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S. HRG. 108–66

S. 285 S. 555 S. 558

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

S. 288

TO ENCOURAGE CONTRACTING BY INDIANS AND INDIAN TRIBES FOR THE MANAGEMENT OF FEDERAL LAND

S. 555

TO ESTABLISH THE NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

S. 558

TO ELEVATE THE POSITION OF DIRECTOR OF THE INDIAN HEALTH SERVICE WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ASSISTANT SECRETARY FOR INDIAN HEALTH

APRIL 9, 2003
WASHINGTON, DC

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WEDNESDAY, APRIL 9, 2003

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:03 a.m. in room 485 Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senator Campbell.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. The committee will be in session. Good morning and welcome to the Indian Affairs hearing on three modest bills that I believe will positively impact the health and status of the Native people if they are enacted. Senator Inouye is running late and may be here in a little while, but we will go ahead and get started.

Two of the bills that we will be dealing with this morning will benefit Indian health by attracting resources and attention to Native health issues, albeit in two different ways. S. 555 will establish the Native Health and Wellness Foundation to serve as the legal entity that can receive tribal, private sector and charitable donations for the purposes of Indian health care. S. 558 will enhance the presence and effectiveness of the Indian Health Service inside the Department of Health and Human Services by transforming the Director into an Assistant Secretary for Indian Health. This is Senator McCain's bill. And S. 285 is a bill that I have introduced for three Congresses in a row now to integrate existing alcohol, drug and mental health programs. Efforts to consolidate disparate Federal grant programs have been embraced by the tribes in the past, and have proven successful, such as the employment and training program known as the 477 program. With S. 285, we are trying to achieve the same kind of success with alcohol, drug and mental health programs.

[Text of S. 285, S. 555, and S. 558 Follow:]

II

108TH CONGRESS
1ST SESSION

S. 285

To authorize the integration and consolidation of alcohol and substance abuse programs and services provided by Indian tribal governments, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 4, 2003

Mr. CAMPBELL introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

---

A BILL

To authorize the integration and consolidation of alcohol and substance abuse programs and services provided by Indian tribal governments, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Native American Alcohol and Substance Abuse Program Consolidation Act of 2003''.

SEC. 2. PURPOSES.

The purposes of this Act are—

(1) to enable Indian tribes to consolidate and integrate alcohol and other substance abuse prevention, diagnosis, and treatment programs, and mental health and related programs, to provide unified and more effective and efficient services to Indians afflicted with mental health, alcohol, or other substance abuse problems;

(2) to recognize that Indian tribes can best determine the goals and methods for establishing and implementing prevention, diagnosis, and treatment programs for their communities, consistent with the policy of self-determination;

(3) to encourage and facilitate the implementation of an automated clinical information system to complement the Indian health care delivery system;

(4) to authorize the use of Federal funds to purchase, lease, license, or provide training for technology for an automated clinical information system that incorporates clinical, financial, and reporting capabilities for Indian behavioral health care programs;

(5) to encourage quality assurance policies and procedures, and empower Indian tribes through training and use of technology, to significantly en-

hance the delivery of, and treatment results from, Indian behavioral health care programs;

(6) to assist Indian tribes in maximizing use of public, tribal, human, and financial resources in developing effective, understandable, and meaningful practices under Indian behavioral health care programs; and

(7) to encourage and facilitate timely and effective analysis and evaluation of Indian behavioral health care programs.

SEC. 3. DEFINITIONS.

In this Act:

(1) AUTOMATED CLINICAL INFORMATION SYSTEM.—The term ''automated clinical information system'' means an automated computer software system that can be used to manage clinical, financial, and reporting information for Indian behavioral health care programs.

(2) FEDERAL AGENCY.—The term ''Federal agency'' has the meaning given the term ''agency'' in section 551 of title 5, United States Code.

(3) INDIAN.—The term ''Indian'' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(4) INDIAN BEHAVIORAL HEALTH CARE PROGRAM.—The term ''Indian behavioral health care program'' means a federally funded program, for the benefit of Indians, to prevent, diagnose, or treat, or enhance the ability to prevent, diagnose, or treat—

(A) mental health problems; or

(B) alcohol or other substance abuse problems.

(5) INDIAN TRIBE.—

(A) IN GENERAL.—The term ''Indian tribe'' has the meaning given the term in section 4 of the Indian Self Determination and Education Assistance Act (25 U.S.C. 450b).

(B) INCLUSIONS.—The term ''Indian tribe'', in a case in which an intertribal consortium, tribal organization, or Indian health center is authorized to carry out 1 or more programs, services, functions, or activities of an Indian tribe under this Act, includes the intertribal consortium, tribal organization, or Indian health center.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) SUBSTANCE ABUSE.—The term ''substance abuse'' includes—

(A) the illegal use or abuse of a drug or an inhalant; and

(B) the abuse of tobacco or a related product.

SEC. 4. PLANS.

The Secretary, in cooperation with the Secretary of Labor, the Secretary of the Interior, the Secretary of Education, the Secretary of Housing and Urban Development, the Attorney General, and the Secretary of Transportation, as appropriate, shall, on receipt of a plan acceptable to the Secretary that is submitted by an Indian tribe, authorize the Indian tribe to carry out a demonstration project to coordinate, in accordance with the plan, the Indian behavioral health care programs of the Indian tribe in a manner that integrates the program services into a single, coordinated, comprehensive program that uses, to the extent necessary, an automated clinical information system to better manage administrative and clinical services, costs, and reporting requirements through the consolidation and integration of administrative and clinical functions.

SEC. 5. PROGRAMS AFFECTED.

Programs that may be integrated in a demonstration project described in section 4 are—

(1) an Indian behavioral health care program under which an Indian tribe is eligible for the receipt of funds under a statutory or administrative formula;

(2) an Indian behavioral health care program under which an Indian tribe is eligible for receipt of funds through competitive or other grants, if—

(A)(i) the Indian tribe provides notice to the appropriate agency regarding the intentions of the Indian tribe to include the Indian behavioral health care program in the plan that the Indian tribe submits to the Secretary; and

(ii) the agency consents to the inclusion of the grant in the plan; or

(B)(i) the Indian tribe elects to include the Indian behavioral health care program in the plan; and

(ii) the administrative requirements contained in the plan are essentially the same as the administrative requirements applicable to a grant under the Indian behavioral health care program; and

(3) an Indian behavioral health care program under which an Indian tribe is eligible to receive funds under any other funding scheme.

SEC. 6. PLAN REQUIREMENTS.

A plan of an Indian tribe submitted under section 4 shall—

(1) identify the programs to be integrated;

(2) be consistent with this Act;

(3) describe a comprehensive strategy that—

(A) identifies the full range of existing and potential alcohol and substance abuse and mental health treatment and prevention programs available on and near the service area of the Indian tribe; and

(B) may include site and technology assessments and any necessary computer hardware installation and support;

(4) describe the manner in which services are to be integrated and delivered and the results expected under the plan (including, if implemented, the manner and expected results of implementation of an automated clinical information system);

(5) identify the projected expenditures under the plan in a single budget;

(6) identify the agency or agencies in the Indian tribe to be involved in the delivery of the services integrated under the plan;

(7) identify any statutory provisions, regulations, policies, or procedures that the Indian tribe

requests be waived in order to implement the plan; and

(8) be approved by the governing body of the Indian tribe.

SEC. 7. PLAN REVIEW.

(a) CONSULTATION.—On receipt of a plan from an Indian tribe under section 4, the Secretary shall consult with—

(1) the head of each Federal agency providing funds to be used to implement the plan; and

(2) the Indian tribe.

(b) IDENTIFICATION OF WAIVERS.—Each party consulting on the implementation of a plan under section 4 shall identify any waivers of statutory requirements or of Federal agency regulations, policies, or procedures that the party determines to be necessary to enable the Indian tribe to implement the plan.

(c) WAIVERS.—Notwithstanding any other provision of law, the head of a Federal agency may waive any statutory requirement, regulation, policy, or procedure promulgated by the Federal agency is identified by the Indian tribe or the Federal agency under subsection (b) unless the head of the affected Federal agency determines that a waiver is inconsistent with—

(1) this Act;

(2) any statutory requirement applicable to the program to be integrated under the plan that is specifically applicable to Indian programs; and

(3) any underlying statutory objective or purpose of a program to be consolidated under the plan, to such a degree as would render ineffectual activities funded under the program.

SEC. 8. PLAN APPROVAL.

(a) IN GENERAL.—Not later than 90 days after the date of receipt by the Secretary of a plan under section 4, the Secretary shall inform the Indian tribe that submitted the plan, in writing, of the approval or disapproval of the plan (including any request for a waiver that is made as part of the plan).

(b) DISAPPROVAL.—

(1) IN GENERAL.—The Secretary may disapprove a plan if—

(A) the plan does not provide sufficient information for the Secretary to adequately review the plan for compliance with this Act;

(B) the plan does not comply with this Act;

(C) the plan provides for the purchase, lease, license, or training for, an automated clinical information system, but the purchase,

lease, license, or training would require aggregate expenditures of program funding at such a level as would render other program substantially ineffectual; or

(D)(i) the plan identifies waivers that cannot be waived under section 7(c); and

(ii) the plan would be rendered substantially ineffectual without the waivers.

(2) NOTICE.—If a plan is disapproved under subsection (a), the Secretary shall—

(A) inform the Indian tribe, in writing, of the reasons for the disapproval; and

(B) provide the Indian tribe an opportunity—

(i) to amend and resubmit the plan; or

(ii) to petition the Secretary to reconsider the disapproval (including reconsidering the disapproval of any waiver requested by the Indian tribe).

SEC. 9. USE OF FUNDS FOR TECHNOLOGY.

Notwithstanding any requirement applicable to an Indian behavioral health care program of an Indian tribe that is integrated under a demonstration project described in section 4, the Indian tribe may use funds made avail-

able under the program to purchase, lease, license, or provide training for technology for an automated clinical information system if the purchase, lease, licensing of, or provision of training is conducted in accordance with a plan approved by the Secretary under section 8.

SEC. 10. FEDERAL RESPONSIBILITIES.

(a) RESPONSIBILITIES OF THE INDIAN HEALTH SERVICE.—

(1) MEMORANDUM OF UNDERSTANDING.—Not later than 180 days after the date of enactment of this Act, the Secretary, the Secretary of the Interior, the Secretary of Labor, the Secretary of Education, the Secretary of Housing and Urban Development, the Attorney General, and the Secretary of Transportation shall enter into a memorandum of agreement providing for the implementation of the plans approved under section 8.

(2) LEAD AGENCY.—The lead agency under this Act shall be the Indian Health Service.

(3) RESPONSIBILITIES.—The responsibilities of the lead agency under this Act shall include—

(A) the development of a single reporting format—

(i) relating to each plan for a demonstration project submitted under section

4, which shall be used by an Indian tribe to report activities carried out under the plan; and

(ii) relating to the projected expenditures for the individual plan, which shall be used by an Indian tribe to report all plan expenditures;

(B) the development of a single system of Federal oversight for the plan, which shall be implemented by the lead agency;

(C) the provision of, or arrangement for provision of, technical assistance to an Indian tribe that is appropriate to support and implement the plan, delivered under an arrangement subject to the approval of the Indian tribe participating in the project (except that an Indian tribe shall have the authority to accept or reject the plan for providing the technical assistance and the technical assistance provider); and

(D) the convening by an appropriate official of the lead agency (who shall be an official appointed by and with the advice and consent of the Senate) and a representative of the Indian tribes that carry out projects under this Act, in consultation with each of the Indian

tribes that participate in projects under this Act, of a meeting at least twice during each fiscal year, for the purpose of providing an opportunity for all Indian tribes that carry out projects under this Act to discuss issues relating to the implementation of this Act with officials of each agency specified in paragraph (1).

(b) REPORT REQUIREMENTS.—

(1) IN GENERAL.—The single reporting formats described in subsection (a)(3)(A) shall be developed by the Secretary in accordance with this Act.

(2) INFORMATION.—The single reporting format, together with records maintained on the consolidated program at the tribal level, shall contain such information as the Secretary determines will—

(A) allow the Secretary to determine whether the Indian tribe has complied with the requirements incorporated in the approved plan of the Indian tribe; and

(B) provide assurances to the Secretary that the Indian tribe has complied with all—

(i) applicable statutory requirements; and

(ii) applicable regulatory requirements that have not been waived.

SEC. 11. NO REDUCTION IN AMOUNTS.

In no case shall the amount of Federal funds available to an Indian tribe involved in any project under this Act be reduced as a result of the enactment of this Act.

SEC. 12. INTERAGENCY FUND TRANSFERS.

The Secretary, the Secretary of the Interior, the Secretary of Labor, the Secretary of Education, the Secretary of Housing and Urban Development, the Attorney General, or the Secretary of Transportation, as appropriate, may take such action as is necessary to provide for the interagency transfer of funds otherwise available to an Indian tribe in order to carry out this Act.

SEC. 13. ADMINISTRATION OF FUNDS; EXCESS FUNDS.

(a) ADMINISTRATION OF FUNDS.—

(1) IN GENERAL.—Program funds shall be administered under this Act in such a manner as to allow for a determination by the Secretary that funds made available for specific programs (or an amount equal to the amount used from each program) are expended on activities authorized under the program.

(2) SEPARATE RECORDS NOT REQUIRED.—Nothing in this section requires an Indian tribe—

(A) to maintain separate records tracing any service provided or activity conducted under the approved plan of the Indian tribe to the in-

dividual programs under which funds were authorized; or

(B) to allocate expenditures among individual programs.

(b) EXCESS FUNDS.—With respect to administrative costs of carrying out the approved plan of an Indian tribe under this Act—

(1) all administrative costs under the approved plan may be commingled;

(2) an Indian tribe that carries out a demonstration program under such an approved plan shall be entitled to receive reimbursement for the full amount of those costs in accordance with regulations of each program or department; and

(3) if the Indian tribe, after paying administrative costs associated with carrying out the approved plans, realizes excess administrative funds, those funds shall not be counted for Federal audit purposes if the excess funds are used for the purposes provided for under this Act.

SEC. 14. FISCAL ACCOUNTABILITY.

Nothing in this Act affects the authority of the Secretary or the lead agency to safeguard Federal funds in accordance with chapter 75 of title 31, United States Code.

SEC. 15. REPORT ON STATUTORY AND OTHER BARRIERS TO INTEGRATION.

(a) PRELIMINARY REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources of the House of Representatives a preliminary report that describes the implementation of this Act.

(b) FINAL REPORT.—Not later than 5 years after the date of enactment of this Act, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources of the House of Representatives a final report that—

(1) describes the results of implementation of this Act; and

(2) identifies statutory barriers to the ability of Indian tribes to integrate more effectively alcohol and substance abuse services in a manner consistent with this Act.

SEC. 15. ASSIGNMENT OF FEDERAL PERSONNEL TO STATE INDIAN ALCOHOL AND DRUG TREATMENT OR MENTAL HEALTH PROGRAMS.

Any State with an alcohol and substance abuse or mental health program targeted toward Indian tribes shall be eligible to receive, at no cost to the State, such Federal personnel assignments as the Secretary, in accordance

with the applicable provisions of subchapter IV of chapter 33 of title 5, United States Code, determines to be appropriate to help ensure the success of the program.

○

II

108TH CONGRESS
1ST SESSION

S. 555

To establish the Native American Health and Wellness Foundation, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 6, 2003

Mr. CAMPBELL (for himself and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

---

A BILL

To establish the Native American Health and Wellness Foundation, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Native American Health and Wellness Foundation Act of 2003''.

SEC. 2. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

(a) IN GENERAL.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:

"TITLE VIII—NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

"SEC. 801. DEFINITIONS.

"In this title:

"(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

"(2) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

"(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(4) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

"SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

"(a) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District of Columbia and in accordance with this title, the Native American Health and Wellness Foundation.

"(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

"(c) NATURE OF CORPORATION.—The Foundation—

"(1) shall be a charitable and nonprofit federally chartered corporation; and

"(2) shall not be an agency or instrumentality of the United States.

"(d) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

"(e) PURPOSES.—The purposes of the Foundation shall be—

"(1) to encourage, accept, and administer private gifts of real and personal property, and any income from or interest in such gifts, for the benefit of, or in support of, the mission of the Service;

"(2) to undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and

"(3) to participate with and assist Federal, State, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

"(f) BOARD OF DIRECTORS.—

"(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

"(2) POWERS.—The Board may exercise, or provide for the exercise of, the powers of the Foundation.

"(3) SELECTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the number of members of the Board, the manner of selection of the members (including the filling of vacancies), and the terms of office of the members shall be as provided in the constitution and bylaws of the Foundation.

"(B) REQUIREMENTS.—

"(i) NUMBER OF MEMBERS.—The Board shall have at least 11 members, 2 of whom shall be the Secretary and the Director of the Indian Health Service, who shall serve as nonvoting members.

"(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board—

"(I) shall be appointed by the Secretary not later than 180 days after the date on which the Foundation is established; and

"(II) shall have staggered terms (as determined by the Secretary).

"(iii) QUALIFICATION.—The members of the Board shall be United States citizens who are knowledgeable or experienced in Native American health care and related matters.

"(C) COMPENSATION.—A member of the Board shall not receive compensation for service as a member, but shall be reimbursed for actual and necessary travel and subsistence expenses incurred in the performance of the duties of the Foundation.

"(g) OFFICERS.—

"(1) IN GENERAL.—The officers of the Foundation shall be—

"(A) a secretary, elected from among the members of the Board; and

"(B) any other officers provided for in the constitution and bylaws of the Foundation.

"(2) SECRETARY.—The secretary of the Foundation shall serve, at the direction of the Board, as the chief operating officer of the Foundation.

"(3) ELECTION.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

"(h) POWERS.—The Foundation—

"(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

"(2) may adopt and alter a corporate seal;

"(3) may enter into contracts;

"(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or convenient to carry out the purposes of the Foundation;

"(5) may sue and be sued; and

"(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

"(i) PRINCIPAL OFFICE.—

"(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

"(2) ACTIVITIES; OFFICES.—The activities of the Foundation may be conducted, and offices may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

"(j) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

"(k) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

"(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

"(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of the duties of the member.

"(l) RESTRICTIONS.—

"(1) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed 10 percent of the sum of—

"(A) the amounts transferred to the Foundation under subsection (m) during the preceding fiscal year; and

"(B) donations received from private sources during the preceding fiscal year.

"(2) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funds.

"(3) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not by reason of association with the Foundation be considered to be an officer, employee, or agent of the United States.

"(m) TRANSFER OF DONATED FUNDS.—The Secretary may transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.) if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

"(n) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

"SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.

"(a) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

"(1) may provide personnel, facilities, and other administrative support services to the Foundation;

"(2) may provide funds to reimburse the travel expenses of the members of the Board; and

"(3) shall require and accept reimbursements from the Foundation for—

"(A) services provided under paragraph (1); and

"(B) funds provided under paragraph (2).

"(b) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3)—

"(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

"(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

"(c) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the facilities and services—

"(1) are available; and

"(2) are provided on reimbursable cost basis.".

(b) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act is amended—

(1) by redesignating title V (as added by section 1302 of the American Indian Education Foun-

dation Act of 2000) (25 U.S.C. 458bbb et seq.)) as title VII;

(2) by redesignating sections 501, 502, and 503 (as added by section 1302 of the American Indian Education Foundation Act of 2000) as sections 701, 702, and 703, respectively; and

(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by paragraph (2)), by striking ''section 501'' and inserting ''section 701''.

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II

108TH CONGRESS
1ST SESSION

S. 558

To elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 6, 2003

Mr. MCCAIN (for himself, Mr. BINGAMAN, Mr. CAMPBELL, Mrs. MURRAY, Mr. JOHNSON, and Mr. DOMENICI) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

---

A BILL

To elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. OFFICE OF ASSISTANT SECRETARY FOR INDIAN HEALTH.

(a) DEFINITIONS.—In this section:

(1) ASSISTANT SECRETARY.—The term ''Assistant Secretary'' means the Assistant Secretary for Indian Health appointed under subsection (b)(2)(A).

(2) DEPARTMENT.—The term ''Department'' means the Department of Health and Human Services.

(3) OFFICE.—The term ''Office'' means the Office of the Assistant Secretary for Indian Health established by subsection (b)(1).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(b) ESTABLISHMENT.—

(1) IN GENERAL.—There is established within the Department the Office of the Assistant Secretary for Indian Health.

(2) ASSISTANT SECRETARY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Office shall be headed by an Assistant Secretary for Indian Health, to be appointed by the President, by and with the advice and consent of the Senate.

(B) CONTINUED SERVICE BY INCUMBENT.—The individual serving in the position of Director of the Indian Health Service on the day before the date of enactment of this Act may serve as Assistant Secretary at the pleasure of the President after the date of enactment of this Act.

(3) DUTIES.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian tribes—

(A) facilitate advocacy for the development of appropriate Indian health policy; and

(B) promote consultation on matters relating to Indian health.

(c) ASSISTANT SECRETARY FOR INDIAN HEALTH.—In addition to the functions performed as of the date of enactment of this Act by the Director of the Indian Health Service, the Assistant Secretary shall—

(1) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

(2) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

(3) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

(4) advise the heads of other agencies and programs of the Department concerning matters of In-

dian health with respect to which those heads have authority and responsibility;

(5) coordinate the activities of the Department concerning matters of Indian health; and

(6) perform such other functions as the Secretary may designate.

(d) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (6).'' and inserting ''Assistant Secretaries of Health and Human Services (7).''.

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking ''Director, Indian Health Service, Department of Health and Human Services.''.

(e) DUTIES OF ASSISTANT SECRETARY FOR INDIAN HEALTH.—Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended by striking the section heading and all that follows through subsection (a) and inserting the following:

''SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

"(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service.

"(2) ADMINISTRATION.—The Indian Health Service shall be administered by the Assistant Secretary for Indian Health.

"(3) DUTIES.—In carrying out paragraph (2), the Assistant Secretary shall—

"(A) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

"(B) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

"(C) advise each Assistant Secretary of the Department of Health and Human Services concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

"(D) advise the heads of other agencies and programs of the Department of Health and Human Services concerning matters of Indian health with respect to which those heads have authority and responsibility;

"(E) coordinate the activities of the Department of Health and Human Services concerning matters of Indian health; and

"(F) perform such other functions as the Secretary may designate.".

(f) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO INDIAN HEALTH CARE IMPROVEMENT ACT.—The Indian Health Care Improvement Act is amended—

(A) in section 601 (25 U.S.C. 1661)—

(i) in subsection (c), by striking "Director of the Indian Health Service" each place it appears and inserting "Assistant Secretary for Indian Health"; and

(ii) in subsection (d)(1), by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health"; and

(B) in section 816(c)(1) (25 U.S.C. 1680f(c)(1)), by striking "Director of the In-

dian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(2) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

(A) Section 3307(b)(1)(C) of the Children's Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(B) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

(i) in section 3 (25 U.S.C. 3902)—

(I) by striking paragraph (2);

(II) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

(III) by inserting before paragraph (4) (as redesignated by subclause (II)) the following:

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.";

(ii) in section 5 (25 U.S.C. 3904), by striking the section heading and inserting the following:

"SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH.";

(iii) in section 6(a) (25 U.S.C. 3905(a)), in the subsection heading, by striking "DIRECTOR" and inserting "ASSISTANT SECRETARY";

(iv) in section 9(a) (25 U.S.C. 3908(a)), in the subsection heading, by striking "DIRECTOR" and inserting "ASSISTANT SECRETARY"; and

(v) by striking "Director" each place it appears and inserting "Assistant Secretary".

(C) Section 5504(d)(2) of the Augustus F. Hawkins–Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking "Director of the

Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(D) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(E) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377) are amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(F) Section 317M(b) of the Public Health Service Act (42 U.S.C. 247b–14(b)) is amended—

(i) by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''; and

(ii) in paragraph (2)(A), by striking ''the Directors referred to in such paragraph'' and inserting ''the Director of the Centers for Disease Control and Preven-

tion and the Assistant Secretary for Indian Health''.

(G) Section 417C(b) of the Public Health Service Act (42 U.S.C. 285–9(b)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(H) Section 1452(i) of the Safe Drinking Water Act (42 U.S.C. 300j–12(i)) is amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(I) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)) is amended in the last sentence by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(J) Section 203(b) of the Michigan Indian Land Claims Settlement Act (Public Law 105–143; 111 Stat. 2666) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(g) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or in any document of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

○

The CHAIRMAN. I am somewhat disappointed with the past opposition from the Department of Health and Human Services to this type of legislation. I hope that we will be able to work out our differences. The Department has expended a good deal of energy promoting its One-HHS proposal, which would restructure and consolidate functions within the Department of Health and Human Services to be more citizen-centered and results-oriented. That is the very concept that I think is the foundation of S. 285, yet the Department of Health and Human Services has neither supported past versions of the bill or has offered helpful suggestions as to how we could improve it so that they could support it.

Senator Inouye and I and other members have worked very hard to increase the resources for Indian health, and it is simply unacceptable to me that the inconvenience of the DHHS has not given them the impetus they need to support it or help us move this bill forward.

We will start with our first panel, which is only Dr. William Raub, the acting assistant secretary for Planning and Evaluation for the Department of Health and Human Services. He will be accompanied by Michel Lincoln and Rich Kopanda.

If you would just go ahead and set up there, Dr. Raub, we will start with you. Your complete testimony will be included in the record. If you would like to abbreviate, please feel free to do so. Thank you for appearing.

STATEMENT OF WILLIAM RAUB, ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MICHEL LINCOLN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE; RICHARD KOPANDA, EXECUTIVE DIRECTOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, ROCKVILLE, MD

Mr. RAUB. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you this morning. Mr. Kopanda is with me. We have learned that Mr. Lincoln is en route, caught in one of Washington's infamous traffic jams. With your permission, I will have him join us as he arrives.

The CHAIRMAN. Absolutely. Sure.

Mr. RAUB. I will submit my full statement for the record and just make some brief comments now, as you have suggested, Mr. Chairman.

The CHAIRMAN. That will be fine.

Mr. RAUB. First, with respect to S. 285, S. 285 would permit an Indian tribe to carryout a demonstration project according to a plan approved by the Secretary to consolidate grants for substance abuse and mental health programs into a single comprehensive program for purposes of providing improved services, facilitating implementation of an automated clinical information system, encouraging technology-based quality assurance activities, and facilitating evaluation of these programs. The Department supports the principle that Indian tribes know best how to meet the needs of their members. We have no objection to allowing tribes to consolidate programs addressing substance abuse and mental health prob-

lems where appropriate, consistent with the purposes of the underlying programs and in order to achieve administrative efficiencies.

However, the Department has concerns with several provisions of S. 285 and thus cannot support it as currently drafted. I will summarize these concerns now. My prepared statement contains more extensive comments.

No. 1, the bill does not delineate clearly the programs that would be subject to consolidation under the proposed authority. Nor does the bill delineate the permissible uses of the consolidated funds.

No. 2, the bill is ambiguous with respect to how the grant consolidation authority applies to competitive grant programs.

No. 3, the bill does not require that its authorized waivers of statutory or regulatory provisions be consistent with the statutory objectives of the grants proposed for consolidation. Prudent stewardship demands that such consistency be considered when assessing the appropriateness of a waiver.

No. 4, the 90-day timetable for review of proposed grant consolidations is likely to be insufficient in most cases, given that a consolidation plan could involve up to seven separate Cabinet-level agencies and multiple components of several of them.

No. 5, responsibility for leading the implementation of this Act should be vested in the Secretary of Health and Human Services, not the Director of the Indian Health Service.

No. 6, the bill does not limit the amount of grant funds that could be used for administrative overhead and information technology.

No. 7, the bill is not sufficiently specific as to the extent to which consolidated funds may be used for an automated clinical information system that serves not only the behavioral health program, as defined in the bill, but also the entire Indian health care delivery system.

No. 8, the bill creates an unfunded mandate by shifting responsibilities for oversight of all consolidated programs to the Department, without making provision for transferring the corresponding administrative resources from the affected agencies.

Notwithstanding these comments, Mr. Chairman, we endorse the concept behind S. 285 and are prepared to work with the committee to address our concerns.

With respect to S. 558, we note that it elevates the director of the Indian Health Service to assistant secretary for Indian Health. We believe this action is unnecessary. The director of the Indian Health Service enjoys direct access to the secretary on all health services issues impacting tribes and tribal organizations. Moreover, the director serves as vice chair of the secretary's Intra-departmental Council for Native American Affairs and thus has a leadership role toward ensuring that Native American policy is implemented across all agencies and offices of the Department including human services programs.

With respect to S. 555, we note that the bill authorizes the Secretary of Health and Human Services to establish a foundation through which private sector partnerships with the Federal Government could work to improve the health status of American Indians and Alaska Natives. This legislation is under review within the executive branch.

Thank you for the opportunity to appear today, Mr. Chairman. I will be pleased to respond as best I can to your questions.

[Prepared statement of Dr. Raub appears in appendix.]

The CHAIRMAN. Okay. Thank you, Dr. Raub.

First of all, you listed about eight reasons that you do not like the bill. I did not hear one, except a very general kind of a concept, about what you do like about it. So what I want you to do is not tell the committee so much about what is wrong with it. I want you to tell us how to fix it. I want you to submit some language that you think the Department can live with that we can try and integrate with the existing language.

Mr. RAUB. We would be pleased to do that, sir. As you have indicated, there have been successes in a comparable activity under the 477 authority. The problem and the opportunity for consolidation is often a general issue, not only with the Indian tribes, but with many entities of local government. So it is a concept of interest to the Department, and one of particular interest to the Secretary. So we would be pleased to work with the staff in addressing the aspects of the bill that cause concern.

The CHAIRMAN. I appreciate that.

You stated the strong objection to the IHS as the lead agency. You object, as I understand it, to the bill to elevate the IHS Director in S. 558 on the grounds that the IHS is already the principal point within the DHHS for Indian health. But at the same time, you object to the IHS as the lead agency for the purposes of alcohol and drug integration because, in your view, the Secretary and SAMHSA are the main agencies for substance abuse. Is there some disparity in your belief between those two?

Mr. RAUB. I do not believe so, sir. I think what we are saying is the Secretary, as the responsible official for the management of the Department, would wish to have vested in him the overall authorities. He would use those authorities to involve systematically not only the Administrator of SAMHSA but also the Director of the Indian Health Service and other agency heads as appropriate in addressing issues related to American Indians and Alaska Natives.

The CHAIRMAN. I see.

And also, as I understand your testimony, although I did not hear you say it specifically, but as I understand your testimony, you "expect that the States will address" mental health and substance abuse needs for Indians and Native Alaskans living within the borders of States. It has been my experience that they do not; that an awful lot of Indian people simply fall through the cracks. They do not get their needs addressed. Do you have some statistics that you can provide for the committee that indicates the States are providing this service?

Mr. RAUB. We would be glad to follow up on that question, Mr. Chairman. The reference in the statement was to the statutory provisions on those programs in SAMHSA that focus the awards at the State and look to the State to involve the tribes in funding and their integration with the State programs, but we can followup for the record.

The CHAIRMAN. Well, they should. Sometimes what happens, though is that when Indians go to a general health clinic, they are told that they need to go to their reservation and get it through the

Indian Health Service, which is sometimes 1,000 miles away. That is a little difficult to do. So sometimes they just sort of give up and stay sick and do not have their needs met.

So it seems to me that sometimes there might be some kind of a disparity with what you are saying and what is actually happening out there. So if you could—if there is any indication that you have that is solid, black and white information that we do not know that they are providing it, I would like to have that and I am sure the other committee members would, too.

On the elevation bill, I think Secretary Thompson, who I have known ever since he was a Governor, and he is a very, very fine man, and doing his very best, but sometimes the intentions of one Secretary cannot determine what the intentions of a future Secretary are going to be. I worry that we will end up—sometime in the future we may see the IHS Director relegated back to a second-tier position. I know that Senator McCain is concerned about that. That is why he introduced that elevation bill. Would you like to give us your profound wisdom on that?

Mr. RAUB. I doubt that I have profound wisdom about either the present or the future, Mr. Chairman, but I would say that the Secretary, as you indicated, is strongly committed to involving all the components of the Department with respect to Indian Affairs activities. He believes with his own leadership, that of the Deputy Secretary, the creation of the Intradepartmental Council, and the leadership involvement of the Director of the Indian Health Service in that, that he has actually gone beyond that which is implied by a title change with respect to the Director of the Indian Health Service.

On the other hand, I am sure the Secretary will be attentive to the strong feelings of the members of the Congress with respect to that issue. He is always amenable to considering that.

The CHAIRMAN. You may not want to answer this, but have you noticed any of what can commonly be described as "turf problems" with other agencies not wanting it to encroach on their areas of substance abuse?

Mr. RAUB. Sir, I have not.

Richard.

The CHAIRMAN. Yes; identify yourself for the record before you speak.

Mr. KOPANDA. Richard Kopanda from SAMHSA, Executive Officer.

We have not noticed that either in SAMHSA.

The CHAIRMAN. Would you like to tell Senator McCain that this is probably not a necessary bill? [Laughter.]

I should not even ask you that. I know Senator McCain really well—a very determined man. I thought I would just pass that on to you.

We have some additional questions for you and for IHS, too. I think those I will probably submit in writing to you, Dr. Raub, if that is all right with you. I am not sure if anyone else will be showing up. As you might guess, it is pretty hectic around here. Many of us are trying to cover two committees at the same time.

With that, I do appreciate your being here, and when you get questions in the record from Senator Inouye or other members, if you would answer them in writing, I would certainly appreciate it.

Mr. RAUB. Thank you, sir. We will.

The CHAIRMAN. Thank you.

We will now go to the second panel, which would be Julia Davis-Wheeler from the National Indian Health Board; and Hoskie Benally, the CEO of Our Youth, Our Future, Incorporated in Farmington.

We will go ahead, Ms. Davis-Wheeler. Nice to see you here again. What—twice now in 2 weeks or 3 weeks?

Ms. DAVIS-WHEELER. Yes; 2 weeks.

The CHAIRMAN. Very happy to see you here. Go ahead.

STATEMENT OF JULIA DAVIS-WHEELER, CHAIR, NATIONAL INDIAN HEALTH BOARD

Ms. DAVIS-WHEELER. Good morning everyone. It is a pleasure to be here. As stated for the record, my name is Julia Davis-Wheeler and I am chairperson of the National Indian Health Board. I also serve as Secretary for the Nez Perce Tribe Council in Idaho. On behalf of the National Indian Health Board, it is a great pleasure to be here to offer testimony regarding this health-related legislation. At NIHB, we serve all the Federal-recognized American Indians and Alaska Natives tribal governments in advocating for health care delivery to all of our people at home. We strive to advance the level of health care and the adequacy of funding for health services that are operated by Indian Health Service programs, operated directly by tribal governments and other programs.

We have Board members that represent the 12 areas of IHS and are elected at-large by their respective tribal government officials within their region. We continue to work diligently to address the health disparities that continue to plague Indian country. There are several legislative items that have been introduced during the 108th Congress that would help us improve the health status of American Indians and Alaska Natives.

The first one I would like to speak about is the Indian Health Service Director elevation to Assistant Secretary of Indian Health. Before I begin discussing S. 558, I would like to say a few words about the Secretary of Health and Human Services, Tommy G. Thompson. As a tribal leader, I feel very comfortable in saying that Secretary Thompson has been the most accessible Cabinet secretary in this Administration. He and his immediate staff have been available at every possible opportunity to visit with tribal leaders and to see first-hand the health needs of our people. It is good to see visits to Indian country by the President's Cabinet members. I myself was at Tacoma, Washington when Deputy Secretary Claude Allen attended a coastal meeting there with Northwest leaders. It was very well received.

Also, the National Indian Health Board is aware that the committee will consider the nomination of Dr. Charles Grim as Director of the Indian Health Service. As I mentioned in my testimony last week, we support this nomination. We support his nomination and we appreciate his willingness to take on this hard, significant role. Resolutions were passed by Affiliated Tribes of Northwest In-

dians, the National Congress of American Indians, the National Indian Health Board, and tribal leaders have pushed since 1995–1996 to elevate the status of the Indian Health Director as means to recognize the importance of the Federal Government's functions in carrying out its trust responsibility.

I would like to give you an example of why tribal leaders feel this elevation is important. One example is in 1996 when President Clinton had a tribal government meeting at the White House, the Director of Indian Health Service at that time was not allowed to sit with the Cabinet members at this meeting. It proved to be not embarrassing, but a little hard for us as tribal leaders to see the Director of Indian Health Service set to the side, while all the other Cabinet members were brought up forward to meet with tribal leaders and the President.

We have been asking for another meeting with the President. The tribal leaders wish to meet with the President and that has not come about. So I just wanted to mention that to you.

The intent of S. 558 is quite appropriate, as it does just that in a manner consistent with the government-to-government relationship between the United States and the tribal governments that have signed their treaties. As we advance this legislation, we want to take adequate steps to ensure that we build on the improvements that have been made within the Department of HHS over the last few years in addressing tribal issues, and further that the Indian Health Service continues to be a part of this effort. We feel that this can be accomplished with revisions to S. 558, and I have prepared specific recommendations on the language for S. 558. I would like to submit them for the record.

Our recommendations would be to place the Indian health director at the level of the assistant secretary of Indian Health, but do it in a manner which does not diminish the secretary's responsibility to carry out the Federal Government's trust responsibility.

As I mentioned previously, over the past several years Americans Indians and Alaska Natives have slowly crept into the mind set of nearly all areas of DHHS. There are three facts that I would like to bring forward: No. 1, informed personnel and the elevation of tribal issues with the Office of the Secretary. No. 2, the hard work of the Indian Health Service officials to advance issues internally. No. 3, and most importantly, the persistence of tribal governments to ensure that the purpose and intent of the Executive order mandating tribal consultation is properly carried out.

One of the more significant examples of the increased awareness and acknowledgement of the importance of Indian issues within the Department is the revival of the Secretary's Intradepartmental Council on Native American Affairs, which is cochaired by the Indian Health Service Director. Because of the many critical issues that need to be addressed within the Department of HHS, we feel that any changes to the structure of the Department must be done in a manner that does not isolate Indian health issues, but instead makes those issues a common thread among all Department areas.

The integration and consolidation of alcohol and substance abuse—all of the purposes expressed in S. 285, the Native American Alcohol and Substance Abuse Program Consolidation Act of 2003, serve to improve the delivery of alcohol and substance abuse.

As a tribal leader, I commend the Senator for introducing this bill. American Indians and Alaska Native tribal governments are consistently searching for ways to develop more effective and efficient programs to better serve tribal members, and are extremely interested in providing such services, utilizing the best practices available.

While we are certainly supportive of legislation that seeks to coordinate and improve the delivery of alcohol and substance abuse throughout Indian Country, tribal leaders have expressed their concern with certain provisions of this legislation. Many of the concerns are due to the language establishing a lead agency. The National Indian Health Board feels the IHS is an appropriate and capable agency to administer such duties. Also, we feel it is equally important to engage all applicable agencies to the greatest extent possible, to ensure that IHS carries out the functions of this collaborative effort in an appropriate manner.

As an advocate for the alcohol and substance abuse, we as tribal leaders need to do all we can to not allow the younger generation to fall to the devastating disease of alcohol and substance abuse. Perhaps this could be achieved by utilizing a committee consisting of the involved agencies, chaired by the Indian Health Service. All activities of the lead agency under this proposed Act would be carried out according to the decisions made by the committee, with input from tribal governments. Further consultation should be included to provide for tribal involvement for all measures that would affect the provision of alcohol and substance abuse treatment in Indian country.

Establishing the Native American Health and Wellness Foundation, the intent and purpose of S. 555, to create this Wellness Foundation, is absolutely appropriate, and mirrors much of what occurs in the private sector delivery of health services. It would serve as a valuable mechanism to maintain a single organization to allow for the Indian Health Service to receive charitable support. Such an entity has not existed previously, which has deterred the donation of such support. The National Indian Health Board urges that the Foundation's activities do not have a negative impact on the Indian Health Service budget, but rather serves to boost the Indian Health Service funding.

I would also like to mention that the National Indian Health Board would be a capable umbrella organization under which the proposed Foundation could operate. As of March 3 of this year, the NIHB fully operates out of the Washington, DC area and is governed by Board members from across Indian country. Many of the activities that would be provided by the Foundation, such as activities furthering the health and wellness of American Indians and Alaska Natives, and participating with and assisting Federal, State, and tribal governments, are already provided by the National Indian Health Board. We would be willing and supportive to discussing this with the committee. We feel this bill should be a part of the consultation process.

In conclusion, I would like to thank the committee for its consideration of our testimony and for your interest in the improvement of the health of American Indians and Alaska Native people. We are certainly pleased that this is the third hearing to take place so

far this year on Indian Health, and we trust that our issues will continue to be a priority for the 108th Congress.

Thank you.

[Prepared statement of Ms. Davis-Wheeler appears in appendix.]

The CHAIRMAN. Thank you, Julia.

Why don't you go ahead, Mr. Benally, and then I will ask a couple of questions of each of you.

STATEMENT OF HOSKIE BENALLY, JR., CHIEF EXECUTIVE OFFICER, OUR YOUTH, OUR FUTURE, INC.

Mr. BENALLY. Thank you.

I come from more of a direct service perspective with regard to this bill, S. 285. I just want to discuss the importance of the management information system. We have run a treatment program for 13 years for Native American adolescents down in New Mexico, and serve not only Navajos, but other tribes in that area. One of the things that we found was that a sound management information system is very helpful in determining the needs of clients, as well as determining the needs of staff members.

Some of the statistics that we got out were very helpful to us—such stats as what kind of drugs are we seeing in our youth? We specialize in adolescent youth treatment, and it would be surprising to see some of the things that we thought were still in the cities coming onto the reservation. So in identifying those types of drugs, such as methamphetamines; ours is a high-traffic for that drug. We were able to again gear up our staff and provide training in that area to help them deal with this drug. But if we did not have this management information system to give us that kind of information, we would not have been able to identify those treatment needs and the client needs in those areas.

But I think the one thing is that in Navajo country or Indian country as a whole (we also provide consultation services to other Indian tribes) is that we really do not have a handle on where we are in the battle against drugs and alcohol, complicated by the addition of the mental issues that go along with that. We know that research shows that a high percentage, I think in the general public 64 percent have a mental health disorder that is driving the substance abuse. In this area, we have been able to train our staff with help from a Ph.D-level clinical psychologist and master's level people to be able to help the youth in this area.

The other thing I would like to say is that this management information system helped us, we are in New Mexico, to become accredited by the Joint Commission on Accreditation of Hospital Organizations, which is a national accreditation—very stringent accreditation that we sought and we received back in 1993. But along with that, we were licensed with the Children, Youth and Families Department of New Mexico. One thing that we are finding out there, in talking to other tribes and also providing consultation services, is that because of the lack of outcome data being produced by treatment programs, they are having a hard time tapping into Medicaid dollars, because Medicaid requires that you be able to provide outcome data to show the effectiveness and quality of your treatment. So we were able to do that, and in addition to receiving

other Federal dollars, we were able to receive Medicaid dollars to supplement the operation of the organization.

Now, I would just like to say also that I think this bill here is something that is long in coming and something that I think is very useful, because we are finding out that tribes out there are not conducting the assessments that are necessary in order to identify some of the mental health issues and some of the drug disorders that are out there. We are primarily focusing on alcohol abuse. With this bill, that will improve that and provide quality and effective services to our Indian people, I feel. It is more from a direct service approach that we are seeing these things happen. So we are real supportive of this bill here.

I would like to say thank you.

[Prepared statement of Mr. Benally appears in appendix.]

The CHAIRMAN. Thank you.

Julia, speaking of S. 285, I might tell you that I briefed your written testimony and then tried to listen as well as I could to your verbal testimony. It is a little bit different—or not maybe different, but it seems to be a little milder than the comments in your written testimony.

I guess this is the third time we have dealt with this bill in hearings on it, and to my knowledge at our previous hearing, there has been no tribal leader, no Indian health organization that has made any objections about it at all. Has something changed since then, or has it been the official position of the member tribes of the NIHB—they just made the decision recently about this bill?

Ms. DAVIS-WHEELER. Senator Campbell, on the S. 285, it was a big discussion at the National Congress of American Indians meeting that we had in San Diego last fall. From the discussion in the Health Committee that I chair, through the human resources structure of NCAI, there was a lot of discussion at that meeting that it needed to be looked at a little bit more.

The CHAIRMAN. Well, was part of that discussion your opposition to having the IHS as the lead agency?

Ms. DAVIS-WHEELER. I did not hear any opposition to having Indian Health Services the lead agency, but I guess in the record there might be a few that did have a little concern.

The CHAIRMAN. You spoke some of a committee of agencies. Do you believe a committee or several agencies can do a better job than having one agency responsible, on whose desk the buck stops?

Ms. DAVIS-WHEELER. The idea was to have someone from each agency on the committee to bring about the awareness of the tribal leaders or tribal governments' needs, as stated by Mr. Benally. We have a lot of drugs on the reservations that are brought in from the cities, and having SAMHSA, the other agencies present where they can hear that from the tribal leaders personally, I think it would help. If anything, it would bring about more awareness to all of the Federal agencies.

The CHAIRMAN. You mentioned the work that Secretary Thompson is doing, and I also said I think he is doing a terrific job. He has been very sensitive, I think, to Indian issues. But he is only going to be there about 6 more years. That is the way it works around here. If the Administration changes, well, maybe less than that, but the max would be 6 more years. Are you confident that

the next person that is going to be there is going to be as sensitive as Secretary Thompson is, because that is one of the reasons I am pushing this bill—to give it some continuity through different Administrations that support Indian programs and are less supportive of Indian programs.

Ms. DAVIS-WHEELER. Senator Campbell, I think you have hit the nail on the head with that one because we as the National Indian Health Board and other national organizations see this Administration as being, I guess, an advocate for us in Indian country to push legislation. It would be great to have Secretary Thompson leave a legacy, in the event that in 6 years he has helped us elevate our health status, but leave a legacy with us as tribal leaders to honor that administrative Cabinet position, and especially in the area of Indian health, but also in the area of elevation of the Indian Health Service Director.

I heard from the testimony previously that the gentleman from the DHHS does not feel that it is necessary. I would respectfully disagree that as a tribal leader, we have been wanting to see this position elevated for such a long time. It would make us, as tribal governments, feel better to see the IHS Director position elevated. He could really do something for us if he would support that.

The CHAIRMAN. I think so, too, but did I understand your testimony, you said that elevation should be in a way that does not diminish the Secretary's responsibilities to tribal governments. Are you worried about an erosion of trust responsibility if that position was elevated?

Ms. DAVIS-WHEELER. No; not at all. I think that those two positions would go hand in hand. Secretary Thompson has been very open and able, when he can, to meet with us. He has shook our hands and talked with us. We really appreciate that. He has given us more time on his agenda than anyone else.

The CHAIRMAN. Was somebody from his agency, or he, at San Diego—at the National Congress of American Indians?

Ms. DAVIS-WHEELER. Yes; but because of the schedules, I cannot remember the exact dates, but they had to just come in for a day or two and then go right back out.

The CHAIRMAN. Mr. Benally, from listening to your testimony, it sounds to me that your organization is doing a terrific job for Native youngsters who are obviously suffering from an increased problem with drugs and alcohol. You talked at length about the information technology. We have received some complaints about this accounting system that is currently used by the IHS called the RPMS—the Registered Patient Management System. Does your member organizations and clinics use that kind of software?

Mr. BENALLY. The program that we originally used—this was introduced by IHS—we are one of several regional adolescent treatment centers throughout the United States that were originally funded by the omnibus drug bill of 1986. We became the third one to open, but Orion (ph) Health Care, which is also called Accurate Assessments and apparently had a contract with IHS back about 1998, I think it was somewhere about that time, to look into developing a management information system and offer it to the adolescent treatment centers. We took advantage of that and brought it into our treatment center and found it to be very, very useful.

The other thing that we added onto that system was a cultural assessment part that we developed with Accurate Assessments to address at some of the cultural needs of our students. But what we are finding out is that the old Cadmus system did not work, and we are finding out now that perhaps IHS is looking at developing another one. I guess my position is why develop another one when you have one that is already working and proven to work, and there is other software out there that can work? It is just going to put us behind time-wise. This management information system that we are using is also being used by 130 other Native American programs in the United States. I think the States are beginning to look at these programs with their tribes that reside within their States. So we have been real happy with it.

The CHAIRMAN. That is a system you would advise the IHS to use with all tribes?

Mr. BENALLY. Pardon?

The CHAIRMAN. Is that a system that you would advise the IHS to use for all tribes?

Mr. BENALLY. Yes; I would very strongly recommend that because we have used it. We have also; in providing consultation to other Indian tribes, found that it is something that is very—can be used by other tribes; has proven to work for us, and we have shared data with them. I think CSAT also—we have a CSAT grant, and CSAT has recognized our program as an exemplary program in using this software, because it helped to provide cost analysis and also helped to provide an evidence-based treatment program. In other words, we did research with this, and it brought a lot of data forward that says that the program that we used, not only with our adolescents but with the families, was very effective. CSAT is now using us as their consultant out there to train others in what they call the Accurate Assessment Addiction Severity Index.

The CHAIRMAN. One of the goals of S. 285 is to try to make it easier for a tribe to take part in grants and programs that might otherwise have been too complicated to apply for, through all the different bureaucratic requirements. Are there any grants or programs that your organization might be interested in that you have found too difficult, too time consuming, or do not have the resources to be able to apply for those grants?

Mr. BENALLY. Yes; well, I am lucky. I have a Ph.D clinical psychologist who has been trained in grant writing, and a master level social worker. But if I did not have those people, I would not be able to apply for these grants at the level of sophistication the grantors are asking for. Now, if the grants come out in accordance to this bill in which that you are asking for a management system, then I think a lot of tribes out there are going to have a tough time with it because I do not think they have that infrastructure at this point in time to realistically or with much knowledge respond to a grant management information systems. I think some kind of transition period of technical assistance needs to be provided in that area because I think these grants are going to require that component before receiving dollars.

The CHAIRMAN. What did you say your Ph.D was in?

Mr. BENALLY. No; I have a clinical psychologist who is a Ph.D that is on my staff.

The CHAIRMAN. Oh, I see. Very good. Thank you.

I have no further questions, but Senator Inouye or other members may submit some for writing. As I told the first panel, I do not want to hear just what is wrong with everything. What I want to hear is how we make it better, how we try and move something that is going to benefit Indian people. So any suggestions you have for S. 285 or any other bills, the other two bills, I would appreciate hearing from you

Yes, Julia?

Ms. DAVIS-WHEELER. Yes; thank you, Senator Campbell.

My oral comments were very different from the written comments that were submitted. For the record, I would like you to know as the Chair of this committee that we will send a revised set of testimony from NIHB.

The CHAIRMAN. Did you talk to somebody between the time you sent in the written testimony and the time you—okay.

Ms. DAVIS-WHEELER. Okay. [Laughter.]

The CHAIRMAN. I have no problem with that. We do it, too. Great. Alright, thank you for being here. I appreciate that.

Ms. DAVIS-WHEELER. Thank you.

The CHAIRMAN. I notice Mr. Lincoln came in. I understand you were tied up in traffic. I have got a little time. Would you like to make your statement for the record, Mr. Lincoln? Oh, you were going to accompany Dr. Raub. I see.

Mr. LINCOLN. I was going to accompany Dr. Raub, and I do apologize to the committee. I mean no disrespect ever to this committee.

The CHAIRMAN. I understand, yes.

Mr. LINCOLN. These bills are important.

The CHAIRMAN. Yes; particularly around the Capitol here with the grounds all torn up and the new sensitivity to post-9–11 problems, it is a mess to try to get around.

But I would like to maybe ask you a question if I could, and that deals with the elevation bill. Is it your view that the IHS Director as the Vice Chairman of the Intradepartmental Council for Native Americans currently enjoys an elevated status without actually being elevated?

Mr. LINCOLN. It is my observation, Mr. Chairman, if I may reflect just briefly on the 11 years that I have been back here at headquarters in the Indian Health Service as the Deputy Director, that Dr. Grim, the Interim Director, indeed does enjoy more access than I have ever seen with the Secretary.

The CHAIRMAN. You have been there 8 years. How many Directors have there been?

Mr. LINCOLN. I came when Dr. Everett Rhodes was the Director, also with Dr. Michael Trujillo and now with Dr. Grim.

The CHAIRMAN. And I think if I am not mistaken Senator McCain has introduced this bill about 8 years in a row or something—about 8 years in a row. It has never really gone anywhere yet. Have you—well, I will not ask you that. It would be subjective. I will not bother asking you.

Okay. Thank you. I appreciate your being here. I may submit additional questions to Dr. Raub or you, too, on behalf of the committee.

Mr. LINCOLN. Thank you, sir.

The CHAIRMAN. I have no further comments or questions. We will keep the record open for two weeks for any additional comments from the audience in general or from the people who testified.

With that, the hearing is adjourned. Thank you for appearing.

[Whereupon, at 10:45 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HOSKIE BENALLY, JR., MEMBER, NAVAJO NATION, SHIPROCK, NM

My name is Hoskie Benally, Jr. I am a member of the Navajo Nation of Shiprock, NM. For the past 14 years, I have been the Chief Executive Officer of a private non-profit American Indian owned organization, Our Youth, Our Future, Inc. (OYOF). OYOF has operated a residential treatment center on the Navajo reservation and a community health center in Farmington, NM. A majority of our funding came from the Indian Health Services (IHS) and the collection of Medicaid dollars.

Currently we serve as advocates for American Indian adolescents and families in the area of alcohol and other drug treatment along with mental health disorders. We conduct outcome base research on our programs and disseminate information in order to improve the lives of our adolescents in need of treatment. Through these endeavors, OYOF has developed the Multi-systemic Cultural Treatment Model for American Indian adolescents and their families. This treatment model uses a multi-modal assessment strategy to measure symptom changes and pro-social functioning at intake, termination, 6, and 12 months following termination. This is one of the few if not the only manualized treatment model for American Indian adolescents that includes a treatment outcome design. In addition, it has a quality assurance system developed for American Indian programs. OYOF has responded to the call of future substance abuse treatment to be guided by a blend of best practice clinical treatment and innovative high-tech computer technologies. This approach is to facilitate alcohol and other drug and mental health treatment that is high-quality, timesaving, consistent, evidence-based and cost-effective. OYOF secured a Center for Substance Abuse Treatment (CSAT) 3-year grant to conduct a program evaluation and a cost analysis of the residential treatment program. Critical information was gleaned from the data that provided pertinent information to improve treatment of our adolescents. Without this vital information our program may not have achieved the success we have experienced.

It is important to realize that a majority of our success was due to the implementation of a user friendly management information system (MIS). The following are some of the tasks that the MIS completed:

Manages clinical service hours (prescribed v. actual received services).

Tracks clinician's billable hours for Medicaid and Managed-Care services.

Tracks client's response to treatment and the need of additional services.

All clinical documentation is automated allowing for close supervision of treatment.

This system generates reporting requirements and supports outcome base treatment. The above tasks improve the overall quality assurance of the program and allows for a structured and consistent treatment to be implemented.

This system allowed us to meet all of our JCAHO accreditations, Children, Youth, and Families Department, State of New Mexico and Medicaid regulations. In addition, we had Government Performance Regulation Act (GPRA) indicators and also the monthly, quarterly, and annual tribal government reports. Many of these re-

ports overlapped and when we were collecting this data on a manual basis was almost impossible to accomplish. Upon implementing a MIS clinical documentation system, our ability to collect and collate the data was improved substantially. However, it is important to note that the overlap continued and we spent many hours disseminating this information for the different governing entities. We created innovative ways to meet these standards by developing a computerized report that met majority of the data reporting requirements. It is important to realize that majority of American Indian treatment programs do not have this capability or the skilled staff to meet this level of reporting. The initial step of implementing a MIS can be costly if an analysis is not conducted to determine the actual need in hardware, software, and staffing. There are many for-profit organizations that have developed such MIS and are being used in Indian country. Accurate Assessments has worked with IHS since 1998 customizing software to meet the specialized needs of the treatment programs. They are currently serving over 130 American Indian treatment programs. This is the MIS that OYOF has used since 1998 and was instrumental in collecting data that secured our CSAT grant.

Recently, IHS has made the decision to write and develop their own MIS for substance abuse. Even though there are excellent programs that exist in the field for possibly half the cost. Therefore, it may not be the most cost effective approach for IHS. We have been waiting for more than 3 years for IHS to respond to the need of treatment programs to have "real time" data that they can access simply by sitting at their computer. In addition, many treatment programs do not collect their GPRA data and the area offices have difficulty meeting their data requirements. This lack of quality data collection is a result of the lack of communication with the field and IHS. The following are some of the reasons why agencies do not receive quality data:

No. 1. Lacks of compliance due to no initial buy in from the field in what to collect and the importance of such data.

No. 2. Trusting IHS to analyze and interpret the data in a culturally appropriate manner.

No. 3. Providing "real time" data reports and/or feedback.

No. 4. Lacks of a user friendly system that can accommodate the many challenges of rural programs.

No. 5. Lacks of ongoing support and training to make the data have practical application to the field.

No. 6. Finally, many of the programs do not have properly trained staff to complete the tasks.

Finally, how do we decrease the "redtape" of securing the funding from the government to the tribes and/or treatment programs? This is not an easy question to answer. It is very complex and has much to do with the lack of standards that are required for tribal treatment programs to meet. Many of the programs do not have evidence-based treatment that requires a data collection component let alone the expertise to collect such data that would be require to write a grant. It will be vital that this committee look at the whole system and take this opportunity to develop a system that not only wants to fund programs, but will demand accountability from any program that secures such funding. However, the most important issue is that my people receive the best treatment possible and that we begin to make gains in keeping our young people from a life of alcohol and drugs, trauma, poverty, and the loss of hope.

I thank you for the valuable opportunity to submit written testimony and to provide oral testimony to this committee.

STATEMENT OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES
HEARING ON
S.285, "Native American Alcohol and Substance Abuse Program Consolidation Act"; S. 555, "Native American Health and Wellness Foundation Act"; and S. 558, IHS Director Elevation Bill

April 9, 2003

Good morning Mr. Chairman, I am William Raub, the Acting Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (DHHS). Accompanying me today are: Michel Lincoln, Deputy Director, Indian Health Services (IHS), and Richard Kopanda, Executive Director, Substance Abuse and Mental Health Services Administration (SAMHSA). I am here today on behalf of Secretary Thompson to present the views of the Department of Health and Human Services (DHHS) on S.285, a bill to authorize the integration and consolidation of alcohol and substance abuse programs and services provided by Indian Tribal governments; S. 558, a bill to elevate the position of the Director of Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health; and, S. 555, a bill to establish the Native American Health and Wellness Foundation; .

S. 285: "NATIVE AMERICAN ALCOHOL AND SUBSTANCE ABUSE PROGRAM CONSOLIDATION ACT"

The first official authorization for the IHS and Indian Tribes to provide alcoholism treatment services was established in 1976 by the Indian Health Care Improvement Act, P. L. 94-437. The Anti-Drug Abuse Act of 1986, P.L. 99-570, and the Omnibus Drug Bill Amendments, P.L. 100-690, expanded this authority to include alcoholism and other

substance abuse treatment and prevention services for American Indian/Alaska Native (AI/AN) youth, women, children, dual diagnosed youth, and family members. All of these authorities were later combined under title VII of the Indian Health Care Improvement Act Amendments of 1992, which is the existing authority for the IHS/Tribal/Urban (I/T/U) programs.

Currently, the IHS receives approximately $137 million in annual appropriations for tribal alcohol program activities. More than 90% of these alcohol-related funds are provided directly to the Tribes under Indian Self-Determination agreements for programs that they design and implement. Indian tribes now administer close to 50 percent of the total IHS funding for health services, including mental health services, under Indian Self-Determination agreements. This process of transferring the Federal functions related to health programs has taught both Tribes and the IHS many lessons in planning and implementing comprehensive health and social programs. Indeed, the evidence suggests that Tribes can address these issues in ways that the Federal partners cannot.

Our Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to States, sub-State jurisdictions, public and private non-profit entities for the purposes of providing mental health and substance abuse prevention and treatment services. The agency's budget is approximately $3.2 billion. The largest programs are the Substance Abuse Prevention and Treatment Block Grant appropriated at $1.753 billion for FY 2003, and the Community Mental Health Services Block Grant, appropriated at $437 million. These funds are distributed to States for their use in

providing substance abuse and mental health services. It is expected that the States will address the mental health and substance abuse needs of American Indians/Alaska Natives living within their borders.

In addition we have $857 million to support discretionary or competitive grants to non-profit private and public entities including Indian Tribes and tribal organizations for the provision of mental health or substance abuse services. In FY 2002, over $50 million of these funds went directly to provide services to American Indians/Alaskan Natives.

S. 285 would permit an Indian tribe to carry out a demonstration project, according to a plan approved by the Secretary, to consolidate grants for "Indian behavioral health care programs" (defined to include substance abuse and mental health programs) into a single, comprehensive program for purposes of providing improved services, facilitating implementation of an automated clinical information system, encouraging technology-based quality assurance activities, and facilitating evaluation of these programs.

The Department supports the principle that Indian Tribes best know how to meet the needs of their members for programs such as those addressed by S. 285. We have no objection to allowing Tribes to consolidate programs addressing substance abuse and mental health problems where appropriate, consistent with the purposes of the underlying programs and in order to achieve administrative efficiencies. However, while we welcome the Committee's work on this important legislation, we have concerns about critical provisions in S. 285 which we will outline below.

Programs Affected: Uses of Consolidated Funds

First, we note that the bill does not delineate clearly the programs that would be subject to consolidation under the proposed authority and the permissible uses of consolidated funds. We believe, based on our review of the bill as a whole, that the intent is to allow consolidation of those grant programs – and only those programs – whose sole or primary purpose is to address either mental health problems or substance abuse problems, or both.

Section 5 provides that a program may be consolidated if under the program the Indian tribe is "eligible for the receipt of funds," under a formula, or through competitive or other grants. We believe the quoted language does not conform to the language used in Federal grant statutes and regulations, and efforts to interpret and implement it would cause serious difficulties and disagreements. States, Tribes or other entities (as specified in a given grant statute or notice) are generally eligible to apply for funding. For competitive grant programs, eligible applicants are awarded funding only if they successfully compete for funding. Thus, the condition under section 5 should instead be that the tribe is eligible to apply for funding under a program and, in fact, is funded, depending on the amount of available funds after peer and advisory council review. We would have no choice but to interpret the term "eligible" in section 5 to mean the tribe has been awarded program funding, but we are concerned that the lack of precision in the bill's language would lead to substantial misunderstandings and quite possibly to litigation.

Lastly on the need for clarification, the bill is not sufficiently specific as to the extent to which consolidated funds may be used for an automated clinical information system that serves not only the behavioral health program but the entire Indian health care delivery system. We are concerned that these uncertainties could cause unnecessary misunderstandings, disagreements, and litigation.

Waiver Authority

Sections 6 and 7 provide waiver authority that could apply to a broad range of programs, as yet unidentified, of various Departments. The practical effect of these provisions may limit flexibility for the HHS Secretary (or other affected agency head) to consider the merits of a waiver request from the standpoint of the Federal grant programs proposed for consolidation.

In addition to authorizing the waiver of any regulation, policy or procedure promulgated by the Federal agency concerned, these provisions would authorize waiver of any statutory requirement, if found necessary to enable a tribe to implement its consolidation plan. The effect of the language suggests the waiver should be denied only if the agency head found the waiver inconsistent with the purposes of S. 285, or with a statutory requirement applicable to the program to be integrated that was specifically applicable to Indian programs.

Significantly, S. 285 does not require that the waiver be consistent with the statutory objectives of the underlying grant program proposed for consolidation, and thus

eliminates a fundamentally important standard for assessing the appropriateness of the waiver. As a practical matter this provision would leave the Secretary (or another affected agency head) no choice but to grant virtually all waiver requests. The failure to require consistency with statutory grant program objectives is highly unusual, and appears to create a troublesome precedent that is not essential to achieve the bill's objectives.

Timetable For Federal Action

Section 7 requires the Secretary, upon receipt of a plan from an Indian tribe, to consult with the tribe and with the head of each Federal agency "providing funds to be used to implement the plan" (which we understand to mean having a program to be consolidated into the tribal plan), and Section 8 requires the Secretary to inform the tribe within 90 days of the approval or disapproval of the plan, including the responsible agency's decision on any waiver request. This 90-day timetable, we believe, will be insufficient in most cases, given that a consolidation plan could involve up to seven separate Executive Branch agencies and multiple components of individual agencies. Substantially more time would need to be afforded, particularly in the early stages of implementation of this legislation, to permit thoughtful and appropriate decision making.

Lead Agency Designation

We strongly object to the language in section 10 designating the Indian Health Service (IHS) as "the lead agency under this Act", responsible for reporting, oversight, technical assistance, and convening meetings between the tribes and the Federal agencies under a

memorandum of understanding between the Secretary of HHS and the other affected Federal agencies. In general, HHS policy supports assigning statutory responsibilities to the Secretary absent particular circumstances making designation of an HHS component appropriate. In the circumstances involved in S. 285, statutory designation of IHS is not appropriate, both because the Secretary needs to retain authority to direct HHS's coordination of programs and activities with the numerous other Cabinet-level agencies involved, and because HHS components other than IHS, notably including the Substance Abuse and Mental Health Services Administration (SAMHSA), are also closely concerned with the programs that S. 285 would make subject to consolidation.

Uses Of Grant Funds

The bill as drafted does not control the amounts of grant funds that could be used for administrative overhead and information technology (IT). First, we foresee problems with respect to the total amount of a tribe's consolidation grant funds permitted to be used for program administration. Some of the grant programs that would be subject to consolidation include statutory or regulatory limits on the percentage of funds that may be so used, but S. 285 neither provides for carrying over these limits into the consolidated grant nor provides an alternative limit. We believe a clear statutory limitation to a modest percentage, or clear authority to insist on such a limitation, is important to ensure that the majority of grant funds are directed to delivering services to the intended program beneficiaries. For similar reasons, we are also very concerned that the provisions of the bill permitting use of grant funds for IT resources and training neither restrict the amount or share of grant funds that may be used for this purpose nor require

that the IT so purchased be closely related to a tribe's behavioral health program. The applicable bill language is so broad that potentially a substantial share of a tribe's consolidation grant could be spent for these extremely expensive resources. We consider it extremely important that these provisions of the bill be appropriately tightened, and that the entire bill be scrutinized carefully to identify any similar problems with other provisions, in order to ensure that the program under the bill be firmly focused on addressing the behavioral health problems that are its intended object.

Federal Oversight

We cannot support the consolidation program proposed by S. 285 unless the bill makes meaningful provision for adequate and effective Federal oversight. The current bill, as a practical matter, does not do so. The bill shifts responsibility for oversight of all consolidated programs to IHS (or, assuming the bill is amended to meet our objection discussed above, the HHS Secretary), as well as assigning to HHS responsibility for much of the coordination and negotiation with tribes and with other Federal agencies, for reports to Congress, and other related activities. But there is no provision for transferring to HHS any administrative resources from the other affected federal agencies for what would be a substantial increase of administrative responsibilities, and HHS (let alone IHS) has no available administrative staff or funds for these new tasks. Notably, section 12, which provides for interagency funds transfers, is explicitly restricted to funds available to Tribes. At a minimum, the bill should be revised to provide for transfer to HHS of an appropriate share of other participating "agencies" administrative resources.

In summary, we cannot support S. 285 as currently drafted, for the reasons discussed in this statement, but the Department is prepared to work with the Committee to address our concerns.

S. 558: ELEVATION OF THE DIRECTOR OF IHS

S. 558 proposes to establish within the Department of Health and Human Services an Office of the Assistant Secretary for Indian Health. The IHS is the principal point of contact on behalf of the Department on health matters related to Tribes. It exists because of the solemn promises the Federal government has made to Indian people. On matters of health care, the head of the Indian Health Service acts principally as the administrator of the vast Indian Health Service system, as well as an advocate on behalf of the Indian Health needs of the nation's more than 550 federally-recognized Indian Tribes.

Currently, the Director of the IHS enjoys direct access to the Secretary in the Department on all health services issues impacting Tribes and Tribal organizations. In addition, the Director serves as Vice-Chair of the Secretary's Intradepartmental Council for Native American Affairs. The Council serves as an advisory body to the Secretary and has the responsibility to assure that Native American policy is implemented across all Divisions in the Department including human services programs. The Council also provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all agencies bear responsibility for the government's obligation to the Native people of this country.

It is our view that the Director as the Vice Chair of the Intradepartmental Council for Native American Affairs currently enjoys an elevated status in the Department. He facilitates advocacy, promotes consultation, reports directly to the Secretary, collaborates directly with the Assistant Secretary of Health, advises the heads of all the Department's divisions and coordinates activities of the Department concerning matters related to Native American health and human services issues. This authority is provided in the Native American Programs Act of 1974. Consistent with the statute, Secretary Thompson has taken steps to assure that this Council receives the highest levels of attention within the Department.

Moreover, the Secretary and Deputy Secretary have traveled widely to Indian Country with their senior staff. These trips have raised the awareness of tribal issues and have contributed greatly to our capacity to speak with one voice, as One Department, on behalf of tribes. Secretary Thompson and Deputy Secretary Allen are daily committed to working with Tribal leaders on Indian health concerns.

In summary, the Director currently is assured the same access to the highest levels as other agencies in the Department and it is not necessary to elevate the IHS Director to the level of Assistant Secretary over other agencies serving American Indians/Alaska Natives (AI/AN).

S. 555: "NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION ACT"

S. 555, the "Native American Health and Wellness Foundation Act of 2003", amends the Indian Self Determination and Education Assistance Act to authorize the Secretary of HHS to establish a foundation through which the IHS mission to improve the health status of American Indians and Alaska Natives could be supported by private sector partnerships with the Federal government. The legislation is currently under review by the Executive Branch.

I want to thank you for the opportunity to testify today on these important bills, and we would like to continue to work closely with the Committee.

Please allow me to address any questions you may have at this time.

WILLIAM F. RAUB, PH.D.

William F. Raub is the Acting Assistant Secretary for Planning and Evaluation, a position he has held since February 2003, as well as the Principal Deputy Assistant Secretary within the Office of the Secretary, Department of Health and Human Services (HHS). From December 2001 through February 2003, he served concurrently as the Deputy Director of the Office of Public Health Emergency Preparedness, also within the Office of the Secretary.

Dr. Raub was the HHS Deputy Assistant Secretary for Science Policy from 1995 to 2001. He was the Science Advisor to the Administrator, United States Environmental Protection Agency from 1992 to 1995 after a one-year assignment as Special Assistant for Health Affairs in the Office of Science and Technology Policy, Executive Office of the President of the United States. Prior to that, he was the Deputy Director of the National Institutes of Health (NIH) in the Department of Health and Human Services from August 1986 through November, 1991. From July 1989 through March 1991, he was the Acting Director, NIH.

From 1978 to 1986, Dr. Raub served first as Associate Director, and later Deputy Director, for Extramural Research and Training at NIH. He was Associate Director of the National Eye Institute from 1975 to 1978 and Chief of the Biotechnology Resources Branch in the Division of Research Resources from 1969 to 1975. Dr. Raub was Acting Chief of the Special Research Resources Branch, Division of Research Resources, in 1968-1969, and was a Health Scientist Administrator in the Division of Research Facilities and Resources from 1966 to 1968. From 1966 through 1979, Dr. Raub led the development of the PROPHET system, the first integrated array of computer-based tools for the study of the relationships between molecular structures and biological effects.

Dr. Raub has received numerous awards from external organizations for his government service — including the Society of Research Administrators' Award for Distinguished Contribution to Research Administration, the American Medical Association's Nathan Davis Award, and election as a fellow of the National Academy of Public Administration. In addition, within HHS, he has twice been presented the Distinguished Service Award and has received the Presidential Meritorious Executive Rank Award and the Presidential Distinguished Rank Award.

Born in Alden Station, Pennsylvania, Dr. Raub was graduated summa cum laude with the A.B. degree in Biology from Wilkes College in Wilkes-Barre, Pennsylvania. He received the Ph.D. degree in Physiology from the University of Pennsylvania, where he also was awarded a National Science Foundation Graduate Fellowship and was a Fellow of the Pennsylvania Plan. During 1965-1966, Dr. Raub was an instructor and post-doctoral fellow at the University of Pennsylvania Medical School.

February 2003

Department Response to Senate Indian Affairs Committee Questions
April 9, 2003 Hearing

1. With regard to S. 558, a bill to designate the Indian Health Service Director to an Assistant Secretary for Indian Health, the Administration stated concerns about the necessity of this legislation, given the Department's internal efforts to address Indian health policy. Several years ago, after a long history of the Department opposing the legislation, I worked very hard to address concerns raised by the Administration in order to secure support for the bill. After the bill was modified to clarify the responsibilities of the new Assistant Secretary, the Administration formally supported this legislation, as documented in the attached letter and committee report. I've also attached prior communications from 1994 which first indicated opposition for similar reasons as those you've stated in your testimony. After years of opposing the bill and then finally supporting it, I'm frustrated that the Administration is changing its position once again.

   A. If the Department is already promoting an elevated status and role of the IHS Director internally, why wouldn't the Department support institutionalizing that role and committing to establishing a position that truly promotes government-to-government relations with Indian tribes?

      The Department believes the access to the Secretary currently enjoyed by the Director of the IHS, in addition to the Director's position on the Intradepartmental Council for Native American Affairs (ICNAA), promotes the government-to-government relationship with Tribes. This improved access, promoted by the Secretary, allows the Director to freely communicate with all other principal leaders in the Department. As such, the role of the IHS Director has been institutionalized and the Department is committed to maintaining this relationship in a manner that is fully supportive and respectful of the government-to-government relationship.

   B. In previous years, the Administration cited problems that the role of the Assistant Secretary for Indian Health might conflict with the role of the Assistant Secretary for Public Health. Changes were made to the legislation to clarify that the Assistant Secretary for Public Health's responsibility remained unchanged by the legislation and he/she retained overall authority for public health affecting the general population. Does S.558 adequately clarify the prospective role and responsibility of the Assistant Secretary of Indian Health with respect to the role of the Assistant Secretary for Health?

This Administration has not specifically cited a conflict with the role of the Assistant Secretary for Public Health. However, the role of any Assistant Secretary depends upon the functional needs of the Office he/she administers. Currently, Department Assistant Secretaries report directly to the Secretary; as do the heads of all HHS agencies or Operating Divisions, including the Director of the IHS. All of the agency heads have direct access to the Secretary.

2. The concept of an Assistant Secretary responsible for Indian health policy and issues within the Department of Health and Human Services enjoys widespread support from tribal leaders and Indian health advocates as a way to better facilitate the government-to-government relationship and raise the level of priority to Indian health for budgetary and policy matters.

   A. Given the fact that the Indian Health Service programs and services remain severely underfunded, how is the current IHS Director able to advocate for the appropriate increases for Indian health care funding to match the rate of inflation and growth of Indian populations?

      The IHS director annually submits budget recommendations for his agency as part of the Department's annual budget process. In addition, the Department and the IHS conduct annual consultation meetings with Tribes. These consultations give Tribes the opportunity to make recommendations about HHS policy and budget issues to HHS leadership, including the IHS Director.

      In addition, the ICNAA provides the Secretary with policy guidance and budget formulation recommendations that spans all Divisions of HHS. As Vice-Chair to the Intradepartmental Council on Native American Affairs, the IHS Director plays a leadership role in these discussions and deliberations

   B. Indian health care still falls far below national standards on various levels, and disparities continue between Indian and non-Indian communities in federal health care expenditures. Would an Assistant Secretary for Indian Health have any greater ability or authority to leverage the necessary resources or address policy concerns to raise the standard of health care for Native Americans?

      An Assistant Secretary for Indian Health would not have any greater authority to leverage resources than the current Director of the IHS. Necessary resources and policy concerns are given full consideration by the Department in a manner that always takes into account the mission of the IHS (i.e., to raise the physical, mental, social, and spiritual health of AI/ANs to the highest possible level.).

As Vice-Chair of the ICNAA, the IHS Director has the ability to convene all senior staff of the Department to address policy concerns not only to raise the standards of health care for Native Americans, but to also review the many human service program resources that address, health, social and economic conditions.

C. How does an Assistant Secretary within the Department recommend policy or budgetary changes to the Secretary? How does that differ from the role of the IHS Director?

There are no distinctions made in the development of HHS budget policy based on the different titles held by HHS component heads. The Secretary seeks advice from all HHS components in developing budget policy. The heads of agencies or Operating Divisions within the Department, such as the Director of the Indian Health Service or the Assistant Secretary for Children and Families, present budgetary recommendations to the Secretary and the Secretary's Budget Council. The policy officials who staff the Secretary, such as the Assistant Secretary for Budget, Technology and Finance and the Assistant Secretary for Planning and Evaluation, provide policy advise by serving as members of the Secretary's Budget Council.

D. Are there any specific recommendations that the Administration might suggest to enable the Department to support the legislation?

Currently, the Director is assured the same access to the highest levels as other agencies in the Department. On matters of health care, the Director acts principally as the administrator of the Indian Health Service system, as well as an advocate on behalf of the health of the nation's federally-recognized Tribes. The Director also sits on the Intradepartmental Council for Native American Affairs, which promotes the government-to-government relationship with Tribes. In addition, the Secretary and Deputy Secretary have traveled widely to Indian Country and are equally committed to working with Tribal leaders on Indian health concerns. As such, we believe it is not necessary to elevate the IHS Director to the level of Assistant Secretary over other agencies serving American Indians/Alaska Natives (AI/AN).

NATIONAL INDIAN HEALTH BOARD

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REVISED

Statement of Julia Davis-Wheeler, Chairperson

National Indian Health Board

On

Indian Health Related Legislation

April 9, 2003 – 10:00 a.m.

Senate Russell Building, Room 485

Chairman Campbell, Vice-Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am Julia Davis-Wheeler, Chairperson of the National Indian Health Board. I am an elected official of the Nez Perce Tribe, serving as Secretary, and also Chair the Northwest Portland Area Indian Health Board. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on several important pieces of legislation affecting the delivery of health care to American Indians and Alaska Natives.

The NIHB serves nearly all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. We strive to advance the level 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 regional area.

As we continue to work diligently to address the health disparities that continue to plague Indian Country, there are several legislative items that have been introduced during the 108th Congress that would help us improve the health status of American Indians and Alaska Natives.

Indian Health Service Director Elevation to Assistant Secretary of Indian Health

Before I begin discussing Senate Bill 558 to elevate the Indian Health Service Director to the position of Assistant Secretary of Indian Health, I would like to say a few words about the Secretary of Health and Human Services, Mr. Tommy G. Thompson. As a Tribal leader, I feel very comfortable in saying that Secretary Thompson has been the most accessible Cabinet Secretary in this Administration. He and his immediate staff have been available at every possible opportunity to visit with tribal leaders and to see first hand the health needs of our people.

Also, the National Indian Health Board is aware that the Committee will consider the nomination of Dr. Charles Grim as Director of the Indian Health Service (IHS). As I mentioned in my testimony last week, we support his nomination and appreciate his willingness to take on such a significant role.

Tribal leaders have long pushed for elevating the status of the IHS Director as a means to recognize the importance of the federal government's functions in carrying out its trust responsibility to American Indian and Alaska Native Tribal governments. The intent of Senate Bill 558 is quite appropriate as it does just that in a manner consistent with the government-to-government relationship between the United States and Tribal governments. Senate Bill 558 is very important to Indian Country and we are extremely hopeful that it is finally signed into law this year.

As we advance this legislation, we want to take adequate steps to ensure that we build on the improvements that have been made within the Department of Health and Human Services (DHHS) over the last few years in addressing Tribal issues and further, that the Indian Health Service does not become isolated from other areas of DHHS. We feel that this can be accomplished with minor revisions to Senate Bill 558.

We recommend that the legislation indeed places the IHS Director at the level of Assistant Secretary of Indian Health, but do it in a manner which does not diminish the Secretary's responsibilities to carry out the federal government's trust responsibility to Tribal governments,

As I mentioned previously, over the past several years, American Indian and Alaska Native issues have slowly crept into the mindset of nearly all areas of DHHS. The raised awareness and are attributable to several things, including the of informed personnel within the Office of the Secretary, the hard work of IHS officials to advance issues internally, and most importantly the persistence of Tribal governments to ensure that the purpose and intent of the Executive Order mandating Tribal consultation is properly carried out.

One of the more significant examples of the increased awareness and acknowledgment of the importance of Indian issues within the Department is the revival of the Secretary's Intradepartmental Council on Native American Affairs, which is co-chaired by the Indian Health Service Director.

Because of the many critical issues that need to be addressed within the Department of Health and Human Services, we feel that any changes to the structure of the Department must be done in a manner that does not isolate Indian health issues, but instead makes these issues a common thread among all Department areas.

Integration and Consolidation of Alcohol and Substance Abuse Programs and Services provided by Indian Tribal Governments

All of the purposes expressed in Senate Bill 285, the Native American Alcohol and Substance Abuse Program Consolidation Act of 2003, serve to improve the delivery of such programs in Indian Country and are commendable and the National Indian Health Board fully supports this legislation. We are well aware of the difficulties Tribal health providers face when encountering the convoluted array of agencies providing alcohol and substance abuse programs in Indian Country. American Indian and Alaska Native Tribal governments are constantly searching for ways to develop more effective and efficient programs to better serve Tribal members and are extremely interested in providing such services utilizing the best practices available.

We are certainly supportive of legislation that seeks to coordinate and improve the delivery of alcohol and substance abuse programs throughout Indian Country and we will work diligently with Congressional members to address and resolve any concerns with the legislation which may create opposition. The National Indian Health Board fully believes that the Indian Health Service is an appropriate and capable agency to administer the duties as lead agency under the act; we feel it is equally as important to engage all applicable agencies to the greatest extent possible.

Perhaps this could be achieved by utilizing a committee consisting of the involved agencies chaired by the Indian Health Service, rather than naming a lead agency. All activities of the lead agency under this proposed act would be carried out according to the decisions made by the committee. Further, mechanisms should be included to provide for Tribal involvement and consultation for all measures that would affect the provision of alcohol and substance abuse treatment in Indian Country.

Establishing the Native American Health and Wellness Foundation

The intent and purpose of Senate Bill 555 to create the Native American Health and Wellness Foundation is absolutely appropriate and mirrors much of what occurs in the private sector delivery of health services. It would serve as a valuable mechanism to maintain a single organization to allow for the Indian Health Service to receive charitable support. Such entity has not existed previously, which has deterred the donation of such support.

While we are certainly supportive of any efforts to increase funding for the Indian Health Service, we want to make sure that the funds generated by such a foundation are not used to offset appropriations for the IHS.

I would also like to mention that the National Indian Health Board would be a capable umbrella organization under which the proposed Foundation could operate. As of March 3rd of this year, the NIHB fully operates out of Washington D.C. and is governed by Board members from across Indian Country. Many of the activities that would be provided by the Foundation, such as activities furthering the health and wellness of American Indians and Alaska Natives, and participating with and assisting Federal, State, and Tribal governments, are already provided by the NIHB. We would be extremely excited about the possibility of discussing this with the Committee.

Conclusion

On behalf of the National Indian Health Board, I would like to thank the Committee for its consideration of our testimony and for your interest in the improvement of the health of American Indian and Alaska Native people. We stand ready to work with Congress, the Administration, and all other involved entities to develop legislation that can successfully be passed this year. We are certainly pleased that this is the third hearing to take place so far this year on Indian health and we trust that our issues will continue to be a priority during the 108th Congress.

Association of Village Council Presidents, Inc.

Testimony on the AVCP Kinguliamta Cuinerkaat (KC) Wellness Program

by

Myron P. Naneng

President

The Association of Village Council Presidents, Inc. (AVCP) is one of the 12 regional Native non-profit organizations in Alaska. The Village Councils established AVCP in 1964 to work for the benefit of the tribal governments and the people of the Yukon River and Kuskokwim River (YK) Delta.

AVCP was involved in the process leading to the federal legislation called the Alaska National Interest Lands Conservation Act (ANILCA) and the Alaska Native Claims Settlement Act (ANCSA.) Since inception, AVCP has grown to become a diverse social service agency, tribal rights advocate, and community development organization.

Our services are varied and not limited to operation under the departments of Administration, Accounting, Education, Employment, Training & Childcare, Natural Resources, Realty, Social Services, Tribal Services, Vocational Rehabilitation, Headstart, Planning, Temporary Assistance to Needy Families Program (TANF,) Village Public Safety Officer Program, Kinguliamta Ciunerkaat (Wellness Program), the Tribal Justice Center and the Yup'ik Cultural Center/Museum.

The 56 communities that make up our region are all federally-recognized Tribes and are members of our organization. Each tribe has a Village Council and representatives of each tribal government make up the AVCP Board of Directors. The Board holds a twice-annual Convention at rotating in-region sites in which to discuss traditional and contemporary issues that affect our culture and communities, including wellness, economic development and Subsistence.

AVCP would like to endorse the concept of establishing a Native American Health and Wellness Foundation to encourage, accept, and administer private gifts of real and personal property, and any income from or interest in such gifts, for the benefit of, or in support of, Tribal Health and Wellness programs such as ours. In these times of war and uncertainty, financial restraints and competition for donations for social programs, Indian Country is in dire need of a focal point for fundraising. A Native American Health and Wellness Foundation could be such an instrument to encourage giving for modest, yet effective programs such as ours.

AVCP Receives 2.5 Million Additional Funding for Children's Future Program

In a quiet signing without ceremony, interim AVCP President Allen Joseph and AFN President Julie Kitka co-signed a simple one page document extending the Kinguliamta Cuinerkaat (Securing a Future for the Children) Program for another year for $2,549,667 making the total program budget $5,099,334.

The KC program was an initiative begun one year ago to respond to concerns of tribal wellness brought about by increased instances of suicide, substance abuse and a loss of traditional culture.

The additional grant monies will go toward helping to support the Village Public Safety Officer Program with $500,000 totaling $1,000,000 over two years and funding to help establish and run a region wide tribal justice program.

The core of Kinguliamta Cuinerkaat (KC) is bringing together the people of all ages in the tribal community to revitalize the spirit and teachings of their traditional culture and use them as tools to create a brighter future for the young people.

AVCP's Kinguliamta Ciunerlaat (Wellness) Department has been working with the youth of this region in conjunction with the Elders to identify the changes, challenges and needs the youth are experiencing in our ever affected culture. The KC has divided the AVCP region into 10 units (sub-regions) to more accurately identify and work with villages that have a relationship with each other.

The 2002 AVCP-KC meetings of all villages (with the exception of one unit,) revealed that the youth delegates felt that the pure isolation of their communities exasperated their sense of uselessness and idleness in their lack of activities.

Emboldened by community and Elder attention, the youth complained about having no common place to meet, aside from school activities during the school year. They felt that with no sanctioned community activities, illicit, albeit, destructive behavior such as drinking, unprotected sex, huffing or drugs are the only means to combat boredom.

The frankness of the KC sponsored community meetings have spurred both Elders and adults to work with the Youth to combat this behavior, take ownership of the void that affects these families. Though many Tribal Councils have acted in curbing some activities like bingo throughout the week to get parents to stay at home with their children, village resources can only go so far to tackle this rampant problem. Some villages are trying to find funding sources to build Youth Centers which could be used for community and youth education and entertainment purposes.

At the AVCP, Inc. Mid-Year Convention of March, 2003, the villages mandated AVCP to coordinate a regional approach to build an infrastructure for such a venture.

AVCP proposes to integrate the Yaaveskaniryaraq (Yaaves) "Moving Forward To Gain Wisdom" Program to supplement the KC program.

One of the KC Elder's vision is to strengthen the Cup'ik/Yup'ik culture. By strengthening the culture of the people of the region, the Elders feel Cupiit/Yupiit will not only gain strength, but that through the teachings of the culture, the ills of individuals as well as the community could be

dealt with. They ways the Elders talk, it is like saying "***no person left behind***" in living a better life.

Yaaves was started by seven people including two Elders in Bethel. It was in planning for three full years. Then in the Fall of 1999, the course was started in Cev'aq (Chevak.) It has been offered every year since then. The Yupiit School District then housed Yaaves after a year. In 2003 two persons are facilitating the Elder instructors to twenty-seven Cup'ik/Yup'ik students, teaching them the culture and how to be facilitators of the course.

This type of program is exactly what the KC Initiative is looking for to help build viable Cup'ik/Yup'ik culture in which a strong, healthy way of life can flourish in. Yaaves, by teaching the course in Cup'ik/Yup'ik way can get the healthy cultural identity going. The by product of this way of teaching can only result in better self-esteem for our young and all who take it.

The Yaaves Program would teach courses, designed by Yup'ik instructors, for students to learn about the literature, history, art, science, spirituality, philosophy, social systems and ways of Cup'ik/Yup'ik Ways of Knowing. Yup'ik Elders are the course's teachers, sharing their knowledge, philosophy, and practices with students. Facilitators will help the Elders with the courses.

The AVCP KC Program would house the Yaaves Program leaving intact the initial intent and its planning and advising group. Yaaves is a viable program, but needs consistent staffing and budget. By its very nature, it has a need for growth as demanded by the Cupiit/Yupiit, and by the KC Elder visioning committee, as well as the sobriety work of the AFN Wellness program.

Students and Elders that participate in Yaaveskaniryaraq would be located in the 50 villages on the Yukon Kuskokwim Delta.

The Yaaves Program would be phased in starting the Fall of 2004 starting with the KC initiative training of 27 students in the Spring of 2003. Over the next three years, the program will work in phases with more students and more Elder instructors and staff housed at AVCP's KC Initiative. In this way, more age groups will be involved in different ways working toward being a sustaining way of life.

Yaaves was developed based on the Clemente Course, as outlined by Earl Shorris' book *New American Blues*. It was then further developed into a locally developed, Yup'ik focused humanities course created in Western Alaska. In 1999-2000, the course was taught in Chevak to 16 students; 2000-2001 the course was taught in the Yupiit School District with 45 students; 2001-2002 the course was taught in the Yupiit School District with 10 students. In 2003 with the help of Kinguliamta Ciunerkaat it is teaching 47 students. It is through this year long course, that healing through positive Cup'ik/Yup'ik "Piciyaraq" traditional values and principles that positive behaviors can get started and work toward daily practices.

Achieving KC / Yaaves Wellness Success

The Association of Village Council Presidents, through Kingulimata Ciunerkaat "Securing A Future For Our Children", would develop partnership with Yaaveskaniryaraq Program and housing the program until perhaps the Tribal College is established. Establishing this initial step will provide AVCP with the opportunity to take the AVCP Tribal College to the next step of it's evolution. By developing these two programs together, parallel planning, coordination and implementation, Yaaveskaniryaraq will be the vehicle for AVCP to grow the Tribal College.

The plan is a phased in approach:

Year	**Yaaveskaniryaraq**	**Tribal College**
Year One	Concept or Vision Development, Approved and Implementation of Program. Funding secured for Start-Up and Operating Budgets. 40 Students.	Concept or Vision Development, Approved and Implementation of Program. Funding secured for Start-Up and Operating Budgets.
Year Two	Implementation of Yaaveskaniryaraq Program Train Facilitators and Elder Instructors. Pilot Project with selected villages via Audio Conferences. 80 Students.	Infrastructure and Administrative Requirements developed. Work with partners to secure funding and to meet accreditation requirements, feasibility plan, curriculum development, staff development, etc.
Year Three	50 villages involved. 180 Students.	Develop framework to offer courses in 50 villages.

Yaaveskaniryaraq Program Piciyaraq classes would be taught to:

Year	**Students** (Note: Students can change) (20 students per class)	**Total**
Year One	Kinguliamta Ciunerkaat Staff (20) AVCP Staff-Directors (20)	40
Year Two	AVCP Staff (60) Pilot Project: Young Adults (20)	80
Year Three	50 Villages (60) Young Adults (40) YKCC Adults (20) AVCP Staff (60)	180

Yaaveskaniryaraq Program's goal is to develop the course from Head Start to Post-Secondary audiences.

Detail	Year One	Year Two	Year Three
Personnel			
Salaries			
Program Director (1 FTE)	70,000.00	70,000.00	70,000.00
Coordinator (1 FTE)	55,000.00	55,000.00	55,000.00
Instructors (.5 FTE @ 30,000)	60,000.00	90,000.00	120,000.00
Instructors (1 FTE @65,000)		65,000.000	130,000.00
Curriculum Developer (1 FTE@ 65,000)	65,000.000	130,000.000	130,000.00
Salaries Sub-Total	250,000.00	410,000.00	505,000.00
Fringe Benefits (35%)	87,500.00	143,500.00	176,750.00
Salaries Total	**337,500.00**	**553,500.00**	**681,750.00**
Travel			
Staff Travel	20,000.00	60,000.00	100,000.00
Student Travel	80,000.00	160,000.00	320,000.00
Elder Travel	20,000.00	40,000.00	80,000.00
Partner Travel	20,000.00	20,000.00	20,000.00
Travel Total	**140,000.00**	**280,000.00**	**520,000.00**
Per Diem			
Staff	8,000.00	16,000.00	32,000.00
Student	30,000.00	60,000.00	120,000.00
Elder	8,000.00	16,000.00	32,000.00
Partner Per Diem	8,000.00	8,000.00	8,000.00
Per Diem Total	**54,000.00**	**100,000.00**	**192,000.00**
Tuition Fees ($246 per 3 credits)	12,000.00	24,000.00	48,000.00
Training Fees	8,000.00	16,000.00	32,000.00
Equipment Purchases	20,000.00	30,000.00	40,000.00
Computers	15,000.00	15,000.00	15,000.00
Supplies	15,000.00	20,000.00	30,000.00
Food	5,000.00	10,000.00	15,000.00
Contractual	20,000.00	40,000.00	60,000.00
Fellowship (1 @ 25,000)	25,000.00	50,000.00	50,000.00
Technical Assistance-Accreditation	30,000.00	30,000.00	30,000.00
Elder Instructor Stipends (.25 FTE @10,000)	40,000.00	80,000.00	160,000.00
Telephone/Fax	15,000.00	18,000.00	20,000.00
Classroom Space	20,000.00	40,000.00	80,000.00
Fees/Other	5,000.00	10,000.00	15,000.00
Total	761,500.00	1,316,500.00	1,998,750.00
AVCP Indirect (22.3%)	169,814.50	293,579.50	443,491.25
Total Cost	**931,314.50**	**1,610,079.50**	**2,432,241.25**

Alaska Native Health Board

Testimony for the Senate Committee on Indian Affairs Record on S. 285, to authorize the integration and consolidation of alcohol and substance abuse programs and services provided by Indian tribal governments, and for other purposes; S. 558, a bill to Elevate the Director of the Indian Health Service to be Assistant Secretary for Indian Health, and for other purposes; and S. 555, to establish the Native American Health and Wellness Foundation, and for other purposes

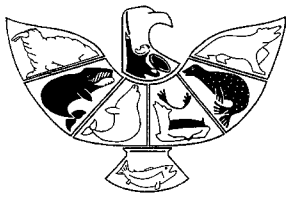
by

Mike Zacharof, Chairman

April 9, 2003
10:00 a.m.
Russell Senate Office Building 485

Alaska residents face some of the most extreme barriers to obtaining health care services in America, the greatest of these barriers being isolation. The goal. . .is to improve access to primary health care and reduce health disparities among underserved populations throughout the state. . . .increase access to health care services in areas where such care has not been available.

It is important that we look to find ways to help Alaskans meet the unique health care challenges that



ALASKA NATIVE HEALTH BOARD
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The Alaska Native Health Board (ANHB) is a 22-member board entity, consisting of one elected or selected representative of the Board of Directors or health committees of Alaska's Native regional health organizations and independent tribal public Law 93-638 compactors/contractors.

The responsibility of owning and operating health care delivery for Alaska Natives inspired Alaska Tribes to establish the Alaska Native Health Board (ANHB) thirty-five years ago. Since then, ANHB has advocated for the health and wellness of the Alaska Native people. The Alaska Native tribal health organizations operate under the Alaska Tribal Health Compact. The Alaska Tribal Health Compact is a self-governance agreement with the Indian Health Service (IHS.)

ANHB works in conjunction with the Alaska Native Tribal Health Consortium (ANTHC) and Health Directors in nine tribally-operated service units to provide comprehensive health services to approximately 119,000Alaska Native people. Tribal hospitals are located in the six rural communities of Barrow, Bethel, Dillingham, Kotzebue, Nome and Sitka. There are 24 tribal health centers and 176 tribal community health aide clinics operated throughout the State. ANTHC manages the Alaska Native Medical Center (ANMC,) the statewide referral hospital within the Alaska Native Health System. The Alaska Native Statewide Health System has developed into one of the most sophisticated and comprehensive tribally-owned and managed health care systems in the world.

ANHB continues to advocate for improvements in both clinical and preventive services in such areas as access to care for patients from rural Alaska, substance abuse & mental health services development, cancer prevention and treatment, long-term care and community-based health services, health promotion and disease prevention, wellness, and the development of the Alaska Native health profession. ANHB constantly strives to achieve the highest possible health status for our generations by advocating to reduce the health disparity gap between the Native population and the general population within the United States. ANHB continues to emphasize the importance of self-determination in health care services, and encourages healthy communities through our continually changing ways of living.

"Promoting the spiritual, physical, mental, social and cultural well-being and pride of Alaska Native People."

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION
ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ARCTIC SLOPE NATIVE ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
EASTERN ALEUTIAN TRIBES
KETCHIKAN INDIAN COMMUNITY
KODIAK AREA NATIVE ASSOCIATION
MANILAQ ASSOCIATION
MT. SANFORD TRIBAL CONSORTIUM
METLAKATLA INDIAN COMMUNITY
NATIVE VILLAGE OF EKLUTNA
NATIVE VILLAGE OF TYONEK
NINILCHIK TRADITIONAL COUNCIL
NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
SOUTH CENTRAL FOUNDATION
TANANA CHIEFS CONFERENCE
VALDEZ NATIVE TRIBE
YUKON-KUSKOKWIM HEALTH CORPORATION

On S. 558 - a bill to Elevate the Director of the Indian Health Service to be Assistant Secretary for Indian Health, and for other purposes

The Alaska Native Health Board (ANHB) has worked with the Department of Health and Human Services (DHHS) and the Indian Health Services (IHS) for thirty-five years. In that time, we have encountered varying degrees of inflexibility, flexibility and cooperation from Administration to Administration.

With Secretary Tommy G. Thompson's visit to Alaska this past summer, we have garnered a champion advocate at an Administrative level and have seen policies and mandates that are of modest benefit to the Tribal Health community. For instance, after touring some of our infamous 'sewer lagoons' in the Yukon-Kuskokwim region of Western Alaska, Secretary Thompson had increased the President's 2004 budget request to include $114 million for IHS sanitation construction projects -- a $20 million increase over the fiscal year 2003 budget and the largest sanitation increase in more than a decade. It is important that he did this not only for Alaska, but for all Indian Country that has sanitation construction needs.

Secretary Thompson even continued a 1998 commitment to provide special funding in the form of $100 million in grants to support programs to prevent and treat diabetes among American Indians and Alaska Natives, especially among children and teenagers. Indian Country experiences a rate of diabetes 2.6 times higher than the rate of non-Hispanic whites of similar age with cardiovascular disease and related diabetes problems being the number one killers among American Indians and Alaska Natives.

But not every Secretary is committed to visiting remote, rural villages and inspecting village built clinics and operations, or able to tour Indian Reservations in the Lower 48 States at our request to realize or respect our needs. This is where elevating the Directorship of the IHS to an Assistant Secretary position within DHHS becomes imperative. An Assistant Secretary designation would carry an authority the Indian Health community seriously needs and deserves within the massive federal regulatory role in the national health, human and social services arena.

The Alaska Native Health Board strongly endorses Senate Bill 558 for empowerment of the Administration status of the Indian Health Service within the Department of Health and Human Services on behalf of Indian Country.

On S. 555 - to establish the Native American Health and Wellness Foundation, and for other purposes

WELLNESS

Very little is known or was passed down in the traditional oral custom of relating history from generation to generation about Alaska Native people suffering from physical and/or mental health problems. Problems that did exist were treated in a culturally prescribed manner aided by the support of family and the community. Early contact between Russians, and subsequently Americans, brought rampant disease and introduced alcohol to Alaska Native peoples. Later, assaults on traditional cultures through forced acculturation that included a compulsory change of language, spiritual beliefs, and isolation and removal from friends, family and traditional homelands, introduced many Alaska Natives to cultural, mental, economic and spiritual poverty.

But today, a great number of factors contribute to poor mental health among Alaska Natives. Lack of education, boredom, and drugs and alcohol contribute to the high percentage of suicide, accidents, and teenage pregnancy among Alaska Natives. The birth rate among Alaska Native teenagers aged 15-19 was 2.5 times higher than their counterparts nationwide in 1988. Death rates from suicide, accidents, alcohol, and motor vehicles were much higher for male Alaska Natives than males of all races in the United States. The Native mortality rate is more than three times the national average, and a significant percentage of deaths are alcohol-related.

All this leads to a statistical marker in making the mental and physical health of Alaska Natives among the worst in the nation and reflect serious, underlying problems within Alaska Native communities.

It is our belief that the creation and investment in the Wellness Program will take our people back to a time when most Alaska Native villages were healthy and free of the devastation. The social pathologies that have plagued our cultures were so serious, Congress itself had set aside $30 million to tackle the problem. Half that initial figure was set aside for Alaska alone, with the remaining going to the rest of Indian Country. The staging ground for the Wellness program has proved so effective, that Congress appropriated another $15 million for the program in succession.

The Wellness funding was channeled through the Indian Health Service to the Alaska Federation of Natives (AFN) to provide social service and justice-related improvements within rural communities. Infrastructure has been set, program and mission statements have been designed per region and communities have already seen promising, responsive and even enthusiastic results. There is a renewed hope, a community desire, to see this culturally relevant healing program through.

ANHB requests that Wellness appropriations continue to be funded by Congress in perpetuity and that an American Health and Wellness Foundation only adds to the progress made by Alaska regions existing programs and not compete or take away from that infrastructure.

On S. 285 - to authorize the integration and consolidation of alcohol and substance abuse programs and services provided by Indian tribal governments, and for other purposes

The Alaska Native people living in rural Alaska need behavioral health services, which can be provided by a generalist provider having basic training and experience across substance abuse and mental health. Historically, these services have been made available through providers who are not from the area and in many instances unfamiliar with local cultural and spiritual practices and beliefs. They are unaware of cultural and spiritual based healing practices and as a result can unknowingly harm those in need and seeking services.

The goal is to utilize the successful Community Health Aide Program (CHA/P) as a model for creating curriculum and certification processes for a Behavioral Health Aide Program (BHA). The goal is to develop Tribally managed and directed training centers using a collaborative effort of the Tribal health Programs, the University of Alaska – Fairbanks, Rural Human Services, and other training resources, such as the Counselor Academy.

The focus of the BHA providers would be on prevention, early intervention and case management within the rural village environment. The BHA program will increase "Team Capacity" of providers already in a village, and will help to reduce outpatient, emergency and inpatient medical workload and cost, as well as reduce long term chronic health problems and family and community disruption.

Specialized curriculum is needed for the BHA program. The curriculum being planned will be standardized (foundation and practice) training covering basic substance abuse and addiction assessment and services; basic mental health assessment and services, prevention services and risk reduction; intervention skills, case documentation and management; professional ethics; and clinical supervision practices for support of the BHA providers.

The BHA program will be included in the Community Health Aide Program as a specialty area of certification for village based behavioral health services throughout rural Alaska. Including BHA with the CHA/P Certification will provide stability and the standardization of qualifications for staffing and scope of practice. The village based health services delivery team will be expanded to include behavior health services needed in rural Alaska. It would also allow for specialized evaluation of BHAs for certification under the federally recognized certification program already in place. Individuals with expertise in behavior health will need to be added to the certification board to support and enhance that process.

Substance Abuse Programs

- **Southcentral Foundations Pathway Home Residential Treatment Center** is a new state residential substance abuse and mental health treatment program for at-risk Native youth, ages 14 up to 17. This program provides integrated and culturally appropriate treatment, education/vocational training, including family and community-centered aspects of substance abuse and mental health treatment rehabilitation.

· **Southcentral Foundations Dena A Coy Program** is a comprehensive FAS prevention program. It offers substance abuse and mental health treatment substance-abusing women and is designed to allow women to remain in treatment throughout the duration of their pregnancy and 10 weeks postpartum. In addition, there is a transitional program assists graduates on an outpatient basis for about two years.

· **Yukon-Kuskokwim Health Corporation's Tundra Swan Inhalant Treatment Program** has the mission of "a statewide, inhalant program providing specialized services for all Alaskan youth, their families and the communities in which they live." It is a multi-culturally based residential treatment program helping youth to heal. There are four phases of care in the program, which includes involvement by families and community care providers – followed by ongoing outpatient follow-up and support. Treatment takes four to six months. Assessment and treatment incorporate the culture values, beliefs and practices of the population being served.

· **SouthEast Alaska Regional Health Consortium (SEARHC) substance abuse prevention programs** - For the purposes of operating and maintaining a residential substance abuse treatment program for 20 women with children in Sitka, Alaska. SEARHC has been providing their Community Family Services Workers (CFSWs) with a higher level of training and can now be responsive to more complex cases on the local community level. CFSWs are offering more extensive aftercare services for those clients returning from their substance abuse treatment programs in Sitka. SEARHC has also introduced a new service in which rural patients can consult with mental health professionals in Sitka using video conferencing technology.

· **Maniilaq, Counseling Services & Suicide Prevention** - For the purposes of providing a broad range of mental health services to residents of the Northwest Arctic Borough, including psychotherapy and counseling for adults and adolescents, play therapy for children, marital and family therapy, anger management group therapy, a sexual offender program, and 24-hour on-call service for mental health crisis intervention, hospital assessments, and court screenings. The Suicide Prevention program is designed to reduce the rate of suicide through education and community involvement. The program offers services at the Maniilaq Health Center and at village clinics by an itinerate staff of counseling professionals including a psychologist, psychiatrist, marriage and family therapist, psychiatric nurse, social workers and Para professionals.

· **Tanana Chiefs Conference joint venture with the Fairbanks Native Association** - Graf Rhenneerhaanjii, which means, "The Place Where Healing Occurs." The primary and overall goal of the adolescent residential program is to assist individual youth who are abusing, dependent on, or addicted to alcohol, drugs, and other substances. Patients are taught a set of skills that will assist them in attaining and maintaining a drug and alcohol-free way of life and in better managing their emotional and behavioral responses to life's problems and experiences without the use of drugs, alcohol, or other substances.

As you can see, the Alaska Tribal Health system already has an established alcohol and substance abuse prevention, diagnosis, and treatment programs, and mental health and related programs, the purposes of this bill would enable us to further determine the goals and methods for continuation and improvement of our programs consistent with the policy of self-

determination. It would be beneficial for us to be able to apply an automated clinical information system to complement our existing systems and be able to use Federal funds to purchase, lease, license, or provide training for technology for such an application that incorporates clinical, financial, and reporting capabilities for our Indian behavioral health care programs.

With this Bill, we hope that we would be able and empower our Tribes through training and use of technology to significantly enhance the delivery of and treatment results from our behavioral health care programs. It would be even more prudent to be able to get a legislative mandate to related funding agencies to be able to use their resources to assist Tribes in maximizing use of public, tribal, human, and financial resources in developing effective, understandable, and meaningful practices under Indian behavioral health care programs.

Chairman Campbell, members of the Committee, we appreciate your efforts to bring more attention to the Indian Health Community issues and hope that we can continue to be of any assistance to the Committee as you strive to create a more efficient, sovereign and self-determined way of life for the American Indian / Alaska Native Tribes.

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