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S. HRG. 108–127

NOMINATION OF CHARLES GRIM

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

NOMINATION OF CHARLES W. GRIM, TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

JUNE 11, 2003
WASHINGTON, DC

U.S. GOVERNMENT PRINTING OFFICE

87–906 PDF WASHINGTON : 2003

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NOMINATION OF CHARLES W. GRIM

WEDNESDAY, JUNE 11, 2003

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

The committee met, pursuant to notice, at 10:01 a.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senators Campbell, Murkowski, Conrad, and Dorgan.

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

The CHAIRMAN. Good morning, and welcome to the committee's hearing on the nomination of Dr. Charles Grim to be the Director of the Indian Health Service.

Since August 2002 Dr. Grim has been serving as the Interim Director of the Indian Health Service. In March 2003, President Bush submitted his nomination to the U.S. Senate.

Dr. Grim is an enrolled member of the Cherokee Nation of Oklahoma, and, despite his relative youth, has already had quite a distinguished career with the Indian Health Service. In fact, I was reading about some of your latest accolades and awards, Dr. Grim. A dentist, Dr. Grim has been twice awarded the U.S. Public Health Service Commendation Medal and the Achievement Medal. He is the recipient of the Jack D. Robertson Award, which is given to senior dental officers in the U.S. Public Health Service who demonstrate outstanding leadership and commitment. He also currently holds the rank of Rear Admiral as part of the Commissioned Corps of the U.S. Public Health Service.

We have, by the way, received numerous letters regarding this nominee, and every single one of them is very positive. I was very pleased to see that Dr. Grim. These and other letters will be included in the record, and during the next 2 weeks, I imagine we will be getting a few more.

I will also tell the Members that it is not my intention to vote on this nomination at the conclusion of this hearing because we will be doing another hearing right afterwards. But we will schedule a vote on it before the end of the month.

Senator Inouye may not be attending this morning, so we will go ahead. Senator Inhofe, if you would like to introduce Dr. Grim.

STATEMENT OF HON. JAMES M. INHOFE, U.S. SENATOR FROM OKLAHOMA

Senator INHOFE. Thank you, Mr. Chairman. It is my honor to be here. I know that Senator Nickles is planning to be here because I talked to him, so I will stall a little bit while he comes. I would like to say that it is kind of unique that our honoree this morning is from Oklahoma. You can say he is from two cities, Tulsa and Ponca City. As it happens, Tulsa is my home town and Ponca City is Don Nickles' home town. So that is a little bit of a coincidence.

It is very meaningful to me, with the background that Charles has, that he has taken the position. I do not think that you could have a more qualified person to confirm for any position than our nominee today. I think probably the best way for me to introduce him is to read to you a proclamation that makes today a very special day in the State of Oklahoma, and it is actually proclaimed by our Governor who is a Democrat, not a Republican. So, if you would allow me to read this proclamation into the record, I would appreciate it.

The CHAIRMAN. Please do.

Senator INHOFE. Here is Don. I will tell you what I will do. I will go ahead and read this proclamation, and then I will turn it over to Don.

The CHAIRMAN. All right.

Senator INHOFE.

Whereas, Charles W. Grim, DDS, is a native Oklahoman and a member of the Cherokee Nation of Oklahoma; and

Whereas, Dr. Grim, a 1983 graduate of the University of Oklahoma College of Dentistry, has served in the IHS for nearly 20 years and has held several positions, most recently serving as Director of the Oklahoma City Area Office; and

Whereas, in August 2002, President George W. Bush appointed Dr. Grim as the Interim Director of the Indian Health Service, an agency of the Department of Health and Human Services; and

Whereas, on June 11, 2003, the Senate Committee on Indian Affairs will officially confirm President George W. Bush's appointment of Dr. Grim to serve as the Director of the Indian Health Service; and

Whereas, as Director, Dr. Grim will administer a nationwide multi-billion dollar health care delivery program providing preventive, curative, and community health care for approximately 1.6 million of the Nation's 2.6 million American Indians and Alaska Natives.

And as the IHS is the principal Federal health care provider and health advocate for Indian people, I will be working very closely with you, Doctor, as we discussed in my office yesterday, on a pet project I have had for quite some time, and that is Indian diabetes and some of the unique problems that we are facing there.

So it is a great deal of honor for me to second the nomination for Dr. Grim. And I turn it over to my senior Senator, Don Nickles.

The CHAIRMAN. Thank you. Senator Nickles.

STATEMENT OF HON. DON NICKLES, U.S. SENATOR FROM OKLAHOMA

Senator NICKLES. Mr. Chairman, thank you very much. I want to join my colleague, Jim Inhofe, in urging the committee toward a rapid confirmation of Dr. Grim to be the Director of Indian Health Service.

We are very honored, to have an Oklahoman and a member of the Cherokee Nation who has 20 years of experience in Indian

Health Service, a lot of that experience in Oklahoma as well as New Mexico. He graduated from the University of Oklahoma School of Dentistry. He also has a Masters degree in Health Services Administration from the University of Michigan. He now holds the rank of Rear Admiral in the Commissioned Corps of the U.S. Public Health Service. Dr. Grim has 20 years of experience in a lot of different capacities. He has served as Area Director of the Oklahoma City Area Indian Health Service—with a jurisdiction that includes Oklahoma, Kansas, and portions of Texas. He oversaw health services for the largest IHS population in the Nation. He has done an outstanding job. Everyone has told us that, both within the Indian Health Service and others that have had the pleasure of working with him.

I am excited about his nomination. I am excited about his eventual confirmation. And I look forward to working with Dr. Grim and others in this committee to see if we can make positive improvements in Indian health throughout the country. I appreciate the Chairman's commitment for doing that as well. I think we have an outstanding nominee who will do a great job in service to our country and to our Nation's Indian population.

Mr. Chairman, thank you very much.

The CHAIRMAN. I thank you, Senator Nickles and Senator Inhofe, for making that very fine introduction. If you have a busy schedule and need to leave, that is fine. But you are certainly invited to stay as long as you can.

Senator NICKLES. We will leave it in your very capable hands, Mr. Chairman. Thank you.

The CHAIRMAN. Dr. Grim, we will now take your statement. I need to tell you that every letter that we have gotten, as I mentioned before, is in support of your candidacy. You have a very outstanding background. There does not seem to be any opposition at all. We will take your complete statement. But I should tell you that around this place sometimes the longer you talk the more questions arise. [Laughter.]

The CHAIRMAN. So you are welcome to submit your complete written statement that will be included in the record, and if you would like to abbreviate or depart from it, that is fine. Please proceed.

STATEMENT OF CHARLES GRIM, DDS, NOMINEE FOR DIRECTOR OF INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC.

Mr. GRIM. Thank you, Mr. Chairman, Mr. Vice Chairman, other distinguished members of the Committee on Indian Affairs. It is a pleasure and an honor for me to be sitting here before you today as the nominee by President George W. Bush, and supported by tribal governments across the Nation, also endorsed by Secretary Tommy Thompson, and for this committee to consider me as the seventh Director of the Indian Health Service.

For those on the committee and those attending this hearing, I would like to introduce myself. My name is Charles W. Grim. I am a member of the Cherokee Nation of Oklahoma, and I am descended from those who walked the Trail of Tears. I come from the town of Cushing, OK. I am the father of two children, Kristen and

Steven, who are sitting behind me and are here today. My sister, Denise Grim, is also here with me to celebrate this honor. My mother, Ruth Kannady Grim, has also travelled to be with me today and understands how important an occasion this is for me.

The CHAIRMAN. Where is your family, Dr. Grim?

Mr. GRIM. They are right here behind me.

The CHAIRMAN. Very good. Thank you.

Mr. GRIM. We got here early so they could have a front row seat.

The CHAIRMAN. Good. Do not worry, in this committee your mom will always have a front row seat.

Mr. GRIM. I also wanted to mention my father, Charles Grim, who has passed away but whose confidence in me gave me the strength to face moments in life such as this.

As a child, both my parents and also my aunt and uncle, Larry and Dorothy Snake, instilled in me a sense of heritage and culture. With their encouragement and guidance, I grew up knowing my Indian heritage while living in a non-Indian world. As an adolescent, I wanted to work for the Indian Health Service as a way to help Indian people. And after I decided on dentistry as my career field and graduated from dental school, my aunt also encouraged me to work for the IHS as part of my National Health Service Corps educational scholarship pay back requirement.

My first assignment was with IHS at the Indian health center in Okmulgee, OK. Working there was like coming home and fulfilling the dream I had as a teenager to help Indian people. I knew then, and I know now just as strongly, that working for the IHS is part of my life. I cannot imagine being as satisfied or having a sense of reward working anywhere else. To be nominated to lead the Indian Health Service, and to be in a position to do so much for so many Indian people is an unexpected and humbling opportunity, as well as a great honor.

The opportunity to set before you today is the culmination of events put into motion in 1784 with the signing of the first treaty between the Federal Government and an Indian Nation. My ancestors and yours helped build this great Nation and have brought us to this moment and the opportunities before us. I pledge both to the Federal and tribal governments that I will do my best to take full advantage of this opportunity and to work with this committee who has done so much for Indian affairs, the Administration, Secretary Thompson, and tribal governments toward our shared goals and objectives.

I am pleased to serve as the Director of the IHS during this time in our Nation's history and also to be a part of the Department's management team under the leadership of Secretary Thompson as this Department undergoes change to respond to the health needs of all Americans. Through Secretary Thompson's leadership as a key policymaker, I am confident that tribal governments and the position of the Director of the IHS will enjoy new opportunities to be involved in the evolution of their health programs. I will also benefit from the Secretary's policy guidance as I lead the IHS to a position of greater influence within the Department that has been envisioned by the Secretary.

I believe one of the overriding questions of my tenure with IHS would be: How will I meet the challenges of eliminating the dispar-

ity between the health status of American Indians and Alaska Natives and the rest of the Nation? I intend to focus heavily on health promotion and disease prevention. The rates of some health disparities within our population are decreasing, but the rates of most leading causes of death for Indian people remain more than double the rates for the rest of America.

In the early history of the Indian Health Service, the greatest achievements in reducing health disparities were through increased medical care and public health efforts that included massive vaccination programs and bringing safe water and sanitation facilities to reservation homes and communities. I believe future reductions in disparities of any significance will be made through health promotion and disease prevention efforts and programs rather than through treatment. I believe the more we invest in promoting good health the less will be needed for treating the consequences of poor health.

The Indian Health Service has a proud history of dramatically improving the health of Indian people. Indian life expectancy has increased by 7.1 years since 1973, although still 6 years below the general U.S. population. And while significant disparities still exist, mortality rates have decreased for many health indicators, and the greater involvement since the passage of the Indian Self-Determination and Education Assistance Act of 1975 of Indian tribes and Indian people in the decisions affecting their health has also produced significant health improvements for Indian people. I will continue to support the decision of tribes to contract, compact, or retain the Indian Health Service as their provider of choice.

The Indian Self-Determination Act gives tribes the right to manage their own health programs. And the continual increase in the number of tribes electing to contract and compact for IHS programs, and the increased political influence of Indian tribes and organizations at the State and national level are also having positive impacts on health indicators. In addition, this Administration and the Secretary have put their words into action and have increased the involvement of tribal and urban Indian representation in advising and participating in the decisionmaking process of the Department.

Increased tribal involvement has also resulted in the development of an American Indian and Alaska Native workforce. The significance of this is twofold: It is a demonstration of self-determination, but it also improves the health status of Indian people, because it is well known that there is a positive co-relation between employment and health status. For example, 69 percent of the 15,000 employees within the Indian Health Service workforce are American Indian or Alaska Native. And because of the location of many of the IHS and tribal facilities, many are the major employers in the area. So, in addition to salaries, most of the operating funds are spent or invested back into the local and surrounding economies, and in many cases through tribal and Indian community businesses and operations.

I feel we should invest wisely in our communities and in promoting good health. We cannot increase our health promotion and disease prevention programs at the expense of our treatment programs. And without improvements in other areas that affect

health, improvement in health status cannot be sustained. Health status is a result of an interwoven tapestry of factors such as socioeconomic status, educational status, community and spiritual wellness, cultural and family support systems, and employment opportunities, just to name a few. The connection between poverty and poor health cannot be broken just by access to health services or treatment alone.

Based on identified trends in Indian health care, I believe that we must begin to lay the groundwork now for the health environment that we want to have 5, 10, or 20 years down the road. I believe we must focus on identifying the emerging infectious and chronic disease patterns, and the related dramatically increasing cost of pharmaceuticals to treat these illnesses and disease. These issues can best be addressed I believe through health promotion and disease prevention activities so that our people improve their health, which will decrease the demand for both health services and pharmaceuticals.

I have mentioned that my health emphasis will be on health promotion and disease prevention. My business emphasis will be to focus on strengthening the infrastructure of the Indian health system, which consists of the Indian Health Service programs, the tribal, and the urban health programs. Just as the health challenge has changed since 1955 when the IHS was transferred to the Department of Health, Education, and Welfare, so too has the infrastructure needed to meet those new demands. In 1955, our 2,500 employees and annual appropriation of approximately $18 million provided health services for a population of 350,000 people with a life expectancy of 58 years. We have since increased to a staff of approximately 15,000 and an appropriation of $3 billion, supplemented by almost half a billion dollars from our third party collections, which provide limited comprehensive health services for now 1.6 million American Indians and Alaska Natives with an average life expectancy of 71 years.

Our collections have become critical to the solvency of our programs because these funds return to the service unit to pay for additional staff, equipment, or other infrastructure elements to address the health needs of the community. It is among my priorities to implement a market-based business plan that actively promotes innovation. The plan is expected to enhance the level of patient care through increased revenue, reduced costs, and improved business processes. The plan will be implemented as part of the reorganization of the headquarters function that I have also initiated.

Our workforce is another infrastructure element that is in crisis. Our annual average vacancy rate for critical health professions such as doctors, dentists, nurses, pharmacists, sanitarians, and engineers is approximately 12 percent, ranging from 5 percent for sanitarians to a high of 23 percent for dentists. I have initiated a review of the various recruitment and retention tools available to the agency in order to establish a more rigorous recruitment and retention effort. Scholarships, recruitment and retention grants, and health career specific collegiate programs are some of the funded tools that will create a greater pool of potential IHS and tribal employees. Currently, the agency is spending approximately $33 million of our budget on those efforts.

However, nationwide the demand for health care professionals and support staff outpaces the supply available. So to augment our health workforce, particularly for remote and isolated locations that are difficult to staff or do not have sufficient workload to justify an on-site or local facility, the agency will need to continue its efforts to maximize the use of telemedicine and export the use of an electronic health record from the few test sites today to across the IHS network as early as next year.

Another infrastructure issue is the age of the IHS buildings. Excluding housing, the IHS has 701 buildings comparable to private sector health facilities. The average age of our health facility buildings is 36 years, ranging from newly opened facilities this past year to the 103 year old Pawnee Health Center. In the private sector, according to the Almanac of Hospital Financial and Operating Indicators, the average age of a health facility is nine years. Only 20 percent of the IHS facilities fall within this range. To strengthen our efforts to modernize or replace facilities, I have emphasized additional consideration of collaborative projects between the IHS and tribes whenever feasible, and I intend to implement a proactive approach to assist tribes in developing project proposals and expedite the review and approval process.

The Indian Health Service and the tribes and the urban Indian health programs are also not alone in trying to meet the health needs of Indian people. The Department of Health and Human Services is a vast resource as well. As the Secretary has stated numerous times at meetings with the tribes, during visits to Indian country, and to all of the operating divisions of the Department, the programs of the Department must do more to make them work better for American Indians and Alaska Natives and increase consultation with tribes in order to improve the HHS policies and services to Indian communities.

To enact that philosophy, the Secretary revitalized the Intradepartmental Council on Native American Affairs, a council on which the Director of the Indian Health Service serves as the vice chair, by relocating it into the Office of the Secretary from an organizational location two levels down within another HHS component agency. The Secretary has also incorporated consideration of Indian programs into his "One Department" initiative as benefits are derived from that initiative throughout the Department. In previous hearings and in my written statement, I have provided numerous examples of those benefits.

The Secretary's One Department initiative also includes consolidating similar functions within agencies to increase mission effectiveness and economies of scale. I have been asked by this committee in previous hearings whether One Department initiatives would be good for the Indian Health Service and Indian people. I fully support the One Department concept and assure you that IHS and Indian people will benefit. As we gain efficiencies in administrative management areas through consolidations and better use of technology, we will be able to redirect resources to our health care programs. And I can assure you that the Department is working closely with the IHS to assess the impact of consolidation on the programs of the agency and the effect it will have on employees, services, and the economic consequences to our communities.

The discussions we have been holding have been positive. For example, since my last appearance before this committee, the Department has finalized their decision that all IHS human resource employees can remain at their current work sites and continue providing personnel services to our staff, even though the human resource positions convert to HHS positions on October 1, 2003. Our staff can remain in place unless they choose to apply for a position within HHS elsewhere.

We have also been informed by the Department that due to concerns of this committee, due to concerns of tribal leaders, and due to concerns that have been laid out to them about the impact on Indian preference, they are working with us to ensure that for the positions in our field locations Indian preference will still apply to our employees there. I also anticipate that future functional consolidations will also benefit from the close working relationship between the Department and IHS and the considerations of any special needs of their particular programs.

I have heard and share the concerns that Indian programs stand a great risk of being lost or forgotten if they are absorbed into a larger organization and program. So to avoid that, we must be vigilant and provide to others the information they need in order to make wise decisions rather than make decisions based on assumptions. Our financial, personnel, and construction needs and requirements are nothing like any other "inside the beltway" agency. Laws governing self-determination, child protection, Buy–Indian, and Indian preference in hiring, for example, are unique to the Indian Health Service.

The IHS is the only Federal program delivering hands-on care to Indian people based on government-to-government treaties. I have found this Administration and particularly this Secretary and his staff to be receptive to receiving factual information as well as an Indian perspective on the interpretation of laws and regulations. I agree with this committee and the tribes of the Nation that influence within the Department is necessary, and I believe this Secretary has strengthened the position of Director of IHS to increase the degree of influence over the decisions of the Department that impact Indian country.

I also believe now that there is an across-the-board understanding by all the operating divisions that the Department is responsible for the health of all the people of the Nation; that the health of American Indians and Alaska Natives is not the exclusive responsibility of the Indian Health Service, and that the Department's resources and funds need to be directed to this population group.

Today we are facing many challenges. Change and challenge is nothing new to the history of the Nation or to our Indian nations. Our history as a people attests to our ability to respond to challenges, to overcome adversities that we sometimes face, and to maximize our opportunities.

I have a great passion about this organization and our mission to raise the health of our people to the highest level possible. My actions will always reflect the honor of being entrusted to provide health services to American Indian and Alaska Native people. And I think I am ready to lead the Indian Health Service, with honor

and respect for our ancestors, and to work with this committee who, again, has done so much for Indian people, and this Administration and Secretary Thompson for the benefit of American Indian and Alaska Native people.

Thank you, Mr. Chairman. I would be pleased to respond to any questions you might have concerning this nomination.

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

The CHAIRMAN. Thank you, Dr. Grim. Well you hit just about all of the high points of the health of American Indians. You mentioned in one part some small increases in health status with Indians. But you know as well as I do, it might not be quite as bad as it was years ago, I might say it went from terrible to just awful, but it is still bad. I know those who have spent a lot of time on reservations, as I do, in fact all our colleagues here today, and it is not an uncommon sight to see people without legs, you mentioned the terrible, terrible tragedy of diabetes, and that has always been one of my big concerns as it is with many of us.

I was particularly encouraged that you are really trying to get young Indian people involved in the health profession. I think that is just terrific.

You also mentioned the interaction between modern medicine and I think you said "cultural," I sometimes use the word "traditional." I think that is extremely important that we try and learn from the past and recognize that some Indian people, particularly elder Indian people, still have a little concern about modern medicine unless there is some healer or somebody there that they really trust from their own standpoint and their own traditional way of healing.

You also mentioned both tribal and urban programs. I think that is extremely important as more and more people leave the reservation and find themselves in big cities where they are not sure where they are supposed to go and are sometimes turned away from normal urban health centers because people will tell them, "well, you are Indian, you need to go back to your reservation," which may be thousands of miles away and they cannot do it.

You also mentioned the shared reviews with tribes when you are going to make some decisions; sometimes we call that negotiated rule-making. I try to encourage everybody to do more of that because it is a lot easier doing that before than having tribes come in here before the committee afterwards and complain that nobody asked them before they put things in place. So, good luck with that too.

You also mentioned the One HHS proposal. What kind of a reaction are you getting from tribes? I do not think I heard you say that.

Mr. GRIM. The reaction to the One HHS efforts, in general, have been positive. The one that has generated the greatest concern among tribes has been the human resource consolidation effort, as this committee is aware. And as I said, since the last committee hearing I was at, the Department has recognized the issues unique to Indian Health Services and has made a couple of decisions that were not available last time. They are going to be allowing all of our human resource employees to stay where they are in the locations in the field. They also have been working with us since that

decision was made to see if there is a way that we can still allow Indian preference in hiring, and we have got that worked out just this week that all of our HR employees in the field, when we need to rehire them, we will be able to use Indian preference in hiring those positions and then transfer them to the Department at the appropriate time.

The CHAIRMAN. Okay. That is good. Have you had a chance to look at S. 556, the Indian Health Care Improvement Reauthorization Act that I introduced again this year along with Senator Inouye?

Mr. GRIM. Yes, sir.

The CHAIRMAN. What is your initial feeling about that?

Mr. GRIM. I think the overall bill is an outstanding bill, a very voluminous bill.

The CHAIRMAN. I am ready to vote for your nomination right now. [Laughter.]

Mr. GRIM. Maybe I should just stop. [Laughter.]

There are three primary concerns the Administration had. One of them was on the qualified Indian Health program and the ability to be able to effectively manage that from a payment perspective; Medicare and Medicaid issues. Another one was on what appeared to be a broad use of negotiated rulemaking for a lot of the regulations within the act and both the cost and the time factors involved with that. And the third issue was the extension of 100 percent F-map payments to providers other than non–Indian health providers, like to the States and the S-chip programs.

The CHAIRMAN. Well you will be before the committee probably dealing with us on that bill. So I would appreciate any insight you would have to try to make a bill that I think is very, very important a better bill that will be acceptable to tribes and to the Administration. So I look forward to working with you on that.

Mr. GRIM. Yes, sir.

The CHAIRMAN. You mentioned diabetes. I had one particular problem, I think I shared it with you once before, all tribes have problems with it too, as you know, but I get involved in it pretty regularly, frankly, because I go home pretty regularly, and that deals with the Northern Cheyenne diabetes. As you know, they were able to secure dialysis machines sometime ago. Now they tell me the IHS will not or cannot or whatever provide trained medical personnel to operate the machine. And to compound their frustration, in the last round of diabetes funding they received such a small amount that it basically did not help at all. You are aware of that I am sure.

Mr. GRIM. Yes, sir; Mr. Chairman.

The CHAIRMAN. I talked to you a little bit about that. I want to do whatever I can to help you make whatever decisions we need to get machines. They have had a new health clinic building up there now I guess for about 4 or 5 years and people still have to drive all the way to I think Crow or to Billings. They go about 100 and something miles about three times a week back and forth. They spend one-half their time in an automobile just to stay alive and that is not right, people should not have to do that. So I would appreciate you looking into that and trying to help there.

Mr. GRIM. I will, Mr. Chairman.

The CHAIRMAN. Let me now go to the Ranking Member today, Senator Conrad. Do you have an opening statement or any questions?

STATEMENT OF HON. KENT CONRAD, U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Thank you very much, Mr. Chairman. Thank you, Dr. Grim, for being here. We welcome your family, I assume this is your family behind you.

Mr. GRIM. Thank you.

Senator CONRAD. I enjoyed very much our opportunity to visit the other day. You are going into a circumstance that is I think one of the most challenging in Government. If we look at the gap between what is being done and what needs to be done, I do not think there is a bigger gap anywhere in the Federal Government. When I go home and visit with people in Indian country talking about health care, housing, the long list of needs, health care is right at the top of the list of concerns. The budget for Indian Health Service that has been proposed is I think $3 billion; is that correct?

Mr. GRIM. Right at $3 billion.

Senator CONRAD. What do you think it would take to really meet the needs across the country to improve Indian health care? And I say that looking at my own State, seeing in the Aberdeen area the life expectancy is 64.3 years, 71.1 for all Indians in the country, average age nationwide for all parts of our population is almost 77 years. So, 13 years less life expectancy in the Aberdeen area for Native Americans. When we look at disease states, 50 percent more likely to have experienced congestive heart failure—these are Native American elders—44 percent more likely to report asthma, 173 percent more likely to be affected by diabetes. The need is not being met. Would you agree with that?

Mr. GRIM. I think we have prioritized as well as we have been able to, Senator, within the resources we have to focus on some of the highest priority needs, and they are many of the ones you mentioned today—diabetes, unintentional injuries, and on down the line. But we do not have all the resources necessary to treat all of the conditions out there.

Senator CONRAD. In your judgement, how much money would be needed to really meet the need?

Mr. GRIM. There are several studies, well actually one study on personal health care expenditures that was accomplished with tribal leadership and with Indian Health Service, it was done with an outside actuarial firm that provided for personal health care expenditures and compared it to a Blue Cross-Blue Shield Federal employees health benefit package. That particular study showed that for the personal health care expenditures we were a little over $1 billion short of what was necessary. The tribes have also done a needs-based budget and worked closely with the Indian Health Service and with the Department, and including our infrastructure needs which include facilities, and I made some statements earlier and in my written statement about our facilities program, they have come up with a number of $15 billion, $7 billion of that is facilities sorts of needs.

Senator CONRAD. And $8 billion would be for?

Mr. GRIM. The number I cited earlier did not address a lot of the needs around the public health infrastructure—sanitation facilities, safe water and sewer systems, things like that.

Senator CONRAD. Okay. Thank you for that. Let me turn to a specific that I have just learned about that concerns me a great deal. I have been told on the Fort Berthold Reservation the service unit there is prohibited by IHS from ever denying a patient authorization for a procedure that qualifies as a contract health care priority one procedure—that would be life or limb threatening—even if the service unit knows it has or will soon run out of contract health care dollars for the year. Additionally, I have been told that the service unit may not carry over contract health care bills from one fiscal year to the next.

So if a tribal member needs a priority one procedure, the service unit approves it, but when the bill is received after the contract health care funds have been exhausted the IHS simply declares that it is now not a priority one procedure. As a result, IHS no longer has a legal obligation to pay the bill. Responsibility for the bill now falls on the tribal member. Oftentimes, tribal members will not learn until weeks later that they are responsible for the bill. If the tribal member cannot pay the bill, which is unanticipated, their credit rating is damaged.

To your knowledge, is this a IHS policy to reclassify procedures if a service unit has exhausted its contract health care funds?

Mr. GRIM. No, sir; I am not aware that is a national policy at all. There are two types of referrals that I would just raise the issue. We have medical referrals that our medical staff make for any patient that they feel needs a type of service that we are not able to provide. So sometimes medical referrals will be made whether the Indian Health Service has sufficient funds to pay for them or not. Then there are those medical referrals that the Indian Health Service will pay for with contract health service funds and they make every attempt to pay for all of the priority one cases that there are out there.

Senator CONRAD. Do they pay for all the priority one cases?

Mr. GRIM. No; the problem that usually arises is that in some service units across the Nation there are so many needs out there that some of the things that fall into our priority one classification system, there is a letter classification within priority one, A, B, C, D, E, and sometimes even though it falls in priority one, if the moneys are expended, they will have to deny payment for priority one level cases.

Senator CONRAD. Let me ask you the fundamental question. Do you believe it is wrong to, first of all, grant that a priority one case be funded, and then after the fact change it?

Mr. GRIM. If a patient was told upon leaving the facility that their case was going to be paid for, then, yes, I would agree with you.

Senator CONRAD. I would ask you to investigate this matter and report back to us on what you find.

Mr. GRIM. Okay. I will do that.

Senator CONRAD. I take this to be a very serious matter.

Mr. GRIM. I agree.

Senator CONRAD. People are told that they are priority one, that their case is to be funded, and then when they run out of contract health care they as a regular practice reclassify, leaving that Native American hit with a bill that they had no idea they were going to be faced with.

The second question I would have on a specific relates to contract health care, and this relates to something I mentioned to you when we had a chance to meet. Mercy Hospital, Devils Lake, North Dakota, which contracts to provide health care, a small hospital, very good institution, really excellent, very highly rated care, has written off more than $1 million in the last 4 years. What sort of changes would you pursue in contracted health care to prevent this kind of ongoing drain? This is a small institution. They cannot handle providing care and then having the payment denied. I cannot tell you how many meetings I have had with your predecessors on this issue. Over and over and over I have been promised that something is going to be done and they go back and they make a few payments and then we are right back in the soup. What can you tell me that you would do.

Mr. GRIM. I am happy to be able to report to you that just since our meeting the other day we have already had some action on that. Our staff out in that location as well as the Area Director have looked into it and met with staff from Mercy. The Area Director there is going to be looking into talking with them about a different sort of contract than we have had with them in the past, potentially a capitation based contract. So that in advance for so many people and certain types of services, Mercy would know how much money they were going to receive, our patients would know what sort of services would be available through the referral process there. So, it is a very unique sort of process, it is not used in very many places, but they are going to approach them and see if that might be amenable to the leadership there at Mercy.

Senator CONRAD. I welcome that initiative and I thank you for thinking outside the box.

The final question I would have, immediately following this hearing the committee will receive testimony on legislation Senator Dorgan and I have authored to authorize a rural health facility for the Three Affiliated Tribes at Fort Berthold. This legislation fulfills a long-standing promise made by the Federal Government to replace the hospital that was destroyed by the construction of the Garrison Dam and Reservoir. If the authorization passed, would you ensure that this facility is placed on the construction priority list the Indian Health Service is currently formulating?

Mr. GRIM. Based on how the legislation is worded, Senator, we would adhere to the legislation.

Senator CONRAD. I thank you for that. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Conrad. Before I yield to Senator Murkowski, let me tell you that I agree with Senator Conrad that we are never going to fix the problem if we are going to focus just totally on bandaging, giving drugs, operating, and so on. That is all what you do after the problem has happened. And I am very happy to hear that you also believe in prevention as part of the big medicine picture. Because although there might be some

problems in Indian health that are genetic, I do not know, or some based on infrastructure with poor water and so on, an awful lot of it has to do with lifestyle. Asthma is related to stress as well as other things. I am not a doctor but I know that from my readings. Diabetes is related to diet. And I have yet to see people who have to live on commodities call that a balanced diet. Heart disease is related to obesity and cholesterol. Dental problems are related to oral hygiene. It just seems to me that if we would put more emphasis toward prevention, we would have a much better and more efficient use of the money that we have to appropriate and spend on Indian health.

I might mention that some tribes are really taking a lead on that. I happen to live on the Southern Ute Reservation in Colorado. They just recently built a building that is used for a lot of things, as a community center, it also has a gymnasium, but the interesting part of it is that they give cooking classes and also lifestyle counseling classes on diet. And if you have not had a chance to visit that, I would recommend you do. It is a wonderful facility, widely used. In fact, the tribe has opened it up to non-Indians too. So there are a lot of people around the community that take advantage of it due to the tribe's good graces. So please come and see that.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

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

Welcome, Dr. Grim. I appreciate your comments this morning, appreciate the opportunity to speak with you yesterday and in the previous opportunities we have had to meet. I suppose the good word coming from my State is there is an endorsement, certainly an enthusiastic response toward your nomination. So I am pleased to be able to speak to that support today. The word that I hear back from Alaska is that you are a good listener.

Mr. GRIM. Thank you.

Senator MURKOWSKI. I think that speaks a lot. And if you listen well to the concerns and are willing then to implement afterwards, I think we all win.

I am particularly pleased to hear your emphasis on health promotion and disease prevention. As you know, in Alaska we have very serious challenges when it comes to the health needs of our Alaska Natives. We have some statistics that, unfortunately, are off the charts when it comes to rates of alcoholism. We have seen recently a huge increase in smoking by Native women who are pregnant and we are seeing lower birth rates. We are seeing more children born with FAS/FAE. We have suicide rates that are absolutely unacceptable. The chairman has mentioned diabetes, the obesity issues. Many of these, many of these we can be more proactive.

One of the problems that we face in many of the Native communities out in the bush is we have got terrible dental problems. Part of it is because of the lack of professionals out there. Another part is we have basic infrastructure issues. We do not have the safe water, and so instead of children even drinking powdered milk,

they cannot do that because the water is not safe, and we cannot get the fresh milk in because of transportation issues, so the kids are drinking pop and their teeth are rotting.

We need to work with our communities on that. We need to work to push the prevention issues. So I am pleased to assist you with that initiative because I think if we work the prevention end, your job is made just that much easier in terms of the health services that are provided for those in my State. So I look forward to working with you on that and so many of these others.

I will extend the invitation, I know you are coming up to the State this summer, and look forward to the opportunity to introduce you to many of our areas, some of our challenges, and, hopefully, many of our opportunities. I do not know whether it is in the Administration's kind of spot light, if you will, to elevate this position as Director to perhaps an Assistant Secretary level, but perhaps you would be the first so named. If that is the case, I think we in Alaska would be very supportive.

I do not have any questions for you today but just wanted to state for the record that we are looking forward to working with you on the health issues that relate to the Alaska Natives as well as all Native Americans.

Mr. GRIM. Thank you, Senator Murkowski.

The CHAIRMAN. Senator Dorgan, did you have any comments or questions?

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

Senator DORGAN. Mr. Chairman, because of the time, we want to get on to the bill that is the subject of the next hearing. We have an 11:15 vote. So I think I will not ask questions. Dr. Grim, I am going to be supportive of your nomination. I think you have very strong credentials. I am very pleased by your nomination and I want you to succeed.

Mr. GRIM. Thank you, Senator.

Senator DORGAN. My colleague Senator Conrad asked the questions I would have asked. But let me just make a comment, if I might. You indicated that the allocations for the IHS within the amount of money that is available are the best that we can do and you are trying very hard. I understand all of that. But in both Democrat and Republican Administrations the IHS budgets have not been sufficient to meet the health care needs of Native Americans. The mortality in Indian country compared to the rest of the country, for example, is seven times higher as a result of alcoholism, it is five times higher as a result of tuberculosis, four times higher as a result of diabetes—on the Fort Berthold Reservation that is 12 times higher due to diabetes—3 times higher due to injuries, twice as high due to suicides, twice as high due to homicides.

The fact is we face an enormous challenge and it is very serious. And the thing that angers me a bit is this: As you get up in the morning and get ready for work, you turn on the radio and listen to the news and you hear that this country has $26 billion to try to persuade Turkey to allow our troops to enter Iraq from the North. And I am thinking to myself, where did the $26 billion come from? We cannot find a half a billion dollars or a billion dollars to

address life and death issues dealing with health care for Native Americans, all of a sudden we have got $26 billion for Turkey. And I see that time after time after time. It is a matter of priorities.

We have got a reservation in North Dakota. Dr. Grim, you are a dentist, so you will particularly understand this. One dentist is serving 4,000 people out of a trailer house. That is not health care. That is not appropriate. On that same reservation, there are the same batch of problems with inadequate funding in social services, with life and health consequences. A young girl named Tamara is beaten severely, nose broken, arm broken, hair pulled out at the roots. Why? Because she was put in a foster care situation by one person, a social worker, who was working 150 cases—150 cases. So they put this young 3 year-old girl into foster care and she is beaten severely. It will affect her the rest of her life. Why? Because we did not have enough money to have enough caseworkers to make sure we protected these young children.

This is not about you, but I get angry about the priorities here in our country. We say we do not have the money to deal with these issues. You know, you just answered my colleague when he asked the question about how much is needed. You know we are desperately short of money for health care for Native Americans. We are desperately short of money. And it is not sufficient for a Democratic Administration or a Republican Administration to say we are doing the best we can allocating money within our resources. The fact is they find resources, every Administration does, for the things they care about. And we all ought to care about the fact that a grandmother freezes to death in this country on the Rosebud Reservation in her home without windows in the winter at 35 below zero—freezes to death in her home. Or a young child is beaten severely, or someone shows up for health care with a sick child someplace or a severe dental problem and the fact is they do not get the kind of health care they need.

So, I have said my piece. I preceded it by saying I am pleased that you are nominated. I am going to be proud to support your nomination. I will be happy to vote for you. But we need to do better, all of us, you, me, my colleagues, the President. These are priorities.

Mr. Chairman, I think my colleague asked the very important questions I would have asked as well. Thank you for holding this hearing.

Dr. Grim, you are going to be confirmed by the Senate and then all of us are going to wish you well. We want to work with you to make you successful in this job.

Mr. GRIM. Thank you, Senator Dorgan. And thanks to all of this committee and their support. You have done a lot for Indian people over the years and I am honored to be working with you.

The CHAIRMAN. Thank you, Dr. Grim.

[Whereupon, at 10:47 a.m., the committee proceeded to other business.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF CHARLES W. GRIM, D.D.S., DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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

It is a pleasure and an honor for me to have been nominated by the President, supported by tribal governments across the nation, endorsed by Secretary Thompson, and for this committee to consider me as the seventh director of the Indian Health Service.

The opportunity to sit before you today is the culmination of events put into motion in 1784 with the signing of the first treaty between the Federal Government and an Indian Nation. My ancestors and yours helped build this great nation and have brought us to this moment and this opportunity. I pledge to both the Federal and tribal governments that I will do my best to take full advantage of this opportunity and to work with this committee, the Administration, and Tribal Governments toward our shared goals and objectives.

For the benefit of guests of this committee and future researchers of the Congressional Record, this is the description of the Indian Health Service today: The IHS has the responsibility for the delivery of health services to approximately 1.6 million federally recognized American Indians and Alaska Natives [AI/ANs] through a system of IHS, tribal, and urban operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population we serve. The agency goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal Government's obligation to promote healthy AI/AN people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

For those on the committee and those attending this hearing, I would like to introduce myself. I am Charles W. Grim. I am a member of the Cherokee Nation of Oklahoma. I come from the town of Cushing, Oklahoma. I am descended from those who walked the Trail of Tears. I am the father of two children, Kristen and Steven, who are here with me today. My sister, Denise Grim, is also here to celebrate this honor. My mother, Ruth Kannady Grim, who has also traveled to be with me today, understands how important an occasion this is for me. I would also like to mention my father, Charles Grim, who has passed away but whose confidence in me gave me the strength to face moments in life such as this. As a child, both my parents, and also my aunt and uncle, Larry and Dorothy Snake, instilled in me a sense of my heritage and culture. With their encouragement and guidance, I grew up knowing my Indian heritage while living in a non-Indian world. As an adolescent, I wanted to work for the Indian Health Service as a way to help Indian people. And after I decided on dentistry as my career field and graduated from dental school, my aunt also encouraged me to work for the IHS as part of my National Health Service Corps educational scholarship pay back requirement. My first assignment with the

IHS was at the Indian health Center in Okmulgee, Oklahoma. Working there was like coming home and fulfilling the dream I had as a teenager to help Indian people. I knew then and I know now, just as strongly, that working for the Indian Health Service is a part of my life. I cannot imagine being as satisfied or having such a sense of reward working anywhere else. To be nominated to lead the Indian Health Service, and to be in a position to do so much for so many Indian people, is an unexpected and humbling opportunity, as well as a great honor.

In addition to my personal connection and desire to lead the agency, I am a Doctor of Dental Surgery and I have a Masters degree in Health Services Administration with focus on the Management and Administration of health services, dental care, and hospital and ambulatory care. I have served with the U.S. Public Health Service for 20 years—through assignments to various offices and programs of the Indian Health Service. I am ready to take on the job of Director of the Indian Health Service.

I believe the overriding question is: How will I meet the challenge of eliminating the disparity between the health status of AI/ANs and the rest of the nation? I intend to focus on health promotion and disease prevention. The rates of some health disparities are decreasing, but the rates of most leading causes of death for Indian people remain more than double the rates for the rest of America—for accidents, the rate for Indian people is 280 percent of the rate for the general U.S. population; for alcoholism, 770 percent; for diabetes, 420 percent; for homicide, 210 percent; and for suicide, 190 percent. The number of AI/ANs enduring end stage renal disease is 2.8 times the rate for whites. The rate of diabetic end stage renal disease for AI/ANs is 6 times the rate for the rest of the nation. Amputations due to circulatory consequences of diabetes have decreased significantly, but still occur at rates 3 to 4 times the rates for the rest of the nation. And the tragedy of Sudden Infant Death Syndrome (SIDS) and adolescent suicide occurs within Indian families at more than twice the rate for other families.

In the early history of the Indian Health Service, the greatest achievements in reducing health disparities were through increased medical care and public health efforts that included massive vaccination programs and bringing safe water and sanitation facilities to reservation homes and communities. I believe future reductions in disparities of any significance will be made through health promotion and disease prevention efforts and programs rather than through treatment. To continue on a treatment track alone would bankrupt the nation's health system, including the IHS. For the Indian health system as well as all the United States health programs, there is no practical way the health resources of this great nation can begin to meet the health demands of an aging population whose chronic health conditions are largely the result of a western diet and sedentary lifestyle.

For example, while the mortality rate for Indian people due to diabetes is 420 percent of that for the rest of the nation, the occurrence of Type 2 diabetes is 2.6 times the national average, and it is rising faster among American Indians and Alaska Native children-and young adults than in any other population group but with minimal changes in diet and exercise, such as reducing body weight by 10 pounds and walking 30-minutes a day—the onset of diabetes can be delayed and, in some cases, can be prevented.

Cardiovascular disease is now the leading cause of mortality among Indian people, with a rising rate that is already almost double that of the U.S. general population; but by modifying or eliminating health risk factors such as obesity, sedentary lifestyles, smoking, high-fat diets, and hypertension, that trend can be reversed.

Another example, infant mortality in Indian country can be reduced by 25 percent—25 percent—as more parents understand that placing their infants on their back to go to sleep removes one of the major risks for SIDS.

And we need to invest in our communities so that despair does not fill the lives of our children. The rate of suicide among Indian youth is twice that for the general population. There are many programs, not just those of the Indian Health Service, which can be implemented to reduce or eliminate the number of our children who are killing themselves.

I believe the more we invest in promoting good health the less will be needed for treating the consequences of poor health. The Indian Health Service has a proud history of dramatically improving the health of Indian people. And the greater involvement, since the passage of the Indian Self-Determination and Education Assistance Act in 1975, of Indian tribes and Indian people in the decisions affecting their health has also produced significant health improvements for Indian people: Indian life expectancy has increased by 7.1 years since 1973 (although still 6 years below the general U.S. population) and while significant disparities still exist, mortality rates have decreased for maternal deaths, tuberculosis, gastrointestinal dis-

ease, infant deaths, unintentional injuries and accidents, pneumonia and influenza, homicide, alcoholism, and suicide.

I will continue to support the decision of tribes to contract, compact, or retain the Indian Health Service as their provider of choice.

In a study of indigenous people and their health, cited in the British Medical Journal (March 2003), it was noted that lack of self-governance, if allowed to continue, can have a devastating impact on health indicators. The Indian Self-Determination Act gives tribe the right to manage their own health programs. The continual increase in the number of tribes electing to contract and compact for Indian Health Service programs and the increased political influence of Indian tribes and organizations at the state and national level, are having a positive impact on health indicators. In addition, this Administration and the Secretary have put their words into action and increased the involvement of tribal and urban Indian representation in advising and participating in the decisionmaking processes of the Department.

Increased tribal involvement also results in the development of an AI/AN workforce—for example, 69 percent of the 15,000 employee Indian Health Service workforce is AI/AN and, excluding the medical professional employees where there is not a large Indian applicant pool, 88 percent of the IHS workforce is American Indian or Alaska Native. The tribal and urban Indian operated programs have similar to, or higher, Indian workforce participation rates than the IHS. Because of the location of many of the IHS and tribal facilities, many are the major employer in the area. So, in addition to salaries, most of the operating funds are spent or invested back into the local and surrounding economies, in many cases through tribal and Indian community businesses and operations.

We should invest wisely in our communities and in promoting good health. We cannot increase our health promotion and disease prevention programs at the expense of our treatment programs. And without improvements in other areas that affect health, improvement in health status cannot be sustained. Health status is the result of an interwoven tapestry of factors such as socioeconomic status, educational status, community and spiritual wellness, cultural and family support systems, and employment opportunities, to name a few. The connection between poverty and poor health cannot be broken just by access to health services or treatment alone.

Based on identified trends in Indian healthcare, I believe we must begin to lay the groundwork now for the health environment we want to have 5, 10, or 20, years down the road. I believe we must focus on identifying emerging infectious and chronic disease patterns, and the related dramatically increasing cost of pharmaceuticals to treat illness and disease. These issues can best be addressed through health promotion and disease prevention activities, so that our people will improve their health, which will decrease the demand for health services and pharmaceuticals.

Preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute and chronic care and expensive treatment processes. It also yields the even more 11 important humanitarian benefit of reducing pain and suffering and prolonging life.

I have mentioned my health emphasis will be on health promotion and disease prevention. My business emphasis will be to focus on strengthening the infrastructure of the Indian health system—the Indian Health Service program and the tribal and urban Indian programs. The infrastructure supports a very comprehensive public health and clinical services delivery program, including such diverse elements as water and sewage facilities, diabetes prevention and wellness programs, emergency medical services, and organ transplants. The IHS is the largest holder of real property in the Department with over 9 million square feet of space. There are 49 hospitals, 231 health centers, 5 school health centers, and 309 health stations, satellite clinics, and Alaska village clinics that support the deliver of health care to our people.

Just as the health challenge has changed since 1955 when the IHS was transferred to the Department of Health, Education, and Welfare; so too has the infrastructure needed to meet those new health demands. In 1955, our 2,500 employees and annual appropriation, of approximately $18 million (or $124 million in today's dollars), provided health services for a population of 350,000 with a life expectancy 58 years. We have since increased to a staff of approximately 15,000 and an appropriation of $3 billion, supplemented by almost half a billion dollars from our third-party collection efforts, which provides limited comprehensive health services for 1.6 million AI/ANs with an average life expectancy of 71 years.

Our collections are critical to the solvency of our programs because these funds return to the service unit to pay for additional staff, equipment, or other infrastructure elements to address the health needs of that community. It is among my prior-

ities to implement a market-based business plan that actively promotes innovation. The plan is expected to enhance the level of patient care through increased revenue, reduced costs, and improved business processes. I have been involved with this plan, developed through a joint IHS-Tribal-urban Indian workgroup, since I served as the IHS cochair of the workgroup when I was the Oklahoma Area Director. The plan will be implemented as part of the reorganization of the Headquarters functions that I have also initiated, and will mention later in my statement, in order to also strengthen our support for infrastructure development.

Our workforce is another infrastructure element that is in crisis. Our annual average vacancy rate for critical health professions such as doctors, dentists, nurses, pharmacists, sanitarians, and engineers is approximately 12 percent, ranging from 5 percent for sanitarians to a high of 23 percent for dentists. I have initiated a review of the various recruitment and retention tools available to the agency in order to establish a more rigorous recruitment and retention effort. Scholarships, recruitment and retention grants, and health career specific collegiate programs are some of the funded tools that will create a greater pool of potential IHS and tribal employees. However, nationwide the demand for healthcare professionals and support staff outpaces the supply. To augment our health workforce, particularly for remote and isolated locations that are difficult to staff or do not have sufficient workload to justify an onsite or local facility, the agency will need to continue its efforts to maximize the use of telemedicine and export the use of an electronic health record from the few test sites today to across the IHS network as early as next year.

Another infrastructure issue is the age of the IHS buildings. Excluding housing, the IHS has 701 buildings comparable to private sector health facilities. The average age of our health facility buildings is 36 years, ranging from newly opened facilities this past year to the 103 year old Pawnee Health Center. In the private sector, according to The Almanac of Hospital Financial and Operating Indicators, the average age of a health facility is 9 years. Only 20 percent of the IHS facilities fall within this range. To strengthen our efforts to modernize or replace facilities, I have emphasized additional consideration of collaborative projects between the IHS and tribes whenever feasible, and I intend to implement a proactive approach to assist tribes in developing project proposals and expedite the review and approval process.

The Indian Health Service and the tribes and urban Indian health programs are not alone in trying to meet the health needs of Indian people—the Department of Health and Human Service is a vast resource as well. As the Secretary has stated numerous times at meetings with the tribes, during visits to Indian country, and to all of the operating Divisions of the Department—the programs of the Department must do more to make them work better for AI/ANs and increase consultation with tribes in order to improve the HHS policies and services to Indian communities. To enact that philosophy, the Secretary revitalized the Intra-departmental Council on Native American Affairs, a Council on which the Director of the Indian Health Service serves as the Vice-Chair, by relocating it into the office of the Secretary from an organizational location two levels down within another HHS component agency. The Secretary has also incorporated consideration of Indian programs into his "One Department" initiative as benefits are derived from that initiative throughout the Department. For example; I have had the privilege of participating in the Intra-departmental Council and the "One Department" initiative since my appointment last August by the President as the Interim Director of the Indian Health Service.

Some of the benefits to Indian country have been the establishment, as one of the four top research priorities of the Department, the identification of the research needs in Indian health and the conducting of such research; a proposed increase in the IHS sanitation facilities construction program of $21 million and the contract health services program of $18 million for Fiscal Year 2004; expanding the responsibility of the office of Intergovernmental Affairs to increase access of tribes to the Secretary and his regional staff; and a review of HHS programs to determine which programs tribes are accessing and what can be done to help tribes access more programs.

The Secretary's "One Department" initiative also includes consolidating similar functions within agencies to increase mission effectiveness and economies of scale. I have been asked by this committee in previous hearings whether "One Department" initiatives would be good for the Indian Health Service and Indian people. I fully support the "One Department" concept and assure you that IHS and Indian people will benefit. As we gain efficiencies in administrative management areas through consolidations and better use of technology, we will be able to redirect resources to our health care programs. I can assure you that the Department is working closely with the IHS to assess the impact of consolidation on the programs of

the agency and the affect it will have on employees, services, and the economic consequences to our communities. Those discussions have been positive.

For example, since my last appearance before this committee, the Department has finalized their decision that all IHS human resource employees can remain at their current work sites and continue providing personnel services to our staff—even though the human resource position converts to HHS positions on October 1, 2003. Our staff can remain in place unless they choose to apply for an HHS position elsewhere. I anticipate that future functional consolidations will also benefit from the close working relationship between the Department and IHS and their considerations of any special needs of our particular programs.

I have heard and share the concerns that, Indian programs stand a great risk of being lost or forgotten if they are absorbed into larger organizations and programs. To Avoid that we must be vigilant and provide to others the information they need in order to make wise decisions rather than make decisions based on assumptions. Our financial, personnel, and construction needs and requirements are nothing like any other "inside the beltway" agency. The laws governing self-determination, child protection, Buy-Indian, and Indian preference in hiring, for example, are unique to the Indian Health Service and expertise with those laws and our programs will be exported through efforts of Departmental consolidation and I believe that the more Indian people and employees with IHS expertise who are dispersed throughout the Department at all levels, the more likely the "One Department" goal of raising the health status of AI/ANs and eliminating health disparities for all Americans can be achieved.

The IHS is the only Federal program delivering hands-on care to Indian people based on government-to-government treaties. I have found this Administration and particularly this Secretary and his staff to be receptive to receiving factual information as well as an Indian perspective on the interpretation of laws and regulations. I agree with this committee and the tribes of the Nation that influence within the Department is necessary. And I believe this Secretary has strengthened the position of Director of the Indian Health Service to increase the degree of influence over the decisions of the Department that impact Indian country.

I believe that now there is an across-the-board understanding by all the Operating Divisions that the Department is responsible for the health of all the people of the nation; that the health of AI/ANs is not the exclusive responsibility of the Indian Health Service, and that their resources and funds need to also be directed to this population group. "One Department" is not the only restructuring effort being undertaken within the Department that affects the Indian Health Service. The IHS and tribes are also working together to restructure the agency. Even before there was the "One Department" initiative, the Indian Health Service entered into an IHS Restructuring Initiative with the tribes and urban Indian representatives. Their recommendations focused on the functions and operations of the agency at the Area Office and field level based on projected health challenges the agency may face in the future. I remain committed to that consultation process and will review the recommendations of the joint workgroup.

In addition to the IHS Restructuring Initiative and the "One Department" initiative, upon my interim appointment I established some short-term management priorities to improve the responsiveness of the agency to the tribes and to the Department. I mentioned some earlier, and also among them was a reorganization of the IHS Headquarters functions. This process, including Tribal consultation, is ongoing and is designed to reflect the restructuring recommendations of the tribes, the "One Department" initiative of the Department, the President's management agenda, and the day-to-day management and operational demands of the $3.5 billion Indian health program.

And, it is not just the Department, the tribes, or the agency calling for change. It is also this committee and the Congress. I agree with the Secretary when he says, about the Department: "Any organization that does business the same way it did 35 years ago is obsolete." That applies to the Indian Health Service—the reauthorization of the Indian Health Care Improvement Act is currently under consideration by this committee. It was passed 28 years ago—but we do not need to wait until 35 years have passed to realize that the health needs of AI/ANs, much less the world, have dramatically changed over time. The proposed language of the Act outlines a restructuring of the authorities of the Indian Health Service to reflect the reality that changes in the health care environment have changed the ability of tribes, urban Indian health programs, the Indian Health Service, and the Department to deliver high quality and much needed services. The Department supports the purposes of the reauthorization of the Act, but has concerns that are valid and deserve further consideration. Just as the concerns of the tribes and this committee

toward consolidation and internal reorganization of the agency are valid and need to be addressed.

Today we are facing many challenges. Change and challenge is nothing new to the history of the Nation or to Indian nations. Our history as a people attests to our ability to respond to challenges, to overcome adversities that we sometimes face, and to maximize our opportunities.

I have great passion about this organization and our mission to raise the health of our people to the highest level possible. My actions will always reflect the honor of being entrusted to provide health services to American Indian and Alaska Native people. I am ready to lead the Indian Health Service, with honor and respect for our ancestors, and to work with you and the Administration for the benefit of American Indian and Alaska Native people.

I am pleased to respond to any questions you may have concerning my nomination.

Thank you.

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