDERATED TRIBES OF UMATILLA INDIAN RESERVATION

Mr. STEWART. Good afternoon, my name is Leo Stewart. I'm the Vice-Chairman of the Confederated Tribes of Umatilla Indian Reservation, which consists of Walla Walla—I almost said Nez Perce because the Cayuse is part of the Nez Perce and the Umatillas.

One of the things, we would like to thank you a lot for reintroducing the Indian health care plan.

Another thing, too, is that we have strong care need, like Julia Davis said about the Indian health care for hospitals in our areas. It's really a need.

It shouldn't specifically be put into designated areas, but into the remote areas that would help our people a lot, and the reaching out for these kinds of funds to make these things work.

Another thing, too, is to the support of all our funds that is important to let the unfairness of facility construction fund is when it takes over 50 percent of IH budget increases to phase in staff and to new facilities, and only three to four of the areas get the

participant end of facility construction plan, so that's what we need.

So I'd just like to thank you and thank you for letting me have this time.

Senator TESTER. Thank you for your comments.

And this applies to everybody, we take written comments, so please, if there's more that you wanted to say that you couldn't, write them and send them in.

Go ahead.

STATEMENT OF EDWIN LITTLE PLUME, CHAIRMAN, HEALTH COMMITTEE, BLACKFEET TRIBAL BUSINESS COUNCIL

Mr. LITTLE PLUME. Good afternoon, Mr. Tester, appreciate you coming back to Montana, as well as Mr. Dorgan, Senator Dorgan. We appreciate your good words for funding for us back in D.C.

As a new member of our Tribal Council, I sit on the health committee and chair that committee. As you know, being a new guy like yourself in Washington, I experience pretty much the same on our home reservation, funding for health care.

Our hospital, in the 30 years since the original facility expansion, many variables have changed. Most noticeably, the hospital visits have continued to increase steadily over the time from 60,000 outpatient visits in 1984 to 124,000.

Our hospital has become a regional hospital, which originally was designed for the Blackfeet people which our treaty stated.

At this time, our hospital visits takes in patients from all the urban centers in the state of Montana. We have patients coming from Illinois, Idaho, Minnesota, Oregon, Washington State, North and South Dakota, are traveling to the Blackfeet Community Hospital in Browning for their health care needs.

The Browning hospital, which was designed for the health of the Blackfeet people has become a regional health facility for many other tribes. The impact of this has become very noticeable to our own people as their needs for health care are not being met.

So, with that, I thank you for listening to today's testimony.

[The prepared statement of Mr. Little Plume and Ms. Tatsey follow:]

PREPARED STATEMENT OF EDWIN LITTLE PLUME, CHAIRMAN, HEALTH COMMITTEE, BLACKFEET TRIBAL BUSINESS COUNCIL AND JANE TATSEY, HEALTH ADMINISTRATOR, BLACKFEET TRIBE HEALTH DEPARTMENT

Dear Senate Committee Indian Affairs Members:

We certainly are pleased that Senate Committee members Senate Byron Dorgan and Senator Max Baucus will be in Montana at the Crow Reservation on August 15, 2005 to meet with the Indian Tribes in the IHS Billings area. It is an honor to have you here.

I am the Blackfeet Tribal Health Administer for the Blackfeet Tribe. The Rocky Mountains border the Blackfeet Reservation on the west and the Canadian Province of Alberta on the north. The Blackfeet Reservation is the gateway to Glacier National Park.

There are 16,000 enrolled members of the Blackfeet Tribe and many of Blackfeet descent. To be enrolled at this time it is necessary to have a Blackfeet Blood Degree of ¼ Blackfeet. There are many Blackfeet children who are not enrolled due to this requirement but are able to receive health care from the IHS.

On the Blackfeet Reservation 64% of the people have an income below the U.S. poverty line. Glacier County consists of 90% of the Blackfeet Reservation. It is one of the poorest counties in the United States (U.S. Census 2000).

We were a healthy people many generations ago. This can be attributed to the healthy lifestyle. As time went on our lifestyle changed from being the "Great Hunters" of the Plains and providing food and healthcare to our people. We were placed on reservations where life was greatly different. Health Care was turned over to someone else. The food changed for us and the many other changes that bring us to where we are today.

We are at a point in our lifetime where we are aware of where we came from and are aware of the many health problems that we face now. "Mending the Blackfeet World" is the direction we are working to improve health and become a healthy people again!

We are requesting your help to assist us in this process for the present generation and the coming generations of the Blackfeet people. There are many health problems that we face today since the change in our lifestyle for the generations that are here today.

The Reauthorization of the Indian Health Care Improvement Act (IHCIA) is very critical today for the Native American Indian people. Since the 1992 when the Act was last authorized, the American health care system has revolutionized, but the Indian health care system has not been. It is imperative that the IHCIA be reauthorized to begin to bridge this gap! It has been 13 years since the Act was last authorized.

The United States has a long standing trust responsibility to provide health services to American Indians and Alaska Indians. This responsibility is carries out by the Secretary of the United States Department of Health and Human Services through the Indian Health Services.(IHS) Since its passage in 1976 the Indian Health Care Improvement Act (IHCIA) has provided the programmatic and legal framework for carrying out the federal government's trust responsibility for Indian Health.

We are aware of the many health disparities that we have as Indian people. We want to have input to help address the health disparities as we are very aware of them and help to improve the health care that came about due to the many changes in out lifestyle for generations.

Thank you for the opportunity to share the Blackfeet Tribe Health Disparities & Health Issues. There are many but the focus will be on those that need to be addressed immediately.

- The reauthorization of the IHCIA as it is extremely important today. This would address many of the health disparities and issues that we are very concerned about today. This has been an ongoing concern of Native Americans for several generations now.

- Health Promotion/Disease Prevention needs to be funded at a much greater level to address the health needs of today. Prevention is the "key" to stop this onslaught of diseases that are appearing with the Indian people. We need to have funding to work on health promotion and disease prevention. We need to be "proactive" in the effort instead of "reactive" after the problem is here. Funding is critical for this.

Although there may be some grants out there for prevention, the tribes need to have access to this funding on a yearly basis with the funding listed for Indian Tribes. We are ready as Indian people to be involved with our health care and continue this "journey to wellness" for the Indian people. Although some funding is available through IHS, it appears not near enough for the prevention that is necessary to become the healthy people

that we once were. We need to be involved with this healing process for our Indian people. We know the problems and live with them every day.

- Traditional Indian Healers are still available to help us with our health problems. There does not appear to be any funding for these people. They are some of the greatest Healers and can help especially in the area of Mental Health. This is an ongoing need and appears to continue to grow in the present time.

- The need for adequate IHS medical staff to meet the needs of the people appears to become greater and the funding continues to diminish.

- The inadequate funding for the Urban Indian Health Clinics is a great concern. Adequate funding absolutely needs to continue for Native Americans living off the Reservation for work and education.

The Billings IHS Area has the third highest population below the poverty level. The unemployment rate is at 75%.

Health Disparities continue to increase – Some areas of need for additional funding for our area is listed as follows:

1. Contract Health Care Services(CHS) funding
2. Cancer
3. Diabetes
4. Heart Disease
5. Alcohol and Substance Abuse
6. Mental Health Services
7. Pharmacy
8. Injuries/Injury
9. Dental Services
10. Health Education
11. Funding for Health Promotion/Disease Prevention is greatly needed to reach all the communities on our Blackfeet Reservation which is 1.5 million acres.

- Funding for the Special Diabetes Project must continue as a great deal of work is being done by the Tribes for this disease. This cannot be curtailed immediately as it took generations to cause diabetes to the degree that it is here now. It will take a few generations of education and health care to combat the illness.

-Meth – funding is greatly needed to address this very critical problem that impacts the lives of many people/families/health problems/ and the future generations of the Native American people. Treatment for this "vicious enemy" has not been funded adequately to deal with this great problem.

- Inflation needs to be considered from year-to-year when funding is available for the health care needs of the Native People. This should be a priority to continue the "Health Promotion/Disease Prevention" that has started with Indian people very involved on the Reservation.

-Elders – this is a very precious group to us Indians. They have a great deal to offer us and one area is the "love and caring" they have for their grandchildren, family, and others. They have many experiences as they have gone through the transition of Indian people in order to live in today's world. They continue the Indian traditions which offers us very important information to understand the changes and how to deal with them in the world we live in today. They are the Historians for our tribes. However, they also need health care at times and adequate funding for their health needs.

Something that is very important in the world continues to be the family strength. I feel this is something that is necessary and very important to each and every person. We must focus on this. If a family is strong we can continue to share and assist each other throughout our lives and deal with life's problems as they arise. I see our country as times as a large family. We must first take care of the needs of the people in our country to keep them strong and healthy and so that we may work together to keep our country strong!

We are grateful for the health care that we have received but we are at the time when we Indian people feel we want to have a strong voice in our health care. We must address the needs to once again make us healthy and strong people. We can contribute to this most important endeavor but we need the funding that is important in today's world to succeed. We realize by working together we can make a difference. Thank you!

Respectfully,

Ms. June Tatsey, Health Administrator
Blackfeet Tribe Health Department

Mr. Edwin Little Plume, HESSChairpersin
Blackfeet Tribe Business Council

My name is Edwin Little Plume, Chairman of the Health Committee Blackfeet Tribal Business Council. Please accept this document on behalf of the Blackfeet People and other tribal groups who also utilize the Blackfeet Hospital. My comments and concerns have been expressed here before to this body, because the most important thing in life for any person, including the people I represent is at stake...***our health.***

I am representing the Blackfeet People. I would like to begin my statement by thanking the Congress for assisting the Blackfeet Tribe in this process.

Although the mission statement of the Indian Health Service is ambitious, "**in partnership with American Indians and Alaska Natives to raise their physical, mental, social, environmental and spiritual health to the highest possible level**" attaining this noble vision is extremely difficult if not impossible without adequate funding and staffing.

From under employment, alcohol abuse, domestic violence, diabetes, cancer, upper respiratory infections, end stage renal disease, HIV, and accidents to PTSD of our veterans returning from Operation Freedom in Iraq and Afghanistan, we need increased funding and staffing to improve and manage these incidences.

The current state of per-capita health care funding provided to Indian Health Services of only $1688 compared to the more than $5,214 enjoyed by a federal prisoner is a serious shortfall that must be addressed and corrected by you, the United States Senate.

If the Indian Health Service mission statement above is to have any validity at all, we must reduce this enormous, unjust and unhealthy disparity.

Indian Health Service Funding is so critically under-funded that the Contract Care budget is backlogged with claims for catastrophic health care requests from FY 2003 and total more than $6.7 million for the Blackfeet Service Unit. This sadly translates to 2,675 patients not being able to receive services but placed on a deferred waiting list until funding becomes available or their health condition can rate high enough to be referred for care.

Many times patients on the backlog list can only watch their health deteriorate or they actually die waiting for a contract care referral. This agonizing pain and unnecessary suffering results in untold and devastating hardships for adults and children alike and could be preventable and/or treatable if the patient were able to receive the health care services most Americans take for granted.

In FY 06, there were 78 Heliport transports from the Blackfeet Community Hospital due to accidents and other trauma. This depleted 38.6% of the CHS budget and impacted patients with non life threatening injuries that unfortunately have to be deferred, resulting in the need for the patient to be placed on medications until there is enough funding to receive medical surgery or other treatment not available at the service unit.

This enormous backlog and burgeoning increase in health care denials is a two edged sword. Not only does the Contract Health Service (CHS) "rationing of health care" system compound the problem of chronic pain and delay the patient form accessing quality health care, it flies in the face of the Indian Health Service mission on a daily basis. **The Indian Health Service cannot begin to raise the mental, social, spiritual or environmental health of the Native American if it cannot even improve the *physical health* of the patient.**

My testimony hopefully enlightens you to appreciate in a small way what many of our patients must experience on a daily basis waiting for the Indian Health Service to authorize health care on a shrinking inadequate under-funded budget.

Blackfeet Community Hospital has over $2.5 million in deferred MRI diagnostic testing procedures that were denied during the first nine months of FY 07. This not only limits the care providers can give their patients but precludes the provider from prescribing a treatment plan without the diagnostic test the patient so desperately needs.

The Blackfeet Tribe recognizes the importance of quality of health care and the impact of the delivery of these services to the overall health of the community and shares the mission of the Indian Health Service to elevate the status of Native American/Alaskan Natives to the highest possible level. To this end, the Blackfeet Tribe requests the Indian Health Service reassess it's original planning document that programmed resources for the construction and staffing of the hospital in the 1970's.

In the 30 years since the original facility expansion, many variables have changed. Most noticeably, the provider visits have continued to increase steadily over that time from 60,000 outpatient visits in 1984 to 124,000 in 2006. Unfortunately, this increasing demand has not been adequately addressed for staffing levels.

This increase is due to the lack of available services not only in the state of Montana but in several surrounding states as well. In addition to the urban centers and all rural areas of Montana, patients from as far away as Illinois, Idaho, Minnesota, Oregon, Washington, North and South Dakota are traveling to the Blackfeet Community Hospital in Browning, Montana for their health care needs. The Browning Hospital, which was designed for the health of the Blackfeet People, has become a Regional Health Facility for many other tribes. The impact has become very noticeable by our own people as services and access becomes difficult at times.

The Indian Health Service has made attempts to handle this unexpected, unplanned, and difficult demand by contracting temporary clinical support positions and juggling available staff to optimize services available through the Urgent Care Department within the hospital. The Administration and Business Office at Blackfeet Community Hospital struggles on a daily basis to maintain and enhance third-party collections to offset these unforeseen costs, and attempts to meet billing requirements placed upon the facility by this ever increasing demand with the contracted support positions noted above. Unfortunately, these temporary positions are not programmed within the Indian Health Service's resource requirement methodology and the hospital must provide the services with a very limited and inadequate budget.

With health care costs continuing to escalate and reimbursements shrinking, and more and more patients seeking care at the Blackfeet Community Hospital, the dilemma of providing quality care for not only the Blackfeet but other tribes' as well will continue to be extremely difficult if not impossible. It cannot be overstated, without additional funding for medical supplies, equipment, medication and staffing the hospital will not be able to meet demand.

The impact this alarming demand by the native populations seeking health care services at the Browning hospital has on the hospitals limited resources is shown by the effect it places on the pharmacy department of the Blackfeet Community Hospital.

The Blackfeet Community Hospital pharmacy department was originally designed and programmed to provide services to approximately 10,000 Blackfeet patients in the 1970's. Today over 16,000 patients

receive care from the pharmacy. The pharmacy drug budget has also escalated steadily over the years where it now exceeds $ 5 million dollars even with a very stringent formulary that is reviewed and managed on a monthly basis by the pharmacy, administration and medical staff.

On average, the pharmacy fills 800 to 900 ambulatory (retail) prescriptions per day (most community pharmacies fill 200 to 300 prescriptions daily). Wait times can be considerable for the average processing time in an ambulatory setting. It is not uncommon for some patients to wait for medications up to eight hours if not longer because of the demand and inadequate staffing in the pharmacy. In addition, we have a pharmacist who is required to manage the pharmaceutical care of hospitalized patients throughout the day and be on call during off duty hours, further compounding the impact to daily pharmacy outpatient duties and capabilities. We also provide pharmacy services to our satellite clinic in Heart Butte four days per week and fill an additional 350 to 400 prescriptions per week at this location. With this volume load, the pharmacy requires at least 11 pharmacists, 11 certified/licensed pharmacy technicians and 2 window clerks to operate. To date we have 7 full time pharmacists and 3 full time pharmacy technicians programmed for staffing the pharmacy departments at the hospital and clinic. Sadly, some pharmacists have left the facility due to burn out and we must fill the void with intermittent, temporary contract pharmacists.

We are still in the process of converting to the national mandated electronic health record (E.H.R.), which has shortened the processing time of prescriptions. Although the national mandate is embraced locally and has several advantages, the mandate is largely unfunded requiring local agencies to bear the costs. Nonetheless, this positive change has enhanced customer service and permits nearly one-half of the medications written on a daily basis to be processed via the electronic health record system. The other 50% of the daily prescriptions are hand written in the charts and must be processed manually. Ideally, a pharmacist would be placed in the clinical setting to assist in this endeavor and counsel patients, but because of our staffing constraints we cannot consider this opportunity to improve efficiency of services and must depend on the antiquated method of the physical presence of patient charts to fill the prescriptions in a less timely and inefficient manner.

Another other unfunded mandate that places additional monetary strain on the local facility is the Pay Act. This cost and the electronic health record mandate are essential to keep pace with the changing environment of health care but become cost balancing acts and will result in the reduction of services if funding levels are not increased.

Earlier, I stated the difficulty our service unit experiences in attempting to implement the mission of the Indian Health Service and would like to re-emphasize the need for a significant increase in a per-patient funding strategy to match that of the Bureau of Prisons so we can begin to practice prevention, concentrate on chronic disease management and implement health promotion initiatives so drastically needed in Indian Country today.

We must start now and curtail rationing emergency care and meet "head-on" the ever growing health care needs of the reservation population, including the care provided to members of many other Native American peoples and urban populations accessing care at the Blackfeet Community Hospital. This can only be accomplished with an increase in funding.

Therefore I seek your continued support and sincerely ask you to increase the budget for the Indian Health Services and in particular direct appropriations for Blackfeet Community Hospital in the amount of $10,000,000.00.

In conclusion, I again want to sincerely thank you for your support of the Blackfeet Tribe in providing appropriations for meeting the basic health care needs of its members and ask for your continued support to increase funding levels so the Blackfeet Community Hospital can provide quality health care services to all patients seeking these services at the facility and insuring adequate staff is available to meet the growing demand. Thank you very much.

Senator TESTER. Thank you.

STATEMENT OF ANDY JOSEPH, JR., CHAIR, HEALTH AND HUMAN SERVICE COMMITTEE, COLVILLE CONFEDERATED TRIBES

Mr. JOSEPH. Good afternoon to my friends here in the Crow Nation and Senator Tester. My name is Andy Joseph, Jr. I'm the chair of the Health and Human Service Committee for the Colville Confederated Tribes.

I'm also the Vice-Chair for the Northwest Portland Indian Health Board of 43 tribes in Washington, Idaho and Oregon.

The testimony that I'd like to give is on the IHS budget. The Office of Management and Budget requires the staff to work on rules-based budget.For the last 4 years we've had to work on a rules-based budget of 2 percent or 4 percent.

This last meeting we requested a 23 percent increase in current spending. That pays for the pay act, Federal employees get a raise every year. It covers the inflation and it also covers the population growth for all of the nations.

By being stuck with a rules-based budget every year, we have to go back there. Dr. Grim negotiates for us the funding that has been given and he's not a tribal leader. I want to see tribal leaders at the table.

I pushed a resolution to have a leader from NCAI, a leader from the National Health Board, a direct service type representative to be at that table. Government staff according to Executive Order should not be talking for us.

As you know, he's a commissioned officer and he doesn't have the high rank to tell his superiors what we really need, and he's paid to save money for the government, but it's costing a lot of our people's lives.

I imagine if you took the numbers down of all the people we've lost over the years, we'd be right up there with our soldiers that we're losing in Iraq.

Senator TESTER. Please, please put it in written testimony. I'm literally going to have to walk out of here in 1 minute. So thank you very much.

Mr. JOSEPH. We'll send in our written testimony from the Northwest Portland Area Indian Health Board on our health care status.

Senator TESTER. I appreciate that very much.

The next two very quick comment, I mean very quick comment because I've got to boogie.

STATEMENT OF MS. WALK ABOVE, MEMBER, CROW TRIBE

Ms. WALK ABOVE. Good afternoon, Jon Tester, I'm (inaudible) Walk Above. I'm a parent, I'm a member of the Crow Tribe.

My baby has been having health problems, which he's okay now, but I have these bills and I've written to the hospital here for them to pay for my bill and have them pay for it, and they didn't approve it.

So I wrote a letter to the Indian Health Service in Billings and they denied my letter. So I wrote a letter to Washington, D.C. I haven't heard from them yet, but I would really appreciate it if they would help me.

And I'm glad that you're here to hear our testimonies because we cannot go to Washington, D.C. and to go and see you.

Thank you.

Senator TESTER. That's one of the reasons we're here. Thank you very much.

STATEMENT OF KEN REAL BIRD, REPRESENTATIVE, CROW TRIBE

Mr. REAL BIRD. Thank you, I'm Ken Real Bird. I'm a victim of this flawed health——

Senator TESTER. Are you an elected official?

Mr. REAL BIRD. Yes, I represent the legislative branch of the Crow Tribe. I'm a victim of this outfit right here. And I think that there needs to be some law so the issue of malpractice is addressed by IHS doctors.

See, when they do something wrong, it's acceptable because they're covered by IHS, but the individual who causes the problems, the doctor needs to be liable for some of the things that they have done.

Now, there's so many problems with the IHS, especially in management. And one of the things that I'd like to bring out is that us Indian people have to wait 5 hours or more to get health care.

Senator TESTER. Could you do me a favor? Could you write it down and send it in because——

Mr. REAL BIRD. Yes, I could send it out. I've written two letters before you were elected. I wrote one to Burns and Baucus on this issues of my problems that I've dealt with.

Thank you.

Senator TESTER. That would be great. If you could do that, that would be marvelous. Thank you.

At this point in time, I have to hurry and I'd like to thank you because we're out of time. I want to first of all thank some staff people here, Mark Jette and Amanda Arnold from my staff; Anna Sorrell from Governor Schweitzer's staff; Richard Litsey and Jim Corson from Senator Baucus' staff; and David Mullon who is from Senator Murkowski's staff, the ranking minority.

I will tell you this, there was one lady that got up and spoke from the Nez Pearce that talked about Chief Joseph, talked and talked and nothing was done.

I can tell you this, and I can speak for Senator Dorgan when I say that, it takes 60 votes to get things done in the U.S. Senate so we can't do it alone, we need 58 other people to help us out.

But we will work and we will work and we will continue to work to make sure that health care is adequate in Indian County. We will be diligent on that, make no mistake about it.

And finally I want to thank the folks who provided us with the facility and the great dinner.

I want to thank Chairman Carl Venne. Carl, I want to thank you very, very much, not only for your friendship but for your hospitality and courtesy in doing all the work necessary to help pull this thing off.

Thank you very much.

Before we go, I want Carl to get the last word in.

STATEMENT OF CARL VENNE, CHAIRMAN, CROW TRIBE

Chairman VENNE. Senator, I want to thank you for coming and the committee. If you look at that map of the United States over there, it says Council of large land-based tribes. That's where most of the Indian people live. That's where most of the land is that Indians own, and we are the poorest of the poorest in the United States of all ethnic groups.

It's sad to see when you look at the Federal budget, when you see wild horses out in the Pryors, when we in this region are in the red for $48 million and they give them horses, which we don't ride or don't eat, $40 million a year.

Something is wrong in this country. We, as Indian leaders, need to speak up. We don't beg no more. It's rightfully yours because of the treaties that we have done with these United States.

During the time of war, 70 percent of all young men and women from all of the tribes enlist to go to war. Did you know that? You're the largest population or ethnic group in these United States who serve this country, but yet to be treated like we are today, is not good.

We, as leaders, have to speak up. You should be mad at what this administration has done to Indian tribes throughout the country.

They wanted to do something way a long time ago when they infested army blankets and gave it to us and everybody got smallpox and died. Is that what is still going on today with this administration?

No, don't take a backseat to nobody. You're entitled as Indian people.

The Indian people working for Indian Health Service, don't be afraid to speak up. You know what is wrong. You know what we need. How can Dr. Grim sit in his office and say no, we don't need no more money when he has a committee that says we need a lot more money.

What is going on in this country? We're not begging the U.S. Government. They made promises.

I can only speak for my tribe, if you look at the Powder River Basin, the billions and billions of dollars that this government has made off of it, and yet we're treated like this today. It's time for Indian leaders to get up and speak.

And I want to thank Senator Tester and his Committee for coming to Crow Country, and I appreciate what they're trying to do for us, but we need to speak up and back them up. We need to get out the vote also.

Thank you.

[Whereupon, at 3:15 p.m. the hearing was adjourned.]

A P P E N D I X

Prepared Statement of The Confederated Salish and Kootenai Tribes of the Flathead Nation

Dear Mr. Chairman and Distinguished Members of the Committee,

The Confederated Salish & Kootenai Tribes appreciate the opportunity to provide testimony for the record on the status of health care on this reservation.

In your opening comments at the field hearing at Crow Agency, Montana, on August 15, 2007 you stated that you wished to hear the truth about health care from Indian people. "The State of Indian Health is in our opinion on **life support**".

We have consistently been under allocated resources to meet the health care needs of our population; we have repeatedly requested additional funds from the Indian Health Service; we have traveled to Washington D.C. to plead our case in person.

On October 1, 2005 Tribes were forced to return the Contract Health Services portion of Self Governance Compact to the Indian Health Services. We experienced a continuing shortfall resulting in losses to other critical programs in order to meet the ever-increasing demand for CHS dollars to meet payment obligations for care provided to the service unit population.

We successfully operated the entire IHS programs here for 14 years. It became apparent to the Tribal Council that if we did not have additional resources, we could very likely bankrupt the Tribe with financial obligations created by the resource shortfall.

I might add, that we had proposed in our trips to Washington, that we felt we were being forced to provide services to persons that were not enrolled or associated in any way with our Tribal community because of the "open door policy" implemented in the service by than Director Dr. Trujillo.

This set of circumstances when Tribes are literally forced to sacrifice care and resources to anyone having any link to a federally recognized tribe totally ignores the laws concerning Tribe enrollment, and recognition, which we believe is solely a Tribal decision.

those resources allocated on the premise of our Treaty of 1855 be directed toward those members of the community that are recognized as members of the community (Indian). We further request that direction be provided to the Indian Health Services clarifying the right of Tribes to make such determinations.

We have been continually under-funded on this reservation because we have not had a direct health care component; most care has been historically purchased from the private sector. This form of care finds itself rooted in the early opening of the reservation to homesteading and the general land allotment and the subsequent adoption of the Hill-Burton legislation, which provided funds to private sectors to provide health to portions of rural America. Our reservation because of the non-Indian population present, and the availability of private care was never allocated resources dedicated solely for Indian facilities. This arrangement while serving a need always had the effect of creating a dependence upon private sector providers. Obviously as time passed, the hospitals emerged from parochial direction to corporate direction and the costs continued to rise. That in addition to everyone who claims a direct link to federal recognition increased our population and the cost of care. Today, we have over 11,500 persons registered of which 3,800 are enrolled members of Salish Kootenai. It becomes extremely difficult to explain on absence of resources to our own membership, when services are being provided to some 8,000 persons that are not enrolled Tribal Members In short, if the United States wants to provide access to everyone who claims a descendency to a federally recognized Tribe, it's is going to cost many times over. This is not a hypothetical situation, it is real and the resources are inadequate.

We want to find a solution; but we need to be able to make some determinations locally, and we need a rationale basis that allocates resources based on need, one that adjusts formulas for purchased care v care provided directly.

We believe that everyone should have access to care; but we also believe that the agreements and laws that created the reservation need to be honored and respected.

We are currently undergoing an extensive evaluation of options that can meet our statutory obligations to the members of other federally recognized Tribes who reside on our reservation and, to efforts that allocate resources to our own membership because of their status as members. This most likely will be a hybrid of the current private / IHS configuration. It will necessitate additional funds for providing both direct care and purchased care.

We are currently funded at 52% of the level of need as determined by the IHS. When you factor in the cost of medical inflation the picture is bleak. In our last year of operating the CHS program (Fiscal year 2005) the Montana Hospital Association conducted a survey that examined the inflation over a five-year period. On average inflation grew at 7+ percent. That constitutes a 35% of the allowable dollars being eaten by price increases. When you only get 52% of what you need and 35% of that is eaten by inflation, it simply does not work.

We know that our problems are not isolated to the Flathead; but indeed across Indian country the system is broken and is desperate need of a fix. That fix will not only require more resources but a different way of doing business within the Indian Health Service.

There continues to be serious problem in recruitment and retention of health care providers and there continues to be a serious problem with inadequate facilities.

We believe the issues we face, as Indian Nation requires a fresh approach that incorporates technology, training and probably most importantly lifestyle changes. We believe we need to

invest in our people, we need to make prevention a priority, and we need to address health conditions as they arise, not defer until they threaten the lives of people, and cost many times the amounts that would have been expended has they been addressed early.

A final recommendation we ask you to consider is to create a "Blue Ribbon Commission" comprised of health care professionals, Tribal representatives, industry, government including Indian Health Service, Veterans Administration, Center for Medicaid/Medicare, and the respective states to provide you and the President with a road map out of this quagmire.

It will take a lot of careful analysis, thought and creativity to craft a solution to meet the needs of America's first citizens.

You asked, we are telling you that this system is broken, that bureaucracy is overreaching and impeding Tribal decision-making, that the resources are totally inadequate and that we accept the responsibility that is ours to implement prevention and health promotion. We desperately need your support.

We thank you for holding the hearing, and look and wait for good things to come as a result of everyone's commitment to provide health care to our members.

Sincerely,

CONFEDERATED SALISH & KOOTENAI TRIBES

James Steele, Jr., Chairman

Cc: S. Kevin Howlett, Department Head, CSKT Tribal Health, POB 880, St. Ignatius, MT 59865
Ruth Swaney, CSKT Policy Analyst, POB 278, Pablo, MT 59855

PREPARED STATEMENT OF DICK BROWN, PRESIDENT, MHA—AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

Dear Senator Dorgan:

I would like to thank you and Sen. Tester for taking the time to conduct the field hearing at Crow Agency on August 15. Your hearing brought much-needed public attention to many of the challenges IHS facilities face in our state.

I regret that I was unable to attend your hearing; however, I would like to take this opportunity to offer a few comments for the hearing record.

MHA...An Association of Montana Health Care Providers represents hospitals, nursing homes, home health agencies, hospices and physician clinics through our state. Indian Health Service facilities have been members of our association for a number of years.

One of MHA's core principles is that all Montanans have reasonable access to high quality, cost effective health care services. MHA has serious concerns about the ability of the IHS to meet this standard.

The Indian Health Service is a very important part of the health delivery system in Montana. A strong IHS operation would go a long way toward ensuring access, high quality and cost-effective medical treatment for Montana's Native American population.

With seven reservations and several community-based health clinics located away from reservations, Native Americans should find access to needed health services. The coverage afforded to the Native American population should also produce a reasonable health status.

However, as testimony at your hearing demonstrated, that isn't the case.

IHS funding has failed to keep pace with the current health needs of the Native American population. Inadequate funding has caused long waiting times for needed health services, an over-reliance on emergency services and a general lack of access to health care services.

Overall, there is little doubt that the health status on Montana's reservations is a national embarrassment.

Montana's health care providers who contract with the IHS to provide care to Native Americans also report major problems. Among these are late and low payments made by the IHS, refusal by the IHS to adhere to its own contract terms and refusal by the IHS to cover certain services provided on an emergency basis. The letter submitted by Margaret Norgaard, CEO of the Northeast Montana Health Services, dramatically illustrates this point.

It is long past the time for the federal government to live up to its treaty and moral obligations to Native Americans. At a time when our country faces so many complex challenges and financial problems it is unreasonable to treat IHS as a forgotten entity.

As the Committee develops legislation to address these issues, I urge you to make sure adequate funding is available to meet the past and current health needs of our state's Native American people.

Thank you for your consideration of our views. If you would like additional information, don't hesitate to contact me or John W. Flink, MHA's Vice President of Government Affairs.

PREPARED STATEMENT OF LAURENE JOHNSON, MEMBER OF THE CONFEDERATED SALISH AND KOOTENAI TRIBES

My name is Laurene Johnson, I am a member of the Confederated Salish & Kootenai Tribes. I am 67 years old, retired and living on a fixed income.

In April of this year I had an ultrasound done on my left carotid artery, and that in turn lead to a cat scan of my artery. After the cat scan in May they discover that I had a 74% blockage in my carotid artery. Dr. Horton a vascular surgeon assured me at some point in time that I would definitely have a stroke. The surgeon requested approval from Flathead Indian Health Service Unit, Contract Health Service, to have surgery to correct this blockage. I have a strong family history of carotid artery surgeries. My father Frederick Glover and enrolled tribal member had this surgery done, my mother Helen Glover had both carotid arteries done and my brother Frederick Gerald had this surgery and subsequently died from complications after surgery.

On June 1, 2007 I receive a denial letter for the surgery from Flathead Indian Health Service Unit, Contract Health Services. On June 26, 2007 I mailed my formal appeal letter to the department of Health & Human Services Area Director in Billings, MT.

This serious medical condition was only given a rating of 7 out of 12, with a 12 being the highest rating with Flathead Indian Health Service Unit, Contract Health Services. I went to the Confederated Salish & Kootenai Tribal council on 2 different occasions asking for any assistance they could suggest. I got direction from the council on how to appeal the decision from the Indian Health Service Unit, Contract Health Services.

Ultimately I ended up having the surgery done on July 12, 2007. I did not want to put off having the surgery in the event that I would have a stroke. The anxiety of waiting for a stroke that could happen any day at my age, was more than I felt I could handle. I chose to have the surgery and make payments.

I did some research about health care in Indian Country and found out a few things that are discriminatory. From what I understand Native American's have a standard of care that dates back to a Snyder Act in 1923 or 1924. That is almost a century ago! It seems that Native Americans are discriminated against because they do not have the same standard of care everyone else has. I think there needs to be an update of this standard of care since it does not equal the standard of care that federal prisoners or illegal aliens have. It is a sad state of affairs that either of these entities can get better health care than a Native American can. Why is there a difference between Native Americans and federal prisoners or illegal aliens?

I will pay the co-pay for the appointments with the surgeon and for the surgery, however I was thinking about other people in Indian Country that don't have insurance to cover any of the costs and they may not have the resources that I have to be able to pay for the surgery. I am trying to be a voice for those that won't or cannot speak out.

PREPARED STATEMENT OF LOU STONE, MEMBER OF THE SNGAYTSKSTX TRIBE

Dear Honorable Senator Dorgan and Honorable Senator Tester and Senate Indian Affairs Committee Members:

I am Lou Stone, member of the Sngaytskstx Tribe, one of and furthest east of twelve of the Confederated Colville Tribes of the Colville Indian Reservation. Our vast usual and customary traditional territory spans the U.S./Canadian border.

This is written testimony regarding the subject of your Crow Agency Field Hearing. Thank you, Senator Tester for your concern for the concerns of Aboriginal Peoples by requesting this Hearing.

On the subject of "service" to Aboriginal Peoples in lieu of fiduciary trust responsibility to members of Sovereign Nations, let me begin by requesting you require an accountable civil service system of federal employees. In a word, competence comes to mind in which competence needs to be put back into the civil service formula as paramount criteria for federal employment. If we begin from a base of competence then we might expect that the federal, congressional mission would be followed in performance of whichever operations were required or expected. I think competence is a congressional oversight responsibility.

The mission for Indian Health Services delivery is what the words mean literally, and should not be about "The Mission." By The Mission, I mean the affect of the Bush Administration ethnic cleansing/cultural oppression of Aboriginal Peoples by rationing health care for Aboriginal Peoples. Congressional oversight is long over due on the Bush Administration's ethnic attacks on Aboriginal Peoples by omitting services to Aboriginal Peoples while at the same time pushing a Christian faith-based philosophy.

This philosophy and practice excludes other religions at best and at worst, it causes coercion to convert to Christianity or Christian faith-based programs just to get trust services expected to be delivered to Aboriginal Peoples without consideration of religion. Everyone is entitled to freedom of speech and of religion but I resent being cajoled fundamentally and fiscally into a main stream theology that does not represent me spiritually or culturally.

In the Bush Administration a faith-based operation is the inherent requirement to choose Christianity or receive no services. A prime example of this is the salvation army while they do great work they receive public dollars and force their brand of faith onto anyone desperate enough to need their help. This not only violates the First Amendment of the U.S. Constitution, it violates the letter and spirit of the American Indian Religious Freedom Act. At the very same time Canada is acknowledging religious and moral human rights abuses of First Nations Peoples in Boarding Schools trauma, the Bush Administration is violating the trust of Aboriginal Peoples. Congress is not performing oversight to the Executive branch assumed authority in bringing cultural and religious oppression, genocide and ethnic cleansing to other countries such as those Muslim and Arab Nations of the Middle East. Just as genocide is a Bush Executive term for democracy, so is the Bush Executive applying this term to Aboriginal Peoples of the United States in not delivering acceptable health care. While this all may be satisfactory for the Bush Executive, it must not be acceptable to Congress.

Our Aboriginal Peoples, in part, suffer trauma of anomie and cultural oppression as self-medication becomes a numbing alternative to the pain, thus, masking the pain. The very lack of Indian Health Care Service contributes to psychological and emotional trauma compounding the physical health issues that stem from pre-federalism original sins and through generations of Administrations past.

Furthermore, it has been reported that the very Aboriginal staffers who show up hat in hand in front of the Bush Administration's "white"-house and HHS are subject to racial attacks from those respective staff. If the Aboriginal staff person had challenged the racism, it would have escalated to setbacks to the Indian Health Care Reauthorization and the ultimate probable termination of the victim of the racial attacks.

The service and mission failures to provide adequate health care for Aboriginal Peoples is criminal just as the Abramoff/Bush anti-Cobell, anti-federal-trust matter sustains the cynicism of low expectations.

Please set your oversight vision upon these objectives for improving Aboriginal health care:

a. Fully fund Indian Health Care prevention and rehabilitation services by passage

of the Indian Health Care Reauthorization Bill

b. Conduct oversight hearings on how faith-based programs (privatization/contracting for Christian operations) diverts funding away from federal trust obligations resulting in "rationing" health care services to Aboriginal consumers

c. That your Committee Members begin to understand your other Senate duties and issues in the same context and sensitivity that best serves our Aboriginal Communities: The suffering of marginalized Peoples is inter-generational and that pain has memory, a memory best soothed through an healthy fiduciary relationship and respect of the other, hence,

d. Cut the Genocide Budget (Defense Budget) by 25% to fund peaceful domestic health care delivery programs and services in order to fulfill federal-tribal trust responsibilities and promote wellness, not hate, not weapons contractors' bottom line benefitting from weapons construction, delivery, asset destruction, and asset re-construction in a violence con on the rest of the world

Thank you for your initiative to hold this hearing and receiving testimony.

PREPARED STATEMENT OF MARGARET NORGAARD, CEO, NORTHEAST MONTANA HEALTH SERVICES (NEMHS)

My name is Margaret Norgaard and I am the CEO of Northeast Montana Health Services (NEMHS), which owns and operates the private health care facilities in the communities of Wolf Point and Poplar and, which are located on the Fort Peck Indian Reservation. Although our hospitals are on the reservation, we are not Indian Health hospitals. Our governance is a private, non-profit corporation. NEMHS works very closely with Indian Health and serves as their primary hospital to which their providers admit.

I was present at the field hearing that took place in Crow Agency on August 15, 2007 regarding the health care needs of the Native American people living on our reservations in Montana. Without a doubt, the Indian Health Service Units in Montana are absolutely under-funded by the federal government. Our Service Unit Director stated that if they received an additional 1.5 million, they would still function at a level 12; and even with a 25% increase from the federal government, they would still only be able to operate at a level 11. The prison system has a larger funding allocation for its inmates per capita than Indian Health. Having listened to problems brought forth by the Tribal leaders, it should be apparent that the federal government has made the Indian Health Service nothing more than an HMO at its very worst.

I wish however, that you would have allowed time for non-tribal related entities to give testimony as this is not just about what is happening at the Indian Health clinics. There is a great deal of collateral damage as well, particularly to the hospital sector.

For the past five (5) months NEMHS has been in the process of negotiating FY05 and FY06 monies owed to us by Indian Health. Although our contract with Indian Health has a discounted rate, Billings Area Contract Officers have told us that unless we want to be here one year from now still negotiating 05 and 06, we need to accept a rate lower than what we are currently discounting! If we negotiate, we will have our money within two (2) weeks. The amount owed to us by contract for 05 and 06 is $892,000.00!

Not only are they behind due to lack of funding for 05 and 06, but also for current year 07. Our billed 07 charges, which remain unpaid, are $1,397,404.10! If you combine all three years, (and 07 is not over), the amount billed to Indian Health, and not paid is $2,289,404.10. Does this sound like a program that is adequately funded?

Then there is the issue of denied claims. Denied claims are claims sent in for payment but denied usually for one of two reasons: a). Alternate source of funding or, b) deemed to be non-emergent, as it did not constitute a loss of life or limb. In FY 06, NEMHS had approximately 3235 claims, which were denied due to being "non-emergent". This represents about $857,000.00 in lost revenue, and approximately 30% of our total Emergency Room visits. Once denied, the patients are billed and in most cases written off to bad debt. For YTD 07 (with two months left to go), denied claims are at 2652, for a total of 30% of our overall Emergency Room visits, and totaling more than $549,000.00. In a two-year period of time, we have over $1,400,000.00 in denied claims because Indian Health is functioning at a level 12 due to inadequate funding.

There are also five other major items of concern, which could be resolved if not for the "red tape" that the government imposes:
1). Assistance with provider recruitment. The Fort Peck Service unit has a 50% vacancy rate between the physician and advanced practice nursing staff. There is one recruiter for all the service units and the service units are not allowed to use an outside recruiting agency and recruit on their own. The process is slow, cumbersome and the service units are competing against each other.

2). The pay scale. The pay scale must be adjusted to meet that of the private sector. For example, Optometrists start out at $60,000.00 per year. This compares to $120,000.00 in the private sector. Advanced practice nursing and nurse anesthetists are paid more. Dentists are paid $180,000.00 as compared to $225,000.00. Family Practice physicians start out at $120,000.00. Service units need to be able to place their providers on an accelerated pay scale or allow their providers the ability to skip some of the levels

3) Loan payback. Indian Health has dropped its loan forgiveness from $30,000.00 a year to $20,000.00 per year. Medical Students are graduating with student loans exceeding $120,000.00. Medical Students are looking for job opportunities, which offer full loan forgiveness and certainly more than $20,000.00 a year. In addition, state taxes are deducted. Also, if you are on an Indian Health Scholarship, you are not eligible for loan forgiveness. Medical Students are still facing loans upon graduation. Why can't this be waived? Physicians are losing the state tax incentive to come to HPSA sites, why?

4). Alternate Resources. Currently, Indian Health advocates for health insurance yet penalizes you for having it. When an IHS beneficiary has private health insurance, Indian Health is to pay for the deductible and any insurance balances...*but only if the care is approved first by Contract care!* What is the point of having private health insurance if contract care is going to dictate what health care you receive and when you will receive it! There should be a different priority established for those having private insurance, or more simply, beneficiaries who carry their own health insurance should not have to go through Contract Care for approval.

5) Joint Ventures. NEMHS and the Fort Peck service unit have joint ventured on several projects. It is usually a long, hard, drawn out affair that in some cases took over a year to accomplish. However, there is so much more that could be done that stop the duplication

of services, decrease expenses, and add revenue-generating services. Why can't we "keep it simple", give the service units latitude to "grow their own", pave new roads and shape new ideas?

The Service Units needs more funding for *contract care services, and provider recruitment,* but they need to think and act more like a private business if they are to compete in the healthcare marketplace.

PREPARED STATEMENT OF GWEN CLAIRMONT, MEMBER OF THE CONFEDERATED SALISH AND KOOTENAI TRIBES

My name is Gwen Clairmont. I live on the Flathead Reservation and am a member of the Confederated Salish & Kootenai Tribes.

I just wanted to begin by giving you a background on my health situation. I am normally a very healthy individual and only go to the doctor's office for my annual checkup. My doctor's nurse jokes with me when I go into the office and says "It is nice to see you this year." , and when I leave she says "See you next year!".

Sure I have had some small problems in the past but for the majority of the time I don't need to go to the doctor.

I have worked for the tribe in 2 different jobs for the past 20 years. I have insurance through my job. Out of the last 20 years I bet I have not met my deductible for more that 5 of those years. I don't go into the emergency room looking for drugs, I don't drink and drive and cause car accidents and don't feel I abuse the Indian Health Care System. I am normally a very active person this time of year. I go camping, fishing, atv riding, and work in my yard this time of year. In Montana there is a saying "Make hay while the sun shines" and I may not make hay but I very seldom slow down. This spring and summer I could not do many of the things I normally do.

I have not felt very good for the last year or so, but early this spring I started having a heavy feeling in my side and shortly after getting this heavy feeling, I started having pain too. I sloughed it off thinking that I had slept wrong or that I had stretched a muscle. I put off going to the doctor until I had my annual physical and mentioned it to my doctor. He said it sounded like I had a gall bladder problem. He sent me over to the hospital for an ultrasound. The radiologist could not find any stones in my gall bladder. I continued having pain which was steadily getting worse and covering a larger area. At this point the pain went from my stomach area just below my ribs to my spine in the back. I tried to change my diet, which did not change the pain. I tried not to eat which did not change the pain. Nothing helped. I kept going to the doctor and even went to the emergency room once. I notified Flathead Indian Health Service Unit Contract Health Services each time I went to the doctor or the emergency room.

I went back to the doctor and he ordered a scan of my gall bladder. The scan showed that my gall bladder was not working right. Up until this point Flathead Indian Health Service Unit Contract Health Services approved everything. I went back to the doctor and he referred me to a surgeon. I asked Flathead Indian Health Service Unit Contract Health Services for approval to see a surgeon. On June 12, 2007, I was denied by our local Flathead Indian Health Service Unit Contract Health Services. They gave me the right to appeal to the Area Indian Health care agency. I had 30 days to appeal this decision. I sent the appeal to the Department of Health & Human Services Area Director on June 15, 2007 and on June 28, 2007 I sent the same request via

certified mail. I did not want my request to get lost. I receive a denial letter dated July 23, 2007 from the Department of Health & Human Services Area Director. This denial was just to see the surgeon. They gave me the right to appeal to the Indian Health Service Director in Rockville MD. I have yet to get a response from the Indian Health Service Director appeal letter.

I kept feeling myself going down hill. I had no energy and could not sleep throughout the night because of the pain and nausea. I could feel myself getting weaker and weaker. I felt if this gall bladder did not get removed, I would start being susceptible to every little virus or infection that came my way. I was missing work often. Between April and mid-June of this year I missed over 50 hours of work because I was nauseated or in too much pain to come into work.

I receive a denial letter dated June 28, 2007 for the surgery itself from the Flathead Indian Health Service Unit Contract Health Services. Again they gave me the right to appeal the decision to the Department of Health & Human Services Area Director. I sent the certified letter to the Area Director on July 9, 2007. I have yet to receive a response for this appeal.

At this point I was in pain all of the time and decided that I would make an appointment with the surgeon, and pay the co-pay the insurance did not cover. I went to the surgeon and we set a date for the surgery. I asked the surgeon to send a request to Flathead Indian Health Service Unit Contract Health Services. I was denied once again, only this time the denial was for the surgery. Once again Flathead Indian Health Service Unit Contract Health Services gave me the right to appeal this decision to the Area Director. I sent my appeal (certified) off to the Area Director on July 9, 2007. Once again I decided that I could not live like this any more and could not stand the pain any more, and chose to have the surgery, and I would pay the co-pay the insurance would not cover. I had my gall bladder removed on July 10, 2007. Neither the ultrasound or the scan of my gall bladder saw the "sand" that was making my gall bladder dysfunctional. The pathology report was the only thing that discovered the irritant. Since the healing process is almost over I have energy back and feel much better. I am not missing work and getting some things done around my yard that I could not do earlier in the year. Why do I have 30 days to appeal a decision, and why doesn't the institution that making the decision on the appeal have 30 days to reply? The appeal process takes too long and I was not willing to stake my life while waiting for the process to be completed.

I did some research about health care in Indian Country and found out a few things that are not quite fair. From what I understand Native American's have a standard of care that dates back to a Snyder Act in 1923 or 1924. That is almost a century ago! It seems that Native Americans are discriminated against because they do not have the same standard of care everyone else has. I think there needs to be an update of this standard of care since it does not equal the standard of care that federal prisoners or illegal aliens have. It is a sad state of affairs that either of these entities can get better health care than a Native American can. I also found out that if a reservation has an Indian Health Care hospital and does not rely on Contract Health Services that a Native American is allowed to have their gall bladder removed at the hospital. Why is there a difference between Native Americans?

I will pay the co-pay for the appointments with the surgeon and for the surgery, however I was thinking about other people in Indian Country that don't have insurance to cover any of the costs and they may not have the resources that I have to be able to pay for the surgery. I am trying to be a voice for those that won't or cannot speak out.

Please consider changing the standard of care for Native Americans to at least equal the standard of care for a federal prisoner or an illegal alien.

Thank you for your time.

PREPARED STATEMENT OF JOHN SINCLAIR, PRESIDENT, LITTLE SHELL TRIBE OF CHIPPEWA INDIANS OF MONTANA

Senator Dorgan and Senator Tester:

Thank you for coming to Montana and holding a field hearing. On behalf of the Little Shell tribe of Chippewa Indians of Montana I would like to request your assistance in resolving a dispute that we are having with the Indian Health Service. For several years now we have been trying to reestablish direct health services to over 1200 (twelve hundred) Little Shell tribal members who were taken off of the Indian Health Service rolls because they were not on the original roll the Little Shell Tribe presented to the Bureau of Indian Affairs in 1989. Most of these members either were not eligible (or not even born) at the time of the original roll. Some were not on the rolls because of clerical oversight.

At first the Indian Health Service in Billings under Pat Conway and Garfield Littlelight said they would accept the work we had done on our enrollment since 1989 and we could send them paperwork showing enrollment. But they changed their minds and then wanted some documentation from Bureau of Indian Affairs certifying our enrollment after 1989. We had several joint meetings with Indian Health Service and Bureau of Indian Affairs and last year Keith Beartusk agreed to do blanket certification for all enrollments after 1989. But the Bureau of Indian Affairs reneged on that saying their solicitors told them they could not.

We then had an informal meeting with Dr. Charles Grim in August of 2006. We explained the situation and he said he would look into it. In September of 2006 I sent Dr. Grim a letter asking him to resolve the issue. Then in March of 2007 we received a letter from him in which he says "I am reviewing your concerns and will be forwarding a more detailed response shortly." But to date I have received no further communication from him. Perhaps it is a matter of the squeaky wheel getting the grease as I have not sent further letters to him. But this seems to be an inordinate amount of time to respond.

In a nutshell what appears to be happening here is an impasse between two government agencies. No one disputes that the people removed should be receiving direct services from the Indian Health Service. The problem is no one wants to take the responsibility to certify the post 1989 enrollments. The Indian Health Service says that they do not certify whether or not people are Indian persons. And the Bureau of Indian Affairs says that although they were involved in the certification of the 1989 roll they no longer do this and it is the responsibility of the individual tribes. So we have a type of "catch 22". We are willing to do whatever the Indian Health Service wants as far as documentation but no one seems to want to take the responsibility and tell us what that might be. Several weeks ago I spoke with Mark Jette about this hopefully he has given you a heads up on this. Thank you for your attention.

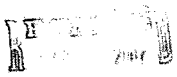
Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

MAR 7 2007



Mr. John Sinclair
President, Little Shell Tribe of
Chippewa Indians of Montana
1807 3rd Street NW, Suite 35A
Box 1384
Great Falls, MT 59403

Dear President Sinclair:

I am responding to your September 25, 2006 letter requesting that the Indian Health Service (IHS) assist the Little Shell Tribe in resolving questions about the eligibility of Tribal members that result in difficulty obtaining IHS health care services. I am reviewing your concerns and will be forwarding a more detailed response shortly.

Sincerely yours,

Charles W. Grim, DDS

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director

United States Department of the Interior

BUREAU OF INDIAN AFFAIRS
Rocky Mountain Regional Office
316 North 26th St.
Billings, Montana 59101

IN REPLY REFER TO: Tribal Operations Code 360

MAY 9 2006

Pete Conway, Director
Indian Health Service
2900 4th Avenue N.
Billings, Montana 59101

Dear Mr. Conway:

At the April 17, 2006, meeting between representatives of the Little Shell Tribe, Bureau of Indian Affairs (BIA) and Indian Health Service (IHS) staff, eligibility for health care services for members of the Little Shell Tribe of Chippewa Indians ("Tribe") was discussed. The IHS is requiring a certification from the BIA that the Little Shell Tribal members are descendants of the Turtle Mountain Chippewa's of North Dakota as a condition of providing services to tribal members.

After review of the several legislative statutes pertaining to "Indians" and/or "Services to Indians" we believe that the Little Shell Tribe of Chippewa Indians meets the criteria established for "Indians" for the IHS and is eligible to receive health care from IHS without a certification from the BIA. We have enclosed the actual wording from United States Code, Title 25, Chapter 18 – Indian Health Care §1603, specifically the definitions for "Service" and "Indians". This is statutory language that pertains specifically to IHS.

The statute's language, found at 25 U.S.C., Chapter 18 §1603, clearly includes the Little Shell Tribe for the specific purposes identified in the statute. The relevant language reads as follows.

> "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 102 and 103 [25 USCS §§ 1611 and 1612], such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside....
>
> 25 U.S.C. § 1603 (c)(1).

The State of Montana has recognized the Tribe as an Indian Tribe, as evidenced by a letter (enclosed) from Stan Stephens, Governor of the State of Montana, dated June 24, 1992, which recognizes the Little Shell Tribe as an Indian Tribe and that the State has dealt with the Tribe on a government-to-government basis.

We bring this issue to your attention, because Congress has established standards for IHS that differ from services provided by BIA. The definition of "Indian" found in current IHS statutes has broader criteria for eligibility for IHS health care than the definitions used by the BIA in its provision of services. We are also cognizant of the Little Shell Tribe's request for federal recognition through the Department of the Interior Acknowledgment Process. We do not want to impair the Tribe's acknowledgment process by providing such a blanket certification that the Tribe's members are all descendants from the Turtle Mountain Chippewa's, when their request asserts that they have functioned as an autonomous entity throughout history.

If you have further questions on this matter, please contact Norma Gourneau, Indian Services Specialist, at (406) 247-7988.

Sincerely,

Edward Parisian

Acting Regional Director

PREPARED STATEMENT OF GORDON BELCOURT, EXECUTIVE DIRECTOR, MONTANA–WYOMING TRIBAL LEADERS COUNCIL

The Montana Wyoming Tribal Leaders Council would like the following entered into the official record for the Field Hearing on Indian Health, held on August 15, 2007 at Crow Agency, Montana.

Although the topic of "**rules based budget**" was mentioned during the oral testimony at the hearing, its importance was not emphasized in a manner that is consistent with its actual importance. Nor was the time and effort put forth by the Tribes given adequate time and review. Tribal Leaders from across the country have devoted significant Tribal Resources to participate in a "**needs based budget**" process that identified over 22 billion dollars worth of documented, justified, need. This is the kind of necessary increase in base funding that would allow Indian Health Service the means required to effectively meet the needs of those eligible for services, as a way of honoring historical Treaty obligations. This process is actually the only means of identifying and requesting the total funding needs of the Indian Health and Tribal healthcare needs.

According to current budgeting, (with the rules based methodology) the Indian Health Service is funded at a fifty-five (55) percent level of need, this level of funding does not adequately serve the needs of the Native American population in this country. We are concerned for all of the Native Americans in this country, however, we will focus on the needs of the Native Americans in the States of Wyoming and Montana.

A. Contract Health Care

The Billings Area Budget Formulation workgroup, made up of Tribal/Urban/Indian Health Service (I/T/U) has recommended Contract Health Care as their number one priority during the budget formulation for the upcoming fiscal years 2008 and 2009, in addition to the past fiscal years of 2006 and 2007. The following information reinforces the concern among the workgroup and the groups they represent.

1. The unmet need in Contract Health Service for the Billings Area Tribes in FY 2006 was $44,768,354, this amount is based on the eligible Native Americans living within the service delivery area of a Service Unit, which does not include Native Americans living in areas outside of the delivery area.

    a. The Catastrophic Health Emergency Fund (CHEF) was under funded by $4,243,070 in FY 2006
    b. Shortfall Need was $11,589,227
    c. Deferred cases was $4,315,219 (2,203 Medical Referral Procedures, 831 Orthopedic, 481 Surgery Patients)
    d. Denials was $5,714,447 (3,878 Patients)
    e. Unfunded medical inflation was $14,990,866
    f. Population growth unfunded was $3,915,525

B. Needs Base Budget

For the past ten (10) years 1996-2006 the Billings Area Indian Health Service has absorbed $31,229,000 in Current Services, Non-medical inflation, Medical Deflator, Pay Raise, and Population Growth costs. This under funding has created enormous problems in services provided to the Native American population in Montana and Wyoming. Many services have been reduced, personnel cut to accommodate the budget shortfalls, resulting in an increase in sicker people due to lack of care. The Indian Health Service per capita based on 2005 user population and 2006 operating allocations is $1,843 for the Billings Area. The User population for fiscal year 2006 in the Billings Area was 70,384. The budgetary needs for the Indian Health Service for fiscal year 2007 was estimated to be $19,311,552,694, the total Indian Health Service appropriation was $3,180,148,000.

C. Federal Employee Buy-outs

In an effort to balance the budgets the Indian Health Service authorized an employee buy-out in fiscal year 2007. The Billings Area Indian Health Service accepted the offer of buy-

out authority to help balance their Area budget. The Billings Indian Health Service bought out twelve (12) federal employees for $300,000, $25,000 each. These employees were employees with many years of experience. The result of this is as follows:

1. The savings to the Billings Area Indian Health Service was $101,023.

    a) The savings of $101,023 is insignificant compared to the expertise void left by the experienced employees
    b) The difficulty in filling vacated positions, if deemed critical
    c) The remaining employees are required to absorb responsibilities of bought out employees leading to burn-out
    d) Each position remains unfilled until the cost of the buy-out is covered resulting in a longer period of time without the work being done

D. Pharmaceuticals

The current cost of pharmaceuticals does not correspond with annual inflation rate for all pharmaceuticals. According to AARP's Rx Watchdog, "Prices for brand name drugs have jumped 40 percent on average over the past six years, compared to inflation of only 17 percent. ....AARP'S April 10, 2006 news release.

E. Rescissions

From fiscal year 2003 to fiscal year 2006, the Indian Health Service had rescissions to the Appropriations of $142,621,000. From fiscal year 2000 to fiscal year 2006 the rescission amount to the Billings Area was $7,202,374. This amount translates to less health care provided to the Native Americans in the Billings Area.

F. Recruitment and Retention

1. Currently there are twenty (20) full-time Medical Doctors, eleven (11) Dentists, forty-three (43) nurses, two (2) Dietary/Nutrition, ten (10) Pharmacists and two (2) Optometrists vacant positions in the Billings Area Indian Heath Service facilities operated by the Indian Health Service, this information does not include the Compact Tribes. There is a definite problem in recruitment and retention for the vacant positions in the Billings Area. Following are some of the problems encountered:

    a) Problem in hiring in the cumbersome Federal Personnel hiring system

aa) The process of advertising and hiring takes approximately 120 days in the Federal system, prospective employees are recruited by private sector.

bb) The inability to offer salaries, benefits and bonus' at the rate of private sector

G. Catastrophic Health Emergency Fund (CHEF)

1. The Catastrophic Health Emergency Fund (CHEF) appropriation is $18,000,000 for all of the Indian Health Service Areas in the United States The need in this fund is $36,000,000. Due to the competition for these limited funds, the amount allocated is used up in May, four months before the fiscal year ends.

H. Emerging Diseases

The Indian Health Service and Tribes in the Billings Area need assistance in addressing new and emerging Diseases:

a) Diabetes and consequences
b) Methamphetamine Abuse and Addition
c) Hepatitis C
d) Cancer
e) Cardio-vascular
f) Co-occurring addictions-Mental Health
g) Mental Health Treatment Programs
h) Suicide and Suicide Ideations
i) Child Abuse Interventions and Treatment
j) Veterans-Post Traumatic Stress Symptoms
k) Obesity
l) Unintentional Injuries and Mortality
m) Intentional Injuries and Mortality
n) Rheumatoid Arthritis

I. Preventive Initiatives

1. Behavioral Health Initiative

a) Methamphetamine Reduction
b) Suicide Prevention
c) Behavioral Health Management
d) Information System and Child Protection

J. Health Disparities

Refer to the Indian Health Service paper on Facts on Indian Health Disparities dated January 2007.

K. Unfunded Mandates and Assessments

Unfunded mandates and assessments by the Department of Health and Human Services, or the Congress, reduce the funding for needed services in the Indian Health Service. Following are unfunded mandates that the Billings Area Indian Health Service has sustained. These mandates force programmatic cuts and therefore, a reduction in health care. From fiscal year 1996 to fiscal year 2007 the unfunded mandates will cost the Billings Area $4,100,000.

1. Unified Financial Management System
2. Healthy People 2010
3. Behavioral Health Initiative
4. Chronic Care Initiative
5. Health Promotion/Disease Prevention
6. Electronic Health Record

L. Tele-Medicine

a) Access to Remote Diagnosis
b) Access to Remote Consultation
c) Access to Tele-Psychiatry for Veteran
d) Access to Tele-Psychiatry for First Responders

M. Chronic disease Initiatives

Refer to Indian Health Service Director's Initiatives on Chronic Care. Additional chronic disease concerns such as:

a) Home Health Care
b) Dialysis Units
c) Methamphetamine Treatment
d) Wellness Activities
e) Screenings

N. Infrastructure Concerns and Issues

a) Authorization of Indian Health Service as the Primary Health Care Provider for the Tribes of Montana and Wyoming
b) Authorization of Indian Health Service as the Primary Payer of Health Care for the Tribes of Montana and Wyoming
c) Local authority to Certify and Manage CMS Programs
d) Adequate Reimbursement Rates from CMS Programs
e) Traditional Medicine Initiatives
f) Screening Clinics and Interventions
g) Unintentional Injuries
h) Wellness Centers
i) Continued Authorization of Diabetes Initiative
j) Development of a Healthy Reservation Model
k) Funding of Health People 2010
l) Assessment and Impact of GPRA./PART
m) Reinstate Waiver on Rescissions for Indian Health Service

The above information is a snapshot of the needs and concerns facing the American Indian people in Montana and Wyoming resulting from the continued under funding of the Indian Health Service.

Attachment

Promoting Best Practices in Indian Country: Strengthening Traditional Medicine and Cultural Resilience

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Integrating Traditional Medicine Constructs and Principles within Western Medical and Mental Health Paradigm[1]

Key Questions:

How can Traditional Medicine Principles and Practices be integrated into Western Medical Models and specifically the Indian Health Service/Tribal Health Systems?

How can Traditional Medicine Practitioners be integrated into Western Medical Models and specifically the Indian Health Service/Tribal Health Systems?

How can Traditional Medicine Patients and Clients access comprehensive Traditional Medicine Practitioners, Traditional Approaches, and Principles within Indian Health Service/Tribal Health Systems?

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[1] *July 29, 1994*

TRADITIONAL CULTURAL ADVOCACY PROGRAM
POLICY STATEMENT

The Indian Health Service (IHS) recognizes the value of traditional beliefs, ceremonies, and practices in the healing of body, mind, and spirit. The IHS encourages a climate of respect and acceptance in which traditional beliefs are honored as a healing and harmonizing force within individual lives, a vital support for purposeful living, and an integral component of the healing process. It is the policy of the IHS to facilitate right of American Indian and Alaska Native people to their beliefs and health practices as defined by the Tribe's or village's traditional culture. This policy is meant to complement and support previously stated IHS policy for implementing the American Indian Religious Freedom Act of 1978 (Public Law 95-341, as amended).

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Integrating Traditional Medicine Constructs and Principles within Western Medical and Mental Health Paradigm

The need for effective and accessible health care for American Indian families, children, and communities is easily apparent. What has been historically less apparent within healthcare is the need for culturally grounded interventions that build upon the strengths inherent within American Indian cultures. This paper will outline the realities facing American Indian and Alaska Native communities and potential pathways to innovative healing methods. These healing methods integrate cultural foundations of healing within the framework of existing Western medical and mental health paradigms. Cultural resiliency will form the foundation of this approach and an examination of the potential policy implications of this construct will be presented. First it is important to gain an appreciation for the psychosocial and economic realities facing American Indian communities.

An estimated 31.6% of Native Americans live below the national poverty level in contrast to 13.1% for all other racial groups and nearly one half of all American Indian children live below this federal poverty level (U.S. Department of Health and Human Services, Indian Health Services, 2004). Many American Indian families, children, and individuals are resultantly left to cope with significant biological, psychological, and sociological challenges and adverse living situations.

Compared to all other United States racial groups from 1996-1998, the American Indian/Alaska Native death rates due to suicide is 91% greater than other groups, deaths due to homicide 81% greater than other groups, and death rates due to alcoholism are 638% greater than other ethnic groups (U.S. Department of Health and Human Services, Indian Health Services, 2004). American Indians have a lower life expectancy than other groups and approximately 13% of deaths involve American Indians who are less than 25 years of age (U.S. Commission on Civil Rights, 2003). The rates of death due to heart disease, diabetes mellitus, accidental injuries, pneumonia, influenza, firearms, gastrointestinal disease, and cerebrovascular disease are all substantially higher for Native Americans than for any other ethnic group (U.S. Department of Health and Human Services, Indian Health Services, 2004). The infant mortality rate, often

viewed as a sensitive indicator of general health of a population, has decreased recently but remains 24% greater for Native Americans compared to other groups. Consequently, the risk factors facing many Indian individuals encompass the holistic realm of biopsychosocial and economic adversity.

Trauma is a frequent antecedent to the psychological suffering observed within American Indian communities. Manson and his colleagues (2005) provided a comprehensive study in the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project and examined exposure to 16 forms of trauma within 2 American Indian communities (N = 3,098). The authors reported that American Indians sampled reported lifetime exposure rates are significantly higher than their White counterparts in the US. Indeed, 62.4-69.8% of the American Indians in the study reported having been physically attacked, witnessing a traumatic event, and having a close relative experience a significant traumatic event compared to 51.2%-60.7% rates of exposure for other US ethnic groups.

Exposure to traumatic events appears to be an important factor to consider in the discussion of negative self-concept development. American Indian adolescents may be primed to report lower self-esteem or negative self-concepts in part due to the elevated exposure to traumatic events they report. Deters, Novins, Fickensher, and Beals (2006) recently examined posttraumatic stress disorder (PTSD) symptoms in a sample of 89 American Indian adolescents in a substance abuse program. They found that exposure to trauma was pervasive within this sample (98% of participants reported at least one significant traumatic event and 4.1 was the average reported traumatic events.) Respondents also reported high rates of PTSD symptoms within this study. Sexual trauma was found to be the most common predictor of PTSD symptoms.

Trauma is a frequent reality facing many American Indian individuals. "Deculturation stress" is a term proposed to describe potential American Indian identity development. As American Indian individuals face demands to integrate into and identify with a different, more dominant culture, they may begin to lose or perhaps devalue their historical traditions. This leads to what is termed deculturation stress (Mail, 1989). The idea is an outgrowth of research addressing the phenomena labeled historical unresolved grief and loss. This theory posits that due to the massive losses of lives, land, and culture from European contact and colonization

American Indians have experienced a long legacy of chronic trauma, loss, and unresolved grief. These factors and the contemporary exposure to traumatic events are believed to influence current emotional status and identity development. This historically rooted notion is a direct legacy of the resulting self-inflicted or internalized racism that began in assimilation policies and boarding schools. It is believed that these experiences influence American Indians in an intergenerational manner. Furthermore, these factors are believed to contribute to the current high rates of suicide, homicide, violence, child abuse, alcoholism, and social problems observed among American Indian people (Brave Heart & DeBruyn, 1998).

A tragic legacy of the boarding school era remains the fact that entire generations of Native Americans were deprived of living with their own families during their childhoods. This lasting legacy of historically pervasive trauma could be that later exposure to traumatic experiences encountered could be affected. Possible "kindling" or sensitization effects to stress could result because of inadequately developed coping skills. In addition, many American Indians were prevented from learning from their own parents how to be a parent themselves. American Indians were deprived of role models crucial to the development of positive ethnic identities due to forced removal and historical exposure to trauma, genocide, and forced assimilation programs (Brave Heart & DeBruyn, 1998).

Adolescence is a particularly difficult developmental period for most people to navigate this is particularly true for Native American adolescents. One of the main tasks of development is the formation of a personal identity or self-schemata. According to LaFromboise and Howard-Pitney (1990), American Indian adolescents are further challenged by (1) acculturation pressures; (2) poverty, which limits hope for the present and future; (3) the multigenerational effects of alcoholism; and the (4) frequent occurrence of deaths in the family and community. All of these factors can make it more difficult for the development of positive self-referent schemas and may negatively impact self-esteem. Research done on self-esteem and alienation done with American Indian adolescents suggest that they have more negative views of themselves than the norm for Non-Indian teens (U. S. Congress, OTA, 1990). In a governmental review of the developmental status, American Indian adolescents were found to characterized themselves as friendly, helpful, easy-going, but not as being particularly smart, strong, or good looking (Development Associates, 1983). American Indian children may be more susceptible to developing negative self-concepts and feelings.

The most vulnerable among the Tribes may be children and women. Duran (2004) found that 77% of American Indian respondents surveyed reported having had a history of abuse or neglect. Sixty-three percent of the respondents surveyed reported having experienced neglect, and of those respondents nearly 90% were also physically and/or sexually abused. In an urban sample, Saylors and Daliparthy (2004) found that 89% of American Indian women seeking substance abuse treatment at an urban clinic reported a lifetime history of physical abuse and 69% reported a history of sexual abuse.

Nationwide American Indian women are 50% more likely to be the victim of a violent crime than the next highest ethnic group, African American men (U.S. Commission on Civil Rights, 2003). American Indians are twice more likely to be victimized than all other U.S. citizens (U.S. Department of Justice, 1999). American Indians are also more likely to be victimized by members of other racial backgrounds and this has been attributed in part to the inadequately funded Tribal Law Enforcement. American Indians are also incarcerated at a higher rate than other ethnic groups and are estimated to have an incarceration rate that is 38% higher than the national rate (U.S. Department of Justice, 1999).

Despite the clear need for effective health care services for American Indian communities and families, the U.S. Commission on Civil Rights (2003) identified access to healthcare as a primary barriers and the commission also highlighted the current inadequacies in available health care, mental health care, educational, personal safety, and economic opportunities.

Only 23% of American Indians have private insurance and 55% rely upon Indian Health Services for all health care needs. Indian Health Services is one among several federal agencies identified to have federal funding that is insufficient to meet the multiple unmet basic needs identified as healthcare, education, housing, rural development, and public safety (U.S. Commission on Civil Rights, 2003). American Indians made significantly fewer visits to physician's offices (54 visits per 100,000 American Indians compared with 293 visits per 100,000 Whites) and more visits to emergency rooms than other groups (U.S. Census Bureau, 2001). In a review of Indian Health Services, the Commission of Civil Rights concluded that "The unmet healthcare needs for American Indians remain among the most severe of any group in the United States" (p. 42.) Federal prisoners and Medicaid recipients receive twice the amount of federal funding than American Indians (U.S. DHHS, 2003).

Another factor lies within the nature of Western healthcare systems and the empirical basis for so-called "Evidence Based Practices." As Gone & Alcantara (2006) review, some of the factors possibly confounding the identification of best practices for American Indian health care. In the area of psychopathology and psychotherapy the amount of scientific knowledge of cross-cultural differences in pathology, definitions of illness and wellness, definitions healers, expectancies, preferences in therapy, treatment application, and treatment outcome is questionable given the serious lack of empirical research within these realms (Zane, Nagayama Hall, Sue, Young, & Nunez, 2004). Indeed the authors identified the lack of information about psychotherapeutic outcome a "serious problem" (pp. 779). Psychological and medical inquiry systems are based upon, and arguably biased by, western philosophies, ideologies, and scientific methodologies. As a result, western healthcare and mental healthcare applications is similarly biased to western ideas of illness, wellness, diagnosis, and treatment.

One issue that is particularly evident is the western emphasis upon internal validity, which is the hypothesized scientific strength of a particular research methodology. Internal validity is generally understood to be improved when particular controls are implemented within research. Some of these controls are the homogeneity of the research sample (i.e. same socioeconomic background, same diagnosis, no comorbidity, and a controlled research environment.) However, as Sue (1999) highlighted internal validity is often emphasized to the extent that the generalizability of research findings is often overlooked within psychological research. This factor combined with the inadequate funding of research results in the inhibited growth and development of ethnic minority research and practice. Iwamasa and Smith (1996) found that only 1.3% of articles in three psychopathology and psychotherapy research journals focused on ethnic minority groups. Graham found that only 3.6% of articles published between 1970 and 1989 analyzed race and included African Americans. The National Committee on Vital and Health Statistics (2003) concluded that data collection for American Indians and Alaska Natives is "seriously inadequate."

Comas-Dias (2000) eloquently described the racial "cold war" in the United States when examining the effects of oppression, racism, and political oppression on individuals groups and societies. She notes that Jungian psychology tends to represent people of color as "the darker and evil side of personality," and that Jung (1957) observed that the "shadow" was represented by Black or Native people for his American patients. She described a novel ethnopolitical theory,

which also characterized the "post colonization stress disorder" that many members of ethnic minorities experience due to facing racism and cultural imperialism. The bias in psychological research is inherent throughout, Sue and colleagues (1999) wrote:

> *Euro-American psychologists are likely to perceive their worldview as normative, and as a result these biases may be reflected in criteria used to judge normality, abnormality, standards of practice, and codes of ethics.*

Science is "a way to know things" (Sue 1999) and currently psychology is in its infancy in terms of its ability to know things in differential or pluralistic ways. These authors have described the bias inherent in American psychology as monoculturalistic and termed it the "invisible whiteness of being." Native Americans have struggled through a history of genocide, forced assimilation, forced sterilization, and even the removal of the right to parent their own children.

Cultural Resiliency: Roots of survival

Surviving this history has not occurred without substantial costs. However, cultural resiliency is also inherent within the history of Native peoples. This history is deeply rooted within traditional practices, ceremonies, languages, spirituality, and healing methods.

Jones, Dauphinais, Sack, and Somervell (1997) proposed that, due to the poverty, unpredictability, disruption, and overall more frequent experiences with environmental stressors, Native Americans sampled may be experiencing the exposure to trauma as less 'outside the range of usual human experience'. It may be that the chronic nature of trauma occurring in Native American communities result in some subsyndromal PTSD symptoms, but to reduce the relevant processes to this characterization would be a mistake. It is clearly evident that American Indian individuals and communities have demonstrated a considerable amount of resiliency.

Some of the outcomes resulting from historical antecedents have unquestionably led to the significant levels of diverse risk factors facing American Indian people as individuals and as Tribal entities. Philip May (1987) found that Indian communities with the highest rates of rapid change and acculturation stress generally had the highest rates of suicides. Van Winkle and May (1986) also found that acculturated Tribes had the highest rates of suicide. More traditional American Indian Tribes had the lowest and transitional Tribes had intermediate rates. This speaks to the potential important presence of protective cultural factors and challenges historical assumptions that assimilation produces positive outcomes. Adolescence is a time in which young

people are sometimes desperately attempting to form an identity and are faced with many difficult choices. It follows that Indian youth seem to be the group most severely impacted by acculturation stress.

Cultural resiliency is a descriptive term proposed to denote the psychosocial factors and processes that promote adaptively resilient reintegration and coping within American Indian populations (see Belcourt-Dittloff & Schuldberg, 2006). Cultural differences are slowly beginning to be accepted as the rule rather than the exception within contemporary psychological research. Researchers are currently working within diverse cultural groups in efforts to unravel the complexities inherent in cross-cultural psychological and psychopathological functioning in the hope that healthcare practices can be improved for the benefit of patients and practitioners alike.

Garroutte et. al. (2003) recently reviewed data from a comprehensive cross –sectional sample of 1456 American Indians and found that individuals with higher levels of cultural spiritual orientation (as measured by an index of spiritual orientation) had a reduced prevalence of suicide attempts compared with individuals with lower levels of cultural spiritual orientation. In addition, the researchers found that commitment to cultural spirituality was significantly related to a reduction in suicide attempts.

Acculturation is viewed to represent the extent to which an American Indian individual identifies with his or her Tribal Culture, worldview, and beliefs. Five basic levels[2] of acculturation have been identified for American Indians (Garrett & Herring, 2001; Little Soldier, 1985). The levels include (a) Traditional, (b) Marginal, (c) Bicultural, (d) Assimilated, and (e) Pan-traditional. Traditional individuals are believed to speak primarily their native language and to practice traditional customs and beliefs. Marginal individuals may be bilingual or not and are believed to be fully committed to either their Native culture or to mainstream culture. Bicultural individuals are generally accepted by the dominant society and in their Tribal culture this group is generally knowledgeable about both cultures. Assimilated individuals generally are accepted by mainstream society and embrace only mainstream cultural values and practices. Finally, "Pan-traditional" individuals may not have been raised in Tribal based culture however

[2] Five levels of acculturation is an admittedly limited approach to characterize ethnic identity development. Garroute (2003) provides a carefully considered sociocultural analysis of the construct of American Indian racial and ethnic identity within the historical context of North America. Her construct of 'radical indigenism' provides a provocative framework for the validation of indigenous worldviews and philosophies.

subsequently adopt and learn about the culture and its practices of other Tribal cultures; however, they may also only participate in "pan-traditional" practices such as pow-wows or even more Tribally based ceremonial practices (such as sweat lodges and other ceremonies.) Cultural displacement and erosion of historical ceremonial practices can also be an unintentional byproduct of some of the participation of "pan-traditional" practices. Bicultural individuals are believed to display higher levels of resiliency and a stronger sense of themselves, unlike marginal individuals who are believed to be the most likely to experience cultural conflict and difficulties. In fact, Little Soldier (1985) says that marginal individuals are often in a state of conflict with regard to cultural affiliation and this state of conflict often leads to significant problems and potentially serious identity crises.

Recent research findings and reviews have clearly highlighted the emerging trend of increasing rates of disordered eating patterns and symptoms in Native American populations. Specifically, Crago, Shisslak, and Estes (1996) found eating disturbances to be more common among Native Americans when compared to Caucasian, Black, Hispanic, and Asian American females. They found that the risk factors for eating disorders were found to be more prevalent among minority females who were young, heavier, more educated, and more strongly identified with majority group and middle class values.

The authors reviewed four studies in reaching their conclusions regarding eating disturbances and behaviors in Native American females. Rosen and colleagues (1988) surveyed 85 Chippewa women and girls living on or near a reservation in Michigan and found that 74% were trying to lose weight and 75% were using one or more pathogenic weight control methods. These methods included purging (25%), diet pills (41%), and prolonged fasting (33%). They also found that the heavier females were most likely to use these methods. Similarly, Smith and Krejci (1991) surveyed 129 Native American adolescents in New Mexico and found that Native Americans (particularly heavier individuals) scored higher than Caucasian and Hispanic peers on two measures of eating disorders. In addition, Snow and Harris (1989) found that increased weight was associated with more disturbed eating patterns in 51 Native American girls in New Mexico and that 8% of their sample met the diagnostic criteria for bulimia nervosa. They also found that 88% worried about being too fat, 43% fasted for extended periods, and 53% engage in binge eating episodes. Yates (1989) also reported that anorexia nervosa among Navajo girls in

Arizona occurred most frequently in girls who had moved off the reservation and had "upwardly mobile" families.

Cultural Resiliency New Pathways to Healing

The word resiliency describes Native North Americans. They have had to adapt over and over. They laugh, smile, and joke even though they come from generational alcoholism, poverty, violence, and many other hardships. They bounce back from trauma with resilience. They endure. They are tolerant, even though they get no justice in life. I believe the creator is carrying them. He knows what they have been thru. He hears their sorrows and prayers.

(American Indian Research Participant,
Belcourt-Dittloff & Schuldberg, 2006)

Historically, Native Americans were diverse hunter-gatherer societies who relied upon the natural environment for sustenance. Traditional diets were high in protein and fat and low in complex carbohydrates. Native Americans held traditional views with regard to food and these views were reflected in their ceremonial practices and spiritual beliefs. Among the Blackfeet, bison were the central food source and the bison therefore held great importance in terms of ceremonial centrality. In fact, the medicine lodge, which is the most important ceremony for the Blackfeet, revolves around bison. Percy Bullchild, a Tribal elder, said that bison provided the food, clothing, shelter. Therefore, bison were revered ceremonially and bison skulls and most importantly the buffalo tongue used as the host or sacrament of the medicine lodge (Bullchild, 1985). Because the survival of Native American groups was so intricately linked to the animals and resources in the environment many Native Peoples held distinctly different views of their world and ecological landscape. Many Natives held beliefs that all living (and non-living things) had "souls" or were animated, this belief allowed the hunt or harvest to be viewed in the context of a social relationship (Bullchild, 1985). In this world-view there would then be no conceptualization of "good or bad" foods.

It has been over five hundred years since Europeans have begun to colonize the Americas. This process of contact and colonization has led to many radical changes for Native Americans. These changes continue to impact the way many American Indians live their daily lives, interact with others, cope with loss, and work toward future goals.

At the heart of the issue of contemporary healing for American Indians lies the question of spirituality and culture. Goodluck (2002) recently adopted a strength-based perspective in attempting to identify possible well-being indicators specifically relevant to Native Americans. In reviewing 22 psychological publications (descriptive, quantitative, and qualitative) by both Native and Non-Native authors, she identified 24 Native American strengths. The themes of these strengths included the power of the group or communal interdependency and support, spirituality and related ceremonial participation, humor, cultural identity, political relationships and factors (i.e. political involvement, activism, and affiliation), language and stories, Tribal values, children, education, and the land or environment. Other authors (Belcourt-Dittloff & Schuldberg, 2006; Buchwald, Beals, & Manson, 2000; Cross, 1995, Walters, & Simoni, 2002; Marbella et. al., 1998) have begun to highlight the empirical and clinical importance of spirituality within traditional healing methods. In his final book entitled "*The World We Used to Live In,*" Vine Deloria, Jr. asserts the empirical basis for the healing in the cultural and spiritual context of Tribal community: *"I have never emotionally or intellectually questioned the veracity of the old accounts...I have listened to stories told by others or accidentally come across accounts of incidents in which amazing spiritual powers were displayed. Our ancestors invoked the assistance of higher spiritual entities to solve pressing practical problems...*[including] *learning about medicines, participating in healings..."* He went on to affirm the reality and effectiveness of these practices by saying "*I have always considered these accounts as truthful remembrances of past events. Medicine men, for the most part, performed their healings and predictions in front of large Indian audiences that were saying 'Show Me' long before Missouri adopted the slogan for itself."* (Deloria, 2006, xix).

In a large urban American Indian sample ($N = 869$), Buchwald, Beals, and Manson (2000) found that 70% of the sample used traditional health practices and 52% reportedly felt that this use significantly improved their health. In a reservation sample of Northern Plains community college students ($N = 164$), Belcourt-Dittloff and Schuldberg (2006) found that culture, hope, communal mastery, and spirituality were all significantly related to ratings of psychosocial status and adaptive coping following exposure to stressors and/or traumatic events. Subsequently, factors that promote adaptive coping following exposure to traumatic or stressful events within American Indian communities are believed to represent cultural resiliency factors.

American Indians have the right to access adequate health care and to give voice to their own truths, to ask their own questions, and to find the most effective healing methods. Recently (2002) the APA published guidelines on multicultural education, research, practice, and organizational change. It encourages psychologists to have cultural awareness of themselves and others and to foster the spirit of multicultural prioritization throughout psychological research and practice. It directly quotes Comas-Diaz (2000) who writes that, "Psychologists are uniquely able to promote racial equity and social justice. This is aided by their awareness of their impact on others and the influence of their personal and professional roles in society." In order to eliminate the current health disparities and research disparities federal, state, and academic agencies can begin by adopting and adhering to these guidelines in the full spirit of each of the principles. Many agree with Vine Deloria when he wrote that: "We need to glimpse the old spiritual world that helped, healed, and honored us with its presence and companionship. We need to see where we have been before we see where we should go, we need to know how to get there, and we need to have help on our journey" (Deloria, 2006 xix).

The kind of research and clinical practice needed on underrepresented groups includes the entire spectrum of psychological scientific and applied study particularly clinical psychology. This should include scientific investigations of cross-cultural and cross-Tribal differences in pathology, wellness, personality, as well as applied studies of treatment outcome and differential application matters. In distinguishing between what types of research should and should not be conducted I believe that research that helps to increase the holistic understanding of both members of minority groups as individuals and as members of larger communities should be prioritized. This includes both applied clinical studies of outcome and theoretical understandings of pathology, etiology, course, development, and inherent cross-cultural differences.

Future Directions: Promising approaches

Currently, attempts are beginning to be made at the levels of a Tribal individual members and communities to advance the understanding and fostering of resiliency among Native Americans. This resurgence has taken the form of revitalization of traditional Native American languages, ceremonial practices, religions, cultural practices, healing strategies, and mentorship programs, and these have occurred throughout Indian Country. Numerous applied projects have

emerged aiming to promote health and wellness within American Indian Communities (Anderson, Belcourt, & Langwell, 2005). This is a common programmatic effort seen in many Tribal communities today (e.g., Blackfeet, Salish, Kootenai, Crow, and Navajo).

Prominent American Indians have also joined this struggle for health and wellness. N. Scott Momaday, a Pulitzer-prize winning Indian author, has established the Buffalo Trust, an elder mentorship program for Indian children, to combat the spiritual degeneration experienced since the time of initial western contact. Language immersion schools have emerged in many Tribes, including the Blackfeet and Arapaho. Such schools have increased interest in Native Languages and helped to fuel resurgences of interest in Native American traditional culture. In addition, The Navajo Healing Project is a collaborative effort between Navajo and non-Navajo researchers to improve healthcare by understanding the nature of the therapeutic process in Navajo religious healing (Csordas, 2004).

LaFromboise and Howard-Pitney (1994) have developed a curriculum designed to facilitate psychological resilience to prevent suicide. This curriculum is currently (2006) being implemented within multiple American Indian communities and appears to be a promising psychological intervention. The Circles of Care Initiative (Freeman, Iron cloud-Two Dogs, Novins, & Lemaster, 2004; Thurman, Allen, & Deters, 2004), funded by the Center for Mental Health Services, is designed to research culturally appropriate mental health services models for children with emotional disturbances. Each of these clinical approaches collaborates closely with Tribal communities to develop, research, and assess psychological interventions for American Indians.

Collaborations such as these open up important new avenues for the development of a more effective mental health care system for Native Americans. Thus, the journey has begun toward a better understanding of Native Americans and human kind in general. This journey will hold challenges, in that it will cause the field of psychology to question underlying assumptions that have been held for years about American Indians and American Indian communities as well as challenging some Western views about psychological reality. Native Americans do deserve to be accorded the fullest respect as human beings in research, practice, and throughout psychology in general. This process has only just begun and will likely be led by the American Indian communities themselves. Providing scientific, clinical, and professional voice to the narratives of

American Indian resiliency and hope will provide a psychological science that is more representative and inclusive of all peoples.

The heart and soul of scientific research is the search for the truth. This quest is the soul of research and at the heart of effective health care. Problems facing American Indians are significant and multifaceted. The best practice for American Indians would be for health care providers of all nations and training background, Western and Tribal, to come together and learn from each other. Both sides of this discourse have much to offer towards the alleviation of psychological suffering. As Sue (1999) indicated, "Cost is not an acceptable reason for exclusion of minority groups in scientific inquiry." There is much to be gained for every person.

Human beings of all nations and cultures have long experienced suffering, grief, and loss. Many have been able to rise above, adapt to, and overcome extraordinary traumatic losses. Pain, grief, loss, and trauma are an unfortunate reality for many American Indians today. Harnessing the spirit of Cultural Resiliency through science and practice can provide American Indians with untold renewal and regeneration. Emotional healing through cultural resiliency, hope, and spiritual practices and beliefs holds promise for this growth. Trauma and loss may continue to be a reality facing American Indians daily. Through cultural resilience, communities can heal. Lessons can be learned. Hope can be shared. This is the process of healing and of hope. The final paragraph of

One potential proposal to continue to promote community based participatory discourse is for an Inter-Tribal Spiritual Summit to be convened to discuss the topic of integrating Traditional Medicine into Western Medical Models. Currently, plans are being developed to invite spiritual leaders from Tribes in the Northwest to discuss issues related to the integration of Traditional Healing Methods into Western Healthcare. Potential discussion items are included below as potential agenda items. The inclusion of spiritual leaders is crucial in the development of innovative pathways toward understanding and healing for American Indians. Clinicians working within an American Indian community or with American Indian clientele would benefit from considering the inclusion of cultural resiliency factors (such as social support, hope, spirituality, communal mastery, enculturation/ethnic pride, and resilient coping strategies) within intervention plans for families and individuals experiencing traumatic losses or stressors. This also provides particularly strong rationale for the inclusion of family and community members in

the treatment of American Indians who have experienced traumatic experiences or losses (Attneave, 1989).

One American Indian participant in a recent study on Cultural Resiliency (Belcourt-Dittloff & Schuldberg, 2006) wrote about her experiences of recovery after experiencing years of loss, trauma, and violence. She wrote:

> *When I finally had had enough we completely split apart. I wanted no more and I also had to think about my children. I didn't want them to see anymore of what I was going through. But, I also had to think about myself...What would my children do if something happened to me? Because they would have no one. Also, I was and still am somebody.*

She finished by describing how she and her children held each other up. They inspired each other. They saw and validated the abilities and potential in each other. They helped each other and they loved each other. In the end she went on to explain in writing "I have a future to look forward to, as do my children." It is this spirit of hope, determination, bravery, courage, and ferocious love that creates resilient people and resilient recovery from loss and trauma. It is this spirit that will help American Indian people today and tomorrow. Psychological science would be well served to continue investigating and facilitating resiliency within American Indian communities. Together is where strength lies.

If we have been researched to death, maybe it is time
we start researching ourselves back to life."

-Native elder from Alberta, (Quoted in Castellano, 2004-Ethics of Aboriginal research)

Tribes and Tribal communities, and not only individuals, must address the following questions in an ongoing dialogue and/or Summit/s on Traditional Medicine. These are questions that are intended to provoke continuing and ongoing dialogue of this critical facet of health care delivery and its implementation:

- Should we work to integrate traditional medicine into western medical care for American Indian peoples and Tribal Communities?
- How can the erosion and fading of ceremonial practices be addressed?
- How do we define traditional medicine and recognize the importance of specific Tribal histories, ceremonies, and rituals?
- How can traditional medicine be incorporated into existing Western methods of treatment or health care?
- How do we consider ethical issues of cross-cultural applications of traditional medicine?
- Who within the Tribes should advance this application of Traditional Medicine?

- Who would benefit the most from the integration of traditional medicine into western health care?
- How can we create sustainable traditional medicine? (i.e. Ceremony apprenticeships, cultural mentorship programs, immersion programs for health, training of health professionals, & research)
- Questions for all healthcare providers (traditional, western, and both)
- What are the Perceptions and Perceived Barriers of the Western Medical Model?
- What are the Perceptions and Perceived Barriers to the Traditional Medicine Model?
- What are the Perceptions and Perceived Barriers of Indian Health Service?
- What Interventions and Tools combining Western Medicine and Traditional Medicine will address Pandemic, Epidemic Problems and emerging diseases facing American Indians?

Future areas for consideration of traditional medicine integration both for the individual and as a community/Tribe:

Violence and Trauma

- Culturally based prevention and treatment programs aimed at addressing Intimate partner violence, child abuse & neglect, Post Traumatic Stress Disorders and Historical Trauma & Grief Issues both for the individual and as a community/Tribe
- Culturally based Prevention and Intervention Strategies and Practices to address Suicide and Suicide Ideations, Methamphetamine and Poly Drug Addictions, Substance Abuse (Prevention Curricula, Intervention, and Treatment)
- Cultivating Traditional Cultural values and paradigms within all segments of Tribal community/ies.
- Direct Service Tribes need to address all of these issues in coordination and collaboration with Indian Health Service.
- Compact and Contracting Tribes need to define the role of Traditional medicine within the context of their new compact or contract.
- Congress, in coordination with President, must determine and assert the application of Tort Claim Liability for all programs utilizing Traditional Medicine and its principles.

In conclusion, in his 2006 magnum opus entitled "The World We Used to Live In" Vine Deloria Jr. wrote in his final paragraph: "It is my hope that Indians will read these stories and know that many powers are available through the ceremonies and rituals of the tribes and that the powers can be applied to our daily lives to enrich our well-being and enhance our understanding of life in the physical world. Unlike other religious traditions, which have an early revelation followed by millennia of critical examination of the premises and substance of the spiritual experience, Indians have access to these spiritual powers here and now. They can be applied in our lives, and, indeed, the validation of these powers must always be in a change in the conditions of the physical world. Indian spiritual powers manifest themselves immediately in healings and prophecies. We would do well to return to those roots."

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PREPARED STATEMENT OF THE FORT BELKNAP INDIAN COMMUNITY COUNCIL

Thank you Senator Dorgan and Senator Tester and the other members of this important Committee for taking the time to listen to the recipients of Indian Health Care Services on the needs and challenges of Health Care in Indian Country in Montana. As you might expect, this is an emotional issue for us, as it affects the lives and quality of life for all of us.

To start out with some good news, the Indian Health Service provides medical treatment and medicine to thousands on our Reservation. For those who receive timely services, this medical treatment is greatly appreciated.

Unfortunately, there are thousands who receive no treatment or receive treatment at inadequate, untimely levels of care. For many, this lack of available health care causes small problems to escalate to crisis issues and hastens death in others.

These problems are not new. As we sat discussing this testimony for today, none of us on the Tribal Council could remember a time when the problem of inadequate care didn't exist. For generations, we have been coming to hearings like this one, relating horror stories, with no end in sight. Our grandparents and parents experienced the same problems. **"Rationed Health Care"** has been the policy of the Indian Health Service since its creation. It is a policy created because of inadequate funding.

Unfortunately, you cannot sit down with ten (10) Indians from anywhere in Montana without hearing at least thirty (30) horror stories from the group about problems with health care from their immediate families. We would like this circumstance to end with this generation. We would like to itemize some of the categories of concern and a few proposed solutions.

The Indian Health Service has been asked to provide services in often impossible circumstances. With each budget cycle, each agency faces budget shortfalls. Patients are required to be diagnosed with acute symptoms before being treated. This is often nonsensical, not only because of patient pain and danger, but because treating only acute symptoms results in higher costs when treatment is actually rendered. Acute symptoms often escalate into other problems.

Patients have waited days (weeks) for gall bladder symptoms to reach crisis level, only to be help flighted to a hospital for emergency surgery. Numerous heart patients are put off for "routine" surgery, until acute symptoms require more complicated, expensive and more dangerous surgeries.

Dozens and dozens of patients from our reservation have been referred to outside medical treatment facilities for contract care services, only to find the services received were not paid for by the Indian Health Service. Many have faced collection actions and adverse credit reporting when they have been unable to pay for referred services.

Off-reservation service providers in the immediate area have often exhibited "attitudes" towards our members when they arrive for services. Whether because of non-payment for services rendered, or simple prejudice, is unclear. But the attitudes are clearly detrimental. A local hospital in Havre recently diagnosed an individual with cancer and sent him home to Fort Belknap to die, as they said nothing could be done for him. Months later, while in Billings, his symptoms caused him to be hospitalized. While there, a doctor outlined the various treatments

which could be provided to "cure" the cancer. While expensive, they were just as available in Havre as in Billings. The treatment may now be too late.

Many feel like the lack of money has caused "**Termination by lack of appropriation". The Indian Health Service has been underfunded for decades. Adequate funding is needed now to begin reversal of the many problems caused by underfunding.**

Utilization of other existing resources needs to happen now. Many individuals are eligible for Medicare and Medicaid funding. Indian Health Service agency offices need to utilize these resources to stretch their funding.

Use of high-deductible insurance for Indian Health Service, B.I.A. and Tribal employees, and their families, as well as others could dramatically stretch Indian Health Service monies. We have proposed a quasi-self insurance plan, partially funded by Tribal resources. Plans such as this need to be looked at to provide better service NOW!!!

We have been told by Indian Health Service officials that insurance plans are not an alternative. WHY??? IF INSURANCE CAN PROVIDE BETTER SERVICES FOR THE SAME MONEY, IT SHOULD BE AVAILABLE NOW!!

The Indian Health Service often does not listen to Tribal representatives. It doesn't matter who you are, there seems to be a culture of not caring. A member of our Tribal Council was recently told they had Lupus. This was related in a cavalier off-handed manner by the doctor, like it was normal. The doctor said the person had the condition for three (3) years!! (They had never been told!!) They were told they would be referred for treatment and medication. After several months, and no referral and no medication, inquiries revealed that the "new" record keeping system had lost the referral. The doctor involved had failed to follow through. And, by the way, a new examination revealed that the person didn't have Lupus after all. This and numerous other examples draw concerns that the "new" record keeping system does not work. However, each month, administrators from the local service unit report to the Tribal Council and praise the new system as "working great".

A recent cancer patient was refused treatment, as the local agency didn't have the medication needed. No alternative was even suggested. Another cancer patient, dying and in excruciating pain, was repeatedly refused pain medication, as "..it would only make him an

addict". His family tried in vain to find alternatives. He died after months of excruciating pain, as they could not afford medication.

Another enrolled member was diagnosed, after years of being put off, with Lou Gehrig's Disease. Initially refused medication because of the expense, when it was finally provided, he was made to feel guilty about the expense of the medication. No therapy or other services were provided, in spite of numerous routine services being available, according to off-reservation providers.

The attitude of a doctor attending a Diabetes forum recently sums it up. When asked about alternatives, he got up in frustration, threw up his hands and stormed out of the room, saying "I don't have to listen to this...I'm not a Tribal employee". His attitude is indicative of the uncaring attitudes displayed for decades. Just ask the family of a nine month old baby who died thirty (30) years ago from dehydration after being sent home for the fourth time in two days by an Indian Health Service doctor who chastised his concerned parents to quit bothering him with a simple case of diarrhea. The family traumatized this year when their dying family member was refused pain medication, watching needless suffering, is hurting just as that family was thirty (30) years ago when their nine month old was refused treatment and died. Anyone living on reservation could tell you these are not isolated incidents.

The patient stories are tragic and seemingly endless. One solution is to have Indian Health Service required to work more closely with Tribal representatives. Tribes could help provide incentives to bring better doctors. More local services are needed, so that doctors can get to know their patients and vice versa. Sensitivity training is needed for every doctor coming in to serve. More trained Native Americans are needed.

Some efforts have been made. More efforts are needed. We encourage this Committee to listen to the proposed solutions carefully and to take action. Thank you for your willingness to listen.

PREPARED STATEMENT OF DAVID B. MYERS, M.D., BILLINGS MT

The Crow-Northern Cheyenne Hospital (CNCH) at Crow Agency could serve the beneficiaries better with different management decisions and, of course, more funding.

One example is surgical services. A Public Health Service (PHS) Commissioned Officer, a Board Certified general surgeon, Dr Michael Wilcox, came to CNCH about 4 years ago. His talents are underutilized due to periodic short staffing in the operating room (nurses, scrub techs, anesthetists). Many surgical cases are sent to the private surgeons, usually in Billings, MT, that could otherwise be cared for at CNCH. In addition the IHS has be unable to support Dr Wilcox in a well thought out plan to allow him to operate on more complex surgical cases in Billings, thus saving the IHS dollars and providing better continuity of care for IHS beneficiaries.

A second example also illustrates problems with budgeting and the interface between IHS and the private medical community that shares the responsibility of care for patients on the Crow and Northern Cheyenne Reservations. My surgical practice, Billings Surgical Group, PC, could not be paid for medical care rendered due to shortages in the Service Unit's Contract Care budget. Bills were unpaid for two and three years. Only when Senator Max Baucus sent an inquiry to the CNCH administration could the funds be found and released for payment.

PREPARED STATEMENT OF CAROL JUNEAU, STATE SENATOR, SENATE DISTRICT 8, MONTANA

Thank you Senator Dorgan and Senator Tester for coming to Montana and holding these important hearings of the Senate Indian Affairs Committee on Indian Health Service.

Providing access to quality health care is one of our nation's top priorities and it is also one of the top issues facing Indian people. We need to insure that the Indian Health Care Improvement Act is reauthorized and that it includes services that will provide Indian people with the appropriate and necessary health care to insure that their health needs are met.

I also appreciate the fact that you recognize the long standing treaty and legal obligations of the Federal Government in its relationship with Indian tribes – health care being one of these obligations.

Following are a few of the issues I would like to share with you to consider in the reauthorization and funding of Indian Health Service.

1. Adequate funding for Contract Health Services: This is a critical need for Indian Health Care Services. Currently, Indian people are being denied access to contract health services needed to meet their health needs because they do not meet a specified level of "critical need" as determined by a rating scale that requires a rating of "12 points" to be referred to specialists or for additional testing/assessments. Example: If your illness or injury, even though it may be serious, does not receive a "12 point" assessment, you are put on a "deferred" list and left to wait. This results in lack of health care that could possibly prevent more serious illnesses or health care that could improve the quality of life for an individual. One of the problems of the "deferred" health care is the use of pain medicines, that may become addicting, which create a whole new health care issue.

> As an example of this funding need: There currently is a $10.0 million dollar shortfall for the Blackfeet Community Hospital on the Blackfeet Indian Reservation for Contract Health Care. This translates into many people, with health needs, who are waiting in a "deferred" status.

Most of the Contract Health Care money that is available is spent in off-reservation hospitals and clinics with no benefit to the local tribal community. If services and resources were available at the local Indian Health Care facilities for some of this care,

the reservation economic systems would benefit. Example: When a person is sent to Great Falls MT., from Browning, Mt., there is not only the health costs that goes to a Great Falls hospital and providers, but there is the money that is spent by families who also go to be with their loved ones.

2. **Adequate funding for health care professionals.** Staffing levels are still not adequate to meet needs at our Indian Health Care facilities. As an example: The pharmacy at the Blackfeet Community Hospital is staffed at about 50% of the need...it is programmed for 60,000 outpatient visits per year and there are 130,000 outpatient visits.

3. Adequate funding for Equipment/Technology: Indian Health Service Hospitals and Clinics need access to the new equipment and new technology that can save lives and improve the delivery of health care. Being able to identify the health issues and do an accurate diagnosis of need are a key in preventive care and should be available to the health professionals in their services to their patients.

4. **Expanding Health Care through Partnerships:**
The State of Montana is doing a legislative interim study on providing health insurance to all Montanans through health insurance reforms and publicly funded health care programs..... Indian Health Service would be an excellent partner in this effort to not only see how they can help, but perhaps how they might benefit in providing quality health care for all Indians in Montana.

As an example: We need to make sure that Indian Health Service takes proactive steps to insure that all eligible Indian children and families are participating in CHIP and Medicade. This is a win-win situation for Indian Health Care.

Another example would be exploring strategies to help employers on reservations provide health insurance for employees -- this again would be a win-win situation for Indian Health Service. As an example: Many school districts located on reservations provide health insurance to their employees. Other agencies such as the Bureau of Indian Affairs also provide health insurance. Many of these employees are Indian people who are eligible for Indian Health Service Care as well. This creates a win-win situation for Indian Health Service – to have more of their eligible constituents participating in alternative health insurance programs.

These partnerships could expand to include retirees of schools and other employers. Retirees often find it impossible to pay the total premium costs ion order to continue their health insurance and have to rely totally on Indian Health Service for their medical care upon retirement.

5. **Revising Prescription Policies:** The current policy of Indian Health Service allowing only prescriptions filled at their pharmacies that have been prescribed from only Indian Health Care providers limits those Indian people who have their own health care insurance from going to another non-Indian Health Care Provider and having their prescriptions filled at their Indian Health Service Hospital or clinic. If an Individual Indian has their own health insurance that includes prescriptions, couldn't Indian Health Care fill that prescription and then bill that outside provider?

   The current policies discourages Indian people with their own insurance who may need prescriptions from going to a provider outside of Indian Health Service.

6. **Reducing the level of Violence against Indian Women is a health care issue.** Indian Health Care could develop stronger partnerships with law enforcement and the court systems to insure that women and girls who are victims of violence are provided with not only adequate health care, but advocacy support in stopping this violence. Following is some supportive data for this recommendation:

   Per a recent report by Amnesty International, Sexual violence against Indigenous women in the USA is widespread -- and especially brutal. According to US government statistics, Native American and Alaska Native women are more than 2.5 times more likely to be raped or sexually assaulted than other women in the USA.

   According to the US Department of Justice, in at least 86 per cent of the reported cases of rape or sexual assault against American Indian and Alaska Native women, survivors report that the perpetrators are non-Native men.

   Federal government studies have consistently shown that Native American and Alaska Native women experience much higher levels of sexual violence than other women in the United States. According to the US Department of Justice, more than 1 in 3 Native American and Alaska Native women will be raped during their lifetime. Indigenous women are being denied protection and there is a systematic failure to punish those responsible for these crimes

PREPARED STATEMENT OF BARRY ADAMS, BROWNING MT

Wilma Adams is my mother. She passed away on November 17, 2004 at Benefis hospital in Great Falls Montana. She died a week after falling in her hospital room at the Indian Health Service hospital in the early morning hours of November 10, 2004. She suffered unimaginable pain from a fractured pelvis from the time she fell in Browning until she died in Great Falls. Wilma was almost 83 years old at the time she died. I had lived with her in my house since August 10, 2004. I was separated from my wife and I had moved in with Wilma who had lived in one of my houses for many years by herself. The night she went to the IHS hospital in Browning was November 9, 2007. She had a cold and visited the ER for treatment since it took too long to go through screening. My sister Reva Adams took her to the ER in the evening and the doctor suggests she stay for a couple of days until they could clear up the congestion in her chest. The doctor didn't want her to catch pneumonia. She did not want to be admitted because she did not think she was that ill. The doctor and my sister convinced her that the IHS ward was the best place for her. She was admitted and my sister Reva left her to sleep and called me to let me know what was happening. The next morning at home as I was getting ready to go to work around 8:00am my other sister Karen Vielle called and told me that something was wrong with mom and that I needed to get to the hospital right away. I went to the IHS ward and went to my mother's room and met Karen there. She told me that Wilma had been given narcotic pain medicine. I noticed Wilma seemed uncomfortable and like she was trying to sleep but she was not really awake. I began to wonder what kind of pain medication she was given and why. When she roused from sleep she said she had pain in her lower back or buttocks area. She said she had fallen and her bottom hurt. She was scheduled to go to dialysis that morning but she was unable to get up from the hospital bed. Before she went to the hospital this time she was able to get herself out of bed and take care of herself. So I knew something was wrong at that time. The nurse called the ambulance to come and get my mother from the ward and take her to the dialysis clinic which is on the opposite side of the hospital campus. As the attendants were putting her on the gurney she was in extreme pain and every little movement caused her to cry out. I knew something serious was wrong because she was in so much pain even with the pain meds she had received. They

finally got her loaded on the ambulance and headed for the Dialysis clinic. Every movement caused her extreme pain, even the ride on the gurney was hurting her and each little bump caused her to flinch. The dialysis nurse recognized my mom (she used to call my mother "mom" but she was no relation). She asked "What's wrong with mom?" I told her I did not know but she was in extreme pain when the dialysis staff tried to take her off the gurney. She had to be weighed before dialysis and she usually sat on a wheel chair on the scale platform. Wilma would not let the nurses move her off the gurney and into a wheel chair because it was much too painful. The dialysis nurse said that there was something seriously wrong with mom and that the ambulance should take her to the ER to find out why she was in so much pain. The attendants loaded her back on the gurney and took her back to the hospital ward. I realized that mom was delirious from the pain and medication she was given at the ward. Wilma normally was a very intelligent, clear minded, person who did not suffer from memory loss or delirium. I started to realize that no one at the ward knew what had happened to my mother during the previous night. The reason was that there was a shift change and the night nurse, Purnee Brandvold Odegard had gone home before I arrived and she had not done anything to help my mother except get her pain meds. I requested to see Dr. Hines or Dr. DesRosier but the morning nurse said they were busy making rounds and they would come when they were finished. Dr Hines finally showed up and I told her that I was very concerned about my mother because she was in great pain and they were not doing anything to help her. I requested that they send her to Benefis hospital in Great Falls because she needed more care than the IHS was giving her. Karen had told me by this time that mom had fallen in her room at the ward during the night and may have broken her hip again. Dr Hines agreed to send my mother to Benefis after my sisters and I insisted that she do so. Mom was still in great pain and the staff prepared her to be taken to Great Falls in the ambulance. I was very apprehensive about the trip to Great Falls because the trip to dialysis had been very painful for my mother and I figured it would be much more traumatic for her riding over 120 miles to Benefis hospital. After my mother was taken to Great Falls we found that she had a broken pelvis. She was dialyzed there and seemed be getting better after a couple of days but she was still in great pain and was unable to get comfortable and slept only in short periods. After her brief recovery her improvements started to reverse and she seemed to be getting weaker. I visited her the night of November 17 in her room at Benefis and she was very restless in her half sleep half awake condition. She could not seem to get comfortable and I had to leave because I could not bear to see my mother suffer anymore. I went to my motel and later that evening my nephew Earl Vielle came to see me from the hospital and before he said anything he hugged me and proceeded to tell me that his gramma, Wilma had passed away. He drove me back to the hospital and I was allowed to see my mother's body. She seemed to finally be comfortable. I was relieved that she was no longer suffering. I know she was a strong Catholic and that she believed in the afterlife and that she was at peace. I watched my mother suffer unnecessarily for the last week of her life. I say unnecessarily because she should not have gotten injured the night of November 9, 2004, in the IHS hospital and

should not have been ignored afterwards until the next morning. I had found out later from my sister Reva that the New Robe family who had an ill family member in the room next to my mother's room had heard my mother fall late the night she was admitted. The New Robe's said my mother was yelling for help but no one came until much later. My mother should have been taken to the ER as soon as the night nurse found her but she was not, my mother was put to bed and given narcotics for pain. Her file states that her pain was at ten on a scale of one to ten. The night nurse Purnee did not do her job. She should have taken my mother to the ER and called a family member immediately after she was found on the floor of her room. I believe the reason my mother died when she did is because the IHS night nurse did not make sure my mother was safe in bed. And she did not call the ER or family member when she found my mother on the floor with what we know now was a broken pelvis. I fear that when I get old that I will be treated as badly as my mother. I believe there is no excuse for the way my mother was made to suffer. And she did suffer immensely with a broken pelvis for a week before she died of cardiac arrest. In fact I believe that she was tortured to death and it all started from her having congestion in her chest from a cold. If the person reading this has a mother put yourself in my place and imaging watching your mother writhe in pain for a week before her heart gave out and she cried out hoping to die just to end her misery. It has been over two years since my mother died and I feel guilt, heartache, loneliness, and anger as if she had died yesterday. I feel guilty because I allowed some stranger to care for my mother and she ended up with injuries that I believe caused her death. I am heartbroken because I lived with my mother for the last three months of her life and we were very close and I had to watch her tortured to death the last week of her life. I am lonely because I think about her every day and I am unable to share her company. I am angry because our family is poor and unable to afford any care besides the Indian Health Service. How many more patients have suffered because the night nurse was not there when needed and then ignored and put back to bed after expecting help? I hope someone answers for my mother's pain and suffering I do not want my mother's injury and death to be swept under the rug. I do not want her death to be in vain. My mother did not die from any illness or disease, she died from the care she received at the Browning Indian Health service hospital.

PREPARED STATEMENT OF ALEX WARD, ASSOCIATE STATE DIRECTOR, AARP MONTANA

Senator's Dorgan and Testor, thank you for taking time out of your break to hold a hearing on this important topic to Montanans. My name is Alex Ward, Associate State Director for AARP Montana, a nonpartisan, nonprofit membership organization with 158,000 members in Montana. AARP has a high percentage of American Indian members in relation to their population in the state. Many of our members are grandparents who are raising their grandchildren and great grandchildren. Healthcare is extremely important not only to the elders, but to their children and grandchildren as well.

AARP Montana has been community partners in Indian Country for the past 10 years. We have worked with IHS and tribal programs to expand their reach by enrolling Indian Elders in Public Benefit programs that will pay the individual's share of Medicare costs and in turn will allow IHS to bill Medicare for delivery of services to those Medicare-eligible individuals.

AARP believes that " . . . health agencies play vital roles in protecting and promoting the health and safety of communities by conducting the following activities:

Identifying health risks;
maintaining safe and healthy environments;
detecting, investigating and preventing the spread of disease;
promoting healthy lifestyles;
providing primary care for individuals with limited access to such care . . . ;
informing the public on health issues; and
developing strategies and plans to respond to newly emerging public health threats.

"Reforming health care requires more than expanding coverage. It also involves improving the process of health care delivery itself, from reducing health risks to making decisions about when to seek care, selecting quality providers and appropriate treatment options, and improving management of care and of the entire health care system.

"In the early 1990's AARP developed health care reform principles. Among these are:

All Individuals have a right to health care services when they need them.

All Individuals have a right to high-quality health care.

Health care spending should be more rational and support the goals of more efficient planning, budgeting and resource coordination.

Efforts to promote health and prevent disease should be strengthened.

Individuals share a responsibility for safeguarding their health by educating themselves and taking appropriate preventive measures to protect their health, safety and well-being.

Acute, chronic, and long-term care services should be coordinated and integrated to ensure a continuum of care throughout an individual's lifetime." (Taken from the 2007 AARP Policy Book.)

These are principles that support passage of HR 1328.

As you know, there are large disparities between the status of Indian health care and that of the rest of the Country. The infant mortality rate is 150% greater for Indians than for Caucasian infants; Indians are 2.6 times more likely to be diagnosed with diabetes; Life expectancy for Indians is nearly 6 years less than for the rest of the U.S. population. For further information regarding these statistics see U. S. Commission on Civil Rights Studies – 1) The Quite Crisis (July, 2003) and 2) Broken Promises (July 2, 2004).

In 2007 AARP began a massive campaign to seek health care reform and lifelong financial security for all Americans. The first paragraph of our "Divided We Fail" platform is: **"We believe that the opportunity to have access to health care and long-term financial security is a basic need that all Americans share. We believe it is the foundation for future generations."** In this platform, I believe it is important that AARP support our Indian partners – the National Indian Health Board, the National Indian Council on Aging and the Montana-Wyoming Tribal Leaders Council as well as Indian Tribes and organizations in Montana and our thousands of members who live in Indian Country in urging the passage of HR 1328.

We realize that HR 1328 doesn't solve the entire problem, but is a necessary beginning for movement in the right direction and we therefore ask for your support of the passage of HR 1328. We know that with this effort as well as many others we will tackle in the next few years that if we don't support each other on such crucial issues then indeed, "Divided We Fail".

PREPARED STATEMENT OF THE NEZ PERCE TRIBE

Honorable Chairman and members of the Committee, the Nez Perce Tribe would like to thank you for the opportunity to provide testimony to the Senate Committee on Indian Affairs on an issue that has become the number one priority to Indian Country. The reauthorization of the Indian Health Care Improvement Act has to be accomplished during this first session of the 110th Congress. Your work in trying to move Senate Bill 1200 forward through amendment to the SCHIP legislation helped ensure that the bill will receive the hearing necessary in the Senate Committee on Finance on September 12, 2007. The Nez Perce Tribe applauds your work and believes it is efforts like this that will help finally get the Indian Health Care Improvement act reauthorized. The Tribe agrees with the recent statements of Vice Chairman Murkowski that the reauthroization of the act needs to be accomplished during this first session of the 110th Congress as it has been too long already.

The Nez Perce Tribe also appreciates you holding this field hearing and taking the time to examine the problems with Indian health care across the country up close and personally. The

statistics that state that the infant mortality rate is 150% greater for Indians than that of Caucasian infants or that Indians are 2.6 time more likely to be diagnosed with diabetes only tell a part of the story. Statistics already show that healthcare expenditures for Indians are less than half of what the United States spends for federal prisoners but seeing the system up close and for yourself will put a real face on those sterile numbers.

On the Nez Perce Reservation, the Nez Perce Tribe operates the Nimiipuu Health Clinic in Lapwai, Idaho and its satellite facility in Kamiah, Idaho. The Clinic is constantly struggling to provide adequate service to the people that it is supposed to serve because of a lack of funding. The reason for the struggle is that inadequate funding forces contract health service to constantly work in a mode that merely provides a band-aid to the problems it faces instead of a cure. With the shortage of funding, instead of providing effective preventive and diagnostic care, patients are constantly made to wait for the appropriate care. At that point, the health problems the patients have usually develop into a full blown medical crisis. Some families have had the horrible experience of watching a family member wait to be referred for appropriate medical care because of a lack of funding only to have that patient's condition worsen until it is considered a terminal condition by the time the appropriate referrals are made. That is not health care that is death care.

There are also existing examples of patients having to conduct fund raisers to pay for the medications needed to treat their symptoms because of a lack of funding to provide the proper pharmaceuticals at the usual cost. In addition, patients that live in the community of Kamiah, Idaho should be able to go the extension office of the clinic located there to receive proper treatment. However, because of a lack of funding, the Kamiah facility is constantly facing a staffing shortage. This shortage in staffing mandates that patients make the 70 mile drive to

Lapwai to receive treatment at the main facility of the clinic. Many of these patients are elders who either need assistance in making the trip or cannot make the trip at all. How can the Indian Health Service be expected to provide quality and effective service to Indian Country if the system is continually underfunded because the system does not have the support of the United States behind it?

The Nez Perce Tribe has also wrestled with the issue of trying to recoup contract support costs that were formally withheld for certain fiscal years. Claims were made for these funds by the Nez Perce Tribe in 2005. However, over two years later, the Nez Perce Tribe has only received letter after letter saying that the $600,000.00 claim has not been processed. These issues need to be addressed if the health clinics are to provide the service that Indian Country needs.

Much has been made of the inadequate health care that was being provided to our military personnel at Walter Reed Hospital. It is inexcusable that our government was providing such substandard care to the individuals who fight for this country. The nation was rightfully appalled at the details of the situation. However, it should be noted that Indian Country suffers from the same problems that became a national scandal but yet this does not even make the headlines of a local paper let alone seep into the national conscience.

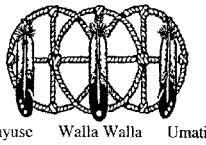
Chairman Dorgan, you recently commented at the confirmation hearing for Dr. Grim that the state of the Indian health care system was scandalous and needed to be addressed. Those words are very true and in fact those same points were outlined 3 years ago in a scathing report issued in September 2004 by the United States Commission on Civil Rights. The report was entitled "Broken Promises: Evaluating the Native American Health Care System." In examining the trust responsibility of the United States to provide health care for Indians that was referenced

by Dr. Grim in his testimony submitted to this Committee prior to it being removed, the Commission stated in the report:

> Treaties and related court decisions form the foundation of the federal government's undisputed responsibility to provide adequate health care to Native Americans. Congress has formally acted upon that responsibility on more than one occasion, and virtually every political leader addressing Native American Health Care has recognized this responsibility. ... Regrettably, the Commission concludes that our nations's lengthy history of discrimination against Native Americans, by way of unfulfilled promises, repeats itself as evidenced by the failure of Congress to provide the resources necessary for the creation and maintenance of an effective health system for Native Americans. [141]

In the report, the Commission also observed that "persistent discrimination and neglect continue to deprive Native Americans of a health system sufficient to provide health care equivalent to that provided to the vast majority of Americans." The final recommendation of the report was that Congress should make "passage of the Indian Health Care Improvement Act a priority on the legislative agenda". The Nez Perce Tribe knows that you concur with this assessment and look forward to working with you and the Idaho delegation to make it a reality. Thank you for the opportunity to provide this testimony on this important issue.

YELLOWHAWK
TRIBAL HEALTH CENTER



Cayuse Walla Walla Umatilla

Pendleton, OR 97801

August 14, 2007

Senator Byron L. Dorgan
312 Federal Building
PO Box 2579
Bismarck, ND 58502

Dear Senator Dorgan,

On behalf of the Confederated Tribes of the Umatilla Indian Reservation (CTUIR) and Yellowhawk Tribal Health Center, thank you for recognizing the importance of the reauthorization of the Indian Health Care Improvement Act and for helping to move this extremely important legislation forward. In this regard, we are particularly pleased with your support of increasing Contract Health Services funding by $49 million over the continuing resolution. We have also taken note of your activities as co-sponsor with Senator Domenici in reauthorizing the Special Diabetes Program for Indians through FY 2013. With this support and your support of realigning health care facility construction funds, there should be little doubt that these significant efforts will positively impact healthcare services for all Northwest Tribes well into the future.

Your leadership and dedication in service to the Indian people of the Northwest is most heartily commended and we look forward to working closely with you and your staff in the future.

Thank you, again!

Sincerely,

Shawna M. Gavin
Chair, CTUIR Health Commission

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