S. HRG. 107–103

INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

ON

THE INDIAN HEALTH CARE IMPROVEMENT ACT FOCUSING ON PERSONNEL ISSUES AND URBAN INDIAN HEALTH CARE PROGRAMS

JULY 31, 2001
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INDIAN HEALTH CARE IMPROVEMENT ACT

TUESDAY, JULY 31, 2001

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

The committee met, pursuant to notice, at 10:05 a.m. in room 485, Russell Senate Building, Hon. Daniel K. Inouye (chairman of the committee) presiding.

Present: Senators Inouye, Conrad, and Campbell.

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. The committee meets this morning to receive testimony on the challenges confronting the Indian Health Service, privately-administered health care programs, and urban Indian health care programs with regard to recruiting and retaining health care professionals today and in the years ahead.

Today's hearing will also address the challenges confronting the urban Indian health care programs as they address the health care needs of Indian people residing in urban areas—a population which now represents 60 percent of the total population in Indian country.

The committee is pleased to welcome the witnesses. We look forward to your testimony.

Before we do, I am pleased to call upon our vice chairman.

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

Senator CAMPBELL. Thank you, Mr. Chairman.

In the 106th Congress the committee held four hearings on various parts of S. 212, and today we will continue with that series of hearings. This bill would reauthorize the Indian Health Care Improvement Act, the core act that authorizes the majority of Indian health programs.

We have both said many times in the past Mr. Chairman, the American Indians and Native Alaskans continue to suffer the worst health status of any group in America. Since 1976 this act has been a powerful tool in helping tribes and the IHS change the health status of Native populations for the better. Since the initial passage of the act, the death rate among the Native population has decreased in all categories, and the provision of health services has

improved overall. I believe S. 212 will put us on the right path of achieving the goals that we first set out to accomplish in 1976.

Today we'll discuss an issue of growing concern to me, and that's the provision of health care for our urban Indian population. Over one-half of our Indian population lives off-reservation, most of them in urban areas, and yet funding for the urban programs in the IHS system is still only 1.14 percent of the entire IHS budget and has remained stable for the last 3 years, even though the urban Indian population is growing.

Today we'll also look at the personnel programs of IHS. One of the purposes of the Health Care Improvement Act was to increase the number of Native people who enter this profession. I think the act has already helped many individuals enter the profession, but I also think we need to look more closely to see if we are doing all we can do to attract more Indian people, as well as other dedicated health professionals, in the Indian Health Services.

I look forward to the hearing, Mr. Chairman. Thank you for calling it.

The CHAIRMAN. I thank you very much.

Our first panel consists of the following: The acting chief medical officer, Office of the Director, Indian Health Service, Department of Health and Human Services, Dr. William C. Vanderwagen; the director of the Natural Resources and Environment, General Accounting Office, Barry T. Hill, and he will be accompanied by Jeffrey Malcolm, senior evaluator, Natural Resources and Environment; and the president of the American Public Health Association, Michael Bird.

I am pleased to call upon Dr. Vanderwagen. Welcome.

STATEMENT OF WILLIAM C. VANDERWAGEN, ACTING CHIEF MEDICAL OFFICER, OFFICE OF THE DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Mr. VANDERWAGEN. Thank you, Mr. Chairman, and good morning to you. It is so good to see you here.

We appreciate greatly the committee taking the time to review with us the issues of concern to the committee and to Indian people with regards to Indian health manpower and the needs of urban Indian people.

I have a prepared statement which I would ask to be entered into the record.

The CHAIRMAN. Without objection, so ordered.

Dr. VANDERWAGEN. Thank you, sir.

As both you and the vice chairman have noted, sir, the health status of Indian people still lags well behind that of the general U.S. population. Diabetes is at least four-fold what it is in the general population, alcoholism is seven-fold what it is in the general population, et cetera.

The Congress has given us what I view to be a very sacred mission, and that is to elevate the health status of American Indians and Alaska Natives to the highest possible level and develop the capacity of Indian communities to manage and direct their own health care systems.

Today, as we talk about manpower, I think the issue of have we discharged that responsibility with some success around building local capacity is what we would like to talk with you about. We believe there are clear indicators of success.

For example, in the ITU setting—that is, in the Indian Health Service, tribal, and urban programs—and we are a health system now that encompasses those three facets—Federal, tribal, urban—75 percent of the staff in those organizations are Indian people, and it is because of the scholarship program, it's because of the CHR program.

I like to believe that the woman who 30 years ago became a CHR supported her daughter through the scholarship program to become an RN, and now her daughter is attending medical school, and we've seen that kind of change in the development of professional skills and capacities in the Indian communities. We think that is good public health. It strengthens those communities and their ability to take care of issues.

We've also had a variety of other opportunities provided to us in terms of how we approach recruitment and retention. Today we have with us here in this audience a number of folks who are working with Indian Health Service this summer. They are future leaders in Indian health. Some of them are wearing uniforms. They came to the co-step program. We have two medical students from the Uniformed Services University here. We have students in the undergraduate area who are here courtesy of the Washington Internship for Native Students at AU. We have people who are here because of the externship program that we have available to us under the Indian health manpower authorities. These are the future leaders of Indian health. So we believe there has been success in developing Indian people's capacity to manage and deliver their own health system.

There are still recruitment issues to be addressed. Using the loan repayment authority provided, we have been able to expand the number of individuals, professional individuals that we are able to bring to Indian country to assist us in meeting these health challenges of diabetes, of alcohol, and other issues. This would include podiatrists, pharmacists, nurses, dentists, physicians. We continue to have vacancy rates that exceed the general population. Our physician-to-population ratio still exceeds 1-to-1,000, compared to, say, the District, where it is 1-to-250. So we still have recruitment challenges to address.

We have significant retention challenges, as well. The difficulty in being isolated, cultural transition, and dealing with a system that is severely rationed does lead to turnover, and, in fact, those vacancy rates that I mentioned earlier in some measure are reflective of those issues.

The average tenure of our staff is less than we would like it to be. Physicians stay on average 8 years. Nurses stay on average 12 years. We'd like to see them for a whole career. That is a challenge that we have in front of us yet in manpower recruitment and retention.

The urban programs are a significant concern to us in the agency. In the last 5-to-7 years, under the leadership of our director, Dr. Trujillo, we have taken the approach that I mentioned earlier—

that we are the Federal, the tribal, and the urban programs that are a health system for delivery of health services to Indian people.

As Mr. Campbell noted, significant increases in urban population are confronting us, in part because cities have now grown to reservation boundaries. Albuquerque can no longer grow north, west, or south, because they have reached reservation boundaries. And, in fact, those Indian people who live on those reservations are now urban Indians in that they live within an SMSA. On the other hand, the population that was moved in the 1950's and their children and grandchildren has expanded significantly, as well. So there are real issues to address in meeting the health needs of urban people.

While we talk about health statistics in Indian populations, we don't have the data we need to fully understand the specific issues that affect urban Indian people. We have only now, in the last 1½ years, established an epidemiology center with a focus on health needs of urban Indian people. The data needs are large for trying to understand where the issues are and how we can best address them, and that's a task that we're taking on in consultation with urban people.

Urban Indians have been included fully in the consultation process around budget allocation. They have been included in the budget formulation process. We will continue to include them as active partners in this health system for Indian people, and we believe that they are active and viable partners.

I would be remiss if I didn't note that most of those programs, on average only about one-third of their funding comes through the Federal sector funded by Indian Health Service. A significant amount of their funding comes from other Federal programs and State and county programs, as well. They have been very successful at surviving and expanding their programs. I will give you but one example.

In Los Angeles County, a 400-square-mile area, the Indian population is diffusely scattered throughout that area. The approach that has been developed is a managed care approach with case managers, since there's really no focused population of urban people, and these case managers work with individual urban people to identify the best care locations for those people, whether they're in the northeast corner of the county or they're in the southwest corner of the county, and it has been a very successful program.

Because of unique needs in behavioral health, the State and county, and particularly the county of Los Angeles, have now helped that clinic start an active outpatient behavioral health program. They just opened it 5 months ago. One-half of the county commissioners appeared at the opening of this program, and it is a testimony to the resourcefulness of those Indian people in L.A. as to the quality of the job that they have been able to do.

There are real challenges, and we appreciate the opportunity to be here today, and I'll be happy to answer any questions you may have as the hearing progresses.

Thank you.

The CHAIRMAN. I thank you very much, Doctor.

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

The CHAIRMAN. May I now call on Mr. Hill.

STATEMENT OF BARRY T. HILL, DIRECTOR, NATURAL RESOURCES AND ENVIRONMENT, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY JEFFERY MALCOLM, SENIOR ANALYST

Mr. HILL. Thank you, Mr. Chairman. It is certainly a pleasure for Mr. Malcolm and me to appear before this committee. We're here today to discuss the issue of Federal tort claims coverage for tribal contractors, and my comments this morning will focus specifically on the FTCA coverage and claims history for tribal self-determination contracts at the Indian Health Service.

If I may, I'd like to briefly summarize my prepared statement and submit the full text of my statement for the record.

The CHAIRMAN. Without objection, so ordered.

Mr. HILL. Last year we issued a report to this committee on the combined FTCA claims history for tribal self-determination contracts at the Indian Health Service [IHS] and the Bureau of Indian Affairs [BIA]. That report provides more details about the provisions that extended FTCA coverage to tribal contractors and four emerging legal issues affecting FTCA coverage for those contractors.

For my testimony today, we've updated the status of the IHS claims since our report last year, and the figures I will be presenting were current as of July 15, 2001.

Let me start my testimony today by briefly describing the process for implementing FTCA coverage for tribal self-determination contracts.

We are here today because accidents happen, and when those accidents are caused by the negligent actions of a tribal employee, the injured parties may be able to seek compensation from the Federal Government for their personal injuries. For example, if a patient receives negligent care at a tribal health facility or there is an accident involving a tribal ambulance, the injured party may be able to seek compensation from the Federal Government. Federal regulations implementing FTCA prescribe the process that Federal agencies must follow in resolving claims arising from the negligent or wrongful acts of Federal employees. With the extension of FTCA coverage to tribal contractors, tribal employees or volunteers under a self-determination contract are considered Federal employees for the purpose of FTCA coverage.

According to the FTCA regulation, claims are subject first to the administrative review and determination by the Federal agency whose actions gave rise to the claim. These claims must be presented in writing to the agency within two years, and they must contain a request for a specific amount of compensation.

At the administrative level, claims arising from IHS programs are filed with the Department of Health and Human Services Claims Branch in Rockville, MD. The Claims Branch has been delegated authority to resolve claims of $10,000 or less, and the Department's Office of General Counsel issues administrative determinations for claims in excess of $10,000.

Due to medical malpractice considerations, medical-related claims go through a much more rigorous review process than nonmedical claims.

If the claim is not resolved administratively, a lawsuit may be filed in Federal court where the Department of Justice will defend it. Administrative and legal settlements may be paid from agency funds, the U.S. Treasury, or a tribe's private liability insurance if duplicate coverage exists.

The Department of Health and Human Services identified 114 claims involving tribal contractors of IHS programs that were filed during fiscal years 1997–99. The total damages claimed were $487 million, with patient care activities accounting for nearly 45 percent of these claims and vehicle accidents accounting for another 35 percent.

These claims involve tribally-contracted programs for 40 contractors. The Navajo Nation, the largest tribe, had the most claims, with 14, and 6 other contractors had 5 or more claims during this 3-year period.

The damages claimed ranged from a low of $75 to a high of $100 million, with a median claim amount of $1 million. And, as of July 15, 40 claims had resulted in settlement payments, 18 were ultimately denied, and the final outcome of 56 claims is still pending either administratively or in litigation. A total of 58 claims or 51 percent have been brought to closure at a cost of $680,000 out of the $230 million claimed in those cases. The small, simple claims for minor incidents, such as a fender bender, are generally resolved quickly, while the large, complex claims may take longer to resolve.

The total settlement figure paid to date amounts to $680,000; however, this figure will likely increase as the remaining claims are resolved.

Finally, we found that claims involving tribal contractors are being processed the same way as claims involving Federal employees, and that the percentage of tribal claims approved and the amount awarded are comparable with the resolution of other FTCA claims at the Department of Health and Human Services.

Mr. Chairman, that concludes my statement. I'd be pleased to respond to any questions that you or members may have.

The CHAIRMAN. Thank you very much.

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

The CHAIRMAN. Now may I call on Mr. Bird.

STATEMENT OF MICHAEL BIRD, PRESIDENT, AMERICAN PUBLIC HEALTH ASSOCIATION, ALBUQUERQUE, NM

Mr. BIRD. Good morning, Mr. Chairman and members of the committee. You have my written document which has been submitted to you. I'd like now just to go into a narrative description on my comments.

I am Michael Bird, Santa Domingo and San Juan Pueblo Indian from New Mexico. I am president of the American Public Health Association. I'm the first American Indian president of the American Public Health Association in 128 years, so if patience is a virtue Indian people must be very virtuous.

Today I am representing the Friends of Indian Health, the coalition of over 40 organizations and individuals. We thank you for the opportunity to testify today and to comment on health care personnel issues that we think should be addressed in the reauthorization of the Indian Health Care Improvement Act.

I'd like to share a quote with you:

The first Americans, the Indians, are the most deprived and most isolated minority group in our Nation. On virtually every scale of measurement—employment, income, education, and health—the conditions of the Indian people ranks at the bottom.

Mr. Chairman, this quote was made over 30 years ago by then President Richard M. Nixon. Unfortunately, little has changed since then, especially in regards to health care for American Indians and Alaska Natives.

Recently, a member of the Friends of Indian Health sought care from the Phoenix Indian Medical Center for a 1 o'clock doctor's appointment. He left his home at 11 a.m., arriving at noon. He knew that he needed to arrive 1 hour before his appointment because patients are seen on a first-come, first-served basis, even those with scheduled appointments. At this facility, the patient-to-doctor ratio is overwhelming. Not only does it serve Indian patients within the Phoenix city limits, but also patients are brought to the Phoenix Indian Medical Center by vans from adjacent reservations that lack inpatient services.

Our friend was eventually seen, but also told that his back condition had worsened and that he would probably need surgery. Because of a lack of orthopedists at Phoenix Indian Medical Center, he was unable to schedule consultation until September 27.

The patient's checkup took all afternoon. This experience is not unique. There is disparity in access to care throughout the Indian health care system. Or another way to view this situation is to compare the IHS to the Phoenix Veterans Medical Center, which is within 1 mile from the Phoenix Indian Medical Center. The total number of outpatient visits at the VA facility was over 8,000, compared to more than 14,000 at the Phoenix Indian Medical Center, a difference of over 6,000. The VA employs nine psychologists, while the Phoenix Indian Medical Center employs four. The total number of behavioral staff at the VA was 75, as compared to 17 at the Phoenix Indian Medical Center.

The Friends of Indian Health believes that by improving access to treatment and prevention the IHS will make significant strides in reducing health disparities and mortality rates. This was demonstrated by the placement of a podiatrist with the Winnebago and Omaha Tribes. During his 4-year tenure, the average annual leg amputations fell from 16 to 0. Not only did this improve the daily living and quality of life for the patients and their families, but resulted in a cost savings of over $2 million in surgical expenses.

But the IHS needs to move quickly to better recruit and retain providers. If the Administration waits too long, the competition will become more intense. Therefore, the Friends of Indian Health suggest that Congress take the following steps:

No. 1, make loan repayments tax free. Currently, the IHS pays providers $20,000 annually, an additional 20 percent of that sum to the Internal Revenue Service [IRS]. Totally, $3.4 million goes to the IRS from the IHS loan repayment account. If the loans were tax free, 170 more providers could be available.

No. 2, give IHS health care personnel 3-year student loan deferments. Volunteers in programs like the armed forces, Peace Corps, or Domestic Volunteer Service do not have to repay the

principal of or the interest on any student loan for 3 years. This provision does not apply to those working in IHS or for tribes. This oversight can cost recent graduates more than $1,000 a month. Faced with this burden, many health care professionals cannot afford to join the IHS or work for tribes or urban programs.

No. 3, conduct exit interviews. As the IHS approaches the next decade and must compete for health personnel, the Friends of Indian Health believes that it should require exit interviews determining whether staff are leaving because of non-competitive salaries, high debt burden, inadequate housing, or lack of esprit de corps would be essential to quickly making corrections to prevent others from leaving.

No. 4, recruit active and retiring health care professionals interested in providing care on a part-time or temporary basis. The American Academy of Pediatrics has received more than 300 requests from active physicians for information about short-term pediatric opportunities at IHS sites. Additionally, we believe that many other providers are not ready to completely retire and would be willing to volunteer 1 week, 1 day, 1 month, or even 6 months to their service. Their experience and expertise particularly are in high demand. The IHS needs to create a program where such volunteers can be recruited, and assure them that liability would not be a problem.

Mr. Chairman, the definition of insanity is doing the same thing over and expecting a different outcome. Therefore, if, in fact, we desire to make changes to produce different outcomes, we have to begin today. The Friends of Indian Health believes our recommendations can move us in that direction.

Mr. Chairman and members of the committee, this concludes my testimony. I will be happy to answer any questions you might have.

Thank you.

The CHAIRMAN. I thank you very much, Mr. Bird. I find your testimony most enlightening.

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

The CHAIRMAN. May I begin my questioning with Dr. Vanderwagen.

I gather that the pay scale of the IHS is tied to DOD; is that correct?

Mr. VANDERWAGEN. Yes, sir; that's true.

The CHAIRMAN. But does that include bonuses and cost of living allowances?

Mr. VANDERWAGEN. For those that are in uniforms, the bonuses and cost of living allowances are consistent with those provided to the other uniformed services.

The CHAIRMAN. But what happens when there is no comparable category to tie it in in certain areas?

Mr. VANDERWAGEN. Well, we have a variety of disciplines, for instance, where there are no such bonus opportunities or other inducements that we might provide, and that presents us with difficulty.

For instance, in nursing there really are no real financial incentives like that provided through the DOD, so we don't have much to offer on our side, either, for those that are in uniform.

The CHAIRMAN. For many, many years DOD has been most reluctant to have joint operations with the VA, and, as a result, we have had VA hospitals and DOD hospitals. But now, with the cold war over, many of our military hospitals have been destined to be closed, and in order to keep them open some have become joint operations with the VA—for example, in Hawaii. And the Hawaii operation is a model operation.

Would you consider, where it is feasible, to have DOD have a joint operation with IHS?

Mr. VANDERWAGEN. I believe that there are opportunities like that—for instance, in western Oklahoma. There are other locations where there may be DOD facilities where, if tribal and urban people had effective policy involvement in the development of those relationships, I think we would be very interested in adding DOD into the partnership.

The CHAIRMAN. Mr. Bird, would that be acceptable to Native Americans?

Mr. BIRD. Well, I think it is something that one has to approach very carefully, because I think there is some concern in terms of most Indian populations that they're going to end up losing out when anything like this is explored.

I know in New Mexico, drawing on my 20 years of experience in the IHS in the Albuquerque area, that there had been initial discussion back about 10 years ago about negotiating some sort of an approach with the VA there in Albuquerque, and, as I best recall, some of the tribes were concerned and actually kind of put a stop to that because they felt like we would—the tribes, in fact, would be losing out in some form or fashion.

I don't know if that was based on any real threat to the services that were provided, but I think that there is that perception out there in the community that somehow it will diminish—possibly diminish the Federal Government's role and responsibility to tribes. But I know that that is a concern.

I think, given the times that we are looking at and the impact, the adverse impact of lack of services for Indian people and Indian populations that's occurring today, I think some tribes might be more open to considering those options.

The CHAIRMAN. We will be thinking about that.

Mr. Vanderwagen, is there any partnering or collaboration between IHS and non-Federal agencies whenever there is a shortage of specialties?

Mr. VANDERWAGEN. Yes; I'm glad you asked that, because, while Michael is here representing the Friends and he was unable to sort of, in his prepared testimony, speak to some of the activities with them—for instance, the American College of OB/GYN routinely assists us in two ways. One is they will go out with us and do field site visits to assess the quality of care, needed improvements in patient safety, protections, medication error management, and that sort of thing, but they also have a program to provide OB/GYN specialists to assist us in locations where we have special needs.

The American Dental Association also has done very similar kinds of site visitation with us and assisted us on a variety of clinical care needs, as well.

American Academy of Pediatrics—a variety of these professional organizations that constitute the Friends of Indian Health have been tremendously helpful, both to the tribal programs and to the Federal programs. I don't know that we have been able to link with the urban programs as effectively as we might with these kind of professional supports, and that's certainly an area where we could work with the Friends of Indian Health to expand that relationship.

The CHAIRMAN. We have an issue on the Federal Tort Claims Act.

Mr. BIRD. Mr. Chairman?

The CHAIRMAN. Yes?

Mr. BIRD. Might I share some thoughts?

The CHAIRMAN. Sure.

Mr. BIRD. I wanted to mention that the American Public Health Association has, since I became president of the association, has been much more involved and much more engaged. There is, in fact, an American Indian and Alaska Native, Native Hawaiian Caucus, which has a 20-year history of association with the American Public Health Association. At our annual meeting this year in Atlanta, which typically draws about 13,000 participants, for the first time in 128 years there will be a plenary session on dealing with indigenous health. We're attempting to have four representatives from Native populations. Actually, there will be a Native Hawaiian physician who will be part of that program and a Canadian representative and someone from South America to look at focusing attention on indigenous health internationally, as well as within this country.

The CHAIRMAN. All right. Thank you.

May I now go to tort claims? Is it true that the Department of Health and Human Services can only approve settlements of less than $25,000?

Mr. HILL. Yes; it is.

The CHAIRMAN. And yet you have testified that the median amount is $1 million?

Mr. HILL. That is correct.

The CHAIRMAN. Then what should we do? Is something wrong there?

Mr. HILL. Well, the current process allows them to settle for those claims that are less than $25,000, but it does allow the Department of Justice to handle claims in excess of that.

The CHAIRMAN. Then what happens?

Mr. MALCOLM. I think that's correct. Some agencies have looked at whether that cap should be increased, kind of adjusting for inflation type of methodology, given the increase in the claim amount. Is the $25,000 gap still a reasonable amount for them to have that authority?

The CHAIRMAN. How does it compare with the VA hospitals? Is there a cap also for veterans going to VA hospitals?

Mr. MALCOLM. The restriction of the $25,000 would be for the entire Federal Government, except where the Department of Justice has delegated a higher settlement authority. The VA has been delegated the authority to settle FTCA claims up to $200,000.

The CHAIRMAN. Is that the same with DOD hospitals?

Mr. MALCOLM. To my knowledge it is the same, but I'd have to confirm that.

The CHAIRMAN. It is the same?

Mr. MALCOLM. To my knowledge it is the same.

The CHAIRMAN. Dr. Vanderwagen?

Mr. VANDERWAGEN. Yes; I agree with him. My understanding is that that's a Federal-wide cap that independent agencies, short of litigation going to the Department of Justice, have placed on them for just settlement.

The CHAIRMAN. And what has been the experience with the Justice Department?

Mr. VANDERWAGEN. In general, our experience has been mixed. Without getting too lengthy, we do an extensive quality review process of any cases brought involving patient care, in particular, and the Department of Justice has not been actively involved in that review process with us, and there are times when we believe that decisions are made despite the review process that weighs on the merit of the case, and that has been of some concern to providers, because if Justice proceeds, despite the fact that the Quality Review Panel does not believe there's merit against that individual, they end up reported to the Practitioner Data Bank, whether they were viewed as really having culpability or not, and that's a problem from the provider perspective, not speaking about the fiduciary responsibility of the Government here, but provider concerns.

The CHAIRMAN. Is it because of this situation that you are not able to fully utilize volunteers?

Mr. VANDERWAGEN. That is part of the situation. The other circumstance, you may be aware there was a malpractice suit brought in a tribal court in New Mexico, and while the tribal council immediately rejected trying that case within tribal court, it created conflict in the State of New Mexico over jurisdictional concerns, and the insurance malpractice carriers for many providers, particularly the pediatricians and obstetricians, since they were the two specialties involved in the case, have been real reticent to counsel their members, their insured providers to practice. In fact, they've discouraged them from practicing in reservation environments.

The CHAIRMAN. And before I call upon the vice chairman, one final question. Is there any medical school that specializes on Indian health? For example, you pointed out that there are problems that you just discovered. Are there any medical schools that specialize on Indian health?

Mr. VANDERWAGEN. Sir, I believe there are one-half dozen institutions nationwide who really have shown tremendous commitment and involvement in Indian communities through their participation with tribes, as well as their participation with providers. Those schools actually have developed a coalition now to explore ways that they might more effectively support Indian health issues.

Without getting too extensive about it, it ranges from Hopkins here in the east to the University of Washington to the southwest, where Arizona and New Mexico have had real interests in Indian health, and, of course, the University of Hawaii has trained a large number of masters in public health and supported Indian health concerns. So there are a variety of schools that have been very helpful.

The CHAIRMAN. Thank you very much.

Mr. Bird, the staff will be working with you on your recommendations.

Mr. BIRD. Thank you.

The CHAIRMAN. Mr. Vice Chairman.

Senator CAMPBELL. Thank you, Mr. Chairman.

While listening to your questions I was just musing to myself about some of the people that I know who have been sick who have needed help. I tell you, you take an average elder in an Indian tribe who is not a very "sophisticated" person, a person that is close to the land and close to their culture, and you start talking to them when they come in about fiduciary responsibilities and the legal ramifications and tort reform or tort problems and punitive damages and all that, I think they're probably not going to understand. All they know is they're sick and need help. Somewhere we've got to find a way to bridge that, you know, and give them more help.

I was interested in the chairman's question about if there's a DOD program that you work with, and I was thinking of one that has worked out really well. It's not directly with DOD, Mr. Chairman, but Fitzsimmons Military Hospital, as you know, in Denver was a few years ago turned over to the University of Colorado. They, in turn, with our help and funding from the Federal Government, are building an American Indian diabetes center there now for research and treatment, too, of diabetes among Indian people, so I think there's some precedent set, maybe not a direct relationship, but through working with local universities there are, I think, some real opportunities.

Let me just scatter some of these questions around. You talked earlier, Dr. Vanderwagen, about the recruitment program. As I understand from Mr. Hill, there is a problem with retention, too. What is the reason? Is it low pay? Do they just go on to better things? Do they get burnout from too many hours, like people in the medical profession often do?

Mr. VANDERWAGEN. Well, I think it is a combination of those factors. I mean, entry level for a pharmacist, let's say, in Indian health, they have to accept 30 percent lesser pay to come to work for us than if they went to work for one of the retail chains in an urban setting, so the pay is an issue.

Second, obviously, if they're working in isolated environments where spouses don't have the ability to get a job and so on, those factors play in.

The concern, as I suggested earlier, about the severe rationing of the system that Mr. Bird referred to and that you just spoke to about an elder seeking service plays on providers severely. When you continually have to pull people out of the river and you do not have the opportunity to figure out how they got there in the first place because you're just so busy trying to meet that flow, after a while you do become tired. There's no question about it.

I was just out in the Dakotas last week, and clearly that was a message that I heard.

Senator CAMPBELL. Do most of them go to jobs in the private sector or just quit altogether?

Mr. VANDERWAGEN. It's a combination of those factors that you spoke to, and I think it is problematic to try and address each of those.

Senator CAMPBELL. Let me ask again, the ones that do leave, do most of them go into the private sector or just burn out and do something else?

Mr. VANDERWAGEN. I think the majority of the people who leave our system will go to another health care environment, just one that meets their needs individually.

Senator CAMPBELL. When you do recruiting, do you do that on the reservation?

Mr. VANDERWAGEN. The scholarship program, if you look at it that way, yes, we do recruit that way. For certain jobs, skills that are available in the community, that's clearly where we would recruit. That's part of the reason why 75 percent of the staff out there are Indian people. We recruit from Indian communities for Indian communities.

Senator CAMPBELL. We have tried to increase the IHS budget. We've put this year, I believe, $78 million more into the budget than was in last year. It's probably still not enough. But does some of that get to the salaries of the people that are in training?

Mr. VANDERWAGEN. Yes, sir; In fact, the highest priority that the tribes, the urbans, and the Federal people developing the budget—the highest priority was let's make sure that the Pay Act for Federal employees and pay increases for tribal and urban employees get covered. That has been the highest priority for expenditure.

Senator CAMPBELL. Let me ask you just a question or two about the urban Indian community. Mr. Bird, you know, a person—an Indian person—gets sick in Albuquerque, it's not a long-distance trip usually to go back to the Pueblos. A lot of them are pretty close. But our biggest city is Denver, we have roughly 25,000 Indian people who live in Denver. The nearest Indian clinic, reservation clinic, is I guess about 250 miles away, the Southern Ute clinic way down at the end of the State. They can't just go home when they get sick. They've got to go downtown.

Do you do any interaction working with local health clinics for Indian people that need help that can't go home? Or do you do any kind of an outreach program so that Indian people know where they can go if they're in the city and need help?

Mr. BIRD. Yes; well, without getting too wordy, we do fund 34 urban Indian programs whose primary mission has been initially to institute an outreach process and provide a way to coherently assist Indian patients. Some of those now have expanded into fully-functioning, ambulatory, primary care facilities. In fact, 14 of them are now federally-qualified health care facilities under the HCFA guidelines. So that is exactly what the intent of the act, as we understood it, title V was, and that's what we've tried to work with the urban programs to accomplish.

Senator CAMPBELL. I see.

Mr. Hill, what's the average time that claims are settled now?

Mr. HILL. We don't have a general timeframe. The process is basically when the claim is filed HHS has 6 months to decide, and certainly a number of those are spilling over that 6-month period,

but after the 6-month period expires the claimant can then go and file suit in court to get it settled.

Senator CAMPBELL. What's the longest you would say it takes to get a claim settled?

Mr. HILL. We found five claims that were filed in fiscal year 1997 that were still pending. That makes them almost 4 years old.

Senator CAMPBELL. Dr. Vanderwagen, you know, there has been some discussion. In fact, there is a bill in to elevate the IHS director to Assistant Secretary in the HHS. Would that be a priority in the Indian health community?

Dr. VANDERWAGEN. In consultation with the tribes and the urban folks, that clearly, from their perspective, is a priority to elevate the director to an Assistant Secretary level.

Senator CAMPBELL. Do you have a personal view on it?

Mr. VANDERWAGEN. I think there are real pluses in terms of the kind of partnership and access to a wide range of departmental programs that could be facilitated—for example, alcohol programs that cross the Department and other kinds of health programs. There appears to be some merit in the proposal from that perspective.

Senator CAMPBELL. There are two demonstration programs, Dr. Vanderwagen, in Oklahoma that are, as I understand, operated a little differently from the normal programs in the IHS that I understand are very successful. How are they different and what makes them so successful?

Mr. VANDERWAGEN. Well, thank you for asking. Those are interesting and, I think, unique programs.

In the past, Congress provided authority for those programs to not only be dealt with under title V as urban programs, but to be dealt with as service units under the Federal process. That means that they could access resources not only limited to the title V budget authority but to all the other budget authorities within the agency—hospitals and clinics, mental health, et cetera.

The plus side of that has been that it has allowed them to expand and become more comprehensive using IHS funds in addressing the health needs of individual urban Indians in Tulsa and Oklahoma City, and therefore reduce the requirement for them to seek funding from other sources, to some degree.

Senator CAMPBELL. There's supposed to be a report made on those demonstration projects, too, as I understand it. Is that report finished? I'm told it is.

Mr. VANDERWAGEN. Yes, sir.

Senator CAMPBELL. And when are we going to get a copy of that report.

Mr. VANDERWAGEN. I would have to check on that, but I could provide you an answer for the record, sir, as to when that would be available. I'm just ignorant at the moment of that.

Senator CAMPBELL. To your knowledge is there any opposition to launching more programs along the lines of those demonstration programs?

Mr. VANDERWAGEN. It is a complicated issue with regards to tribal sovereignty and the responsibilities and authorities of tribal governments vis-a-vis individual Indians who may be in urban settings and how those programs access resources. This is a real difficult

issue, not just involving Oklahoma and Tulsa, but I think all of the Indian health system at this point, the balance between tribal government and the government-to-government relationship and the needs of individual Indian people who happen to live in urban settings. It's very difficult.

Senator CAMPBELL. Well, if they have been successful, there is a good possibility that we could expand that program, then.

Mr. Bird, tell me a little bit more about this. Which organization participated in this, as you called it, "Friends Organization."

Mr. BIRD. Yes.

Senator CAMPBELL. What's their interest in the Indian health field?

Mr. BIRD. Well, their interest is in seeing that, in fact, the needs of American Indian and Alaska Native people are better met, and there is—it's a broad coalition, as was mentioned before, of the American Dental Association, American Association of Colleges of Nursing, American Hospital Association, American——

Senator CAMPBELL. All of them have some health connection?

Mr. BIRD. Yes; all involved in the health arena. I will submit a copy. I do have a list of the members of Friends of Indian Health.

Senator CAMPBELL. Great. Please submit a copy of that. We'll try to make that a part of the record.

Did you go out and recruit those people to help, or is that something they put together themselves and volunteered to do?

Mr. BIRD. It's actually something that the American Dental Association put together, has been active for a number of years because of their interest and their recognition of the fact that there's great disparity in American Indian and Alaska Native communities.

Senator CAMPBELL. I see.

Mr. BIRD. And they are to be commended because they are a very active, viable group, and at their behest I am here today.

Senator CAMPBELL. Okay. Swell.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank you very much.

I have a few more questions.

Mr. Vanderwagen, do you have any thoughts on Mr. Bird's recommendation on having Indian volunteers be on the same par as Peace Corps workers and others?

Mr. VANDERWAGEN. Well, that's a refreshing notion and one that we have not explored, but it certainly seems to have some merit.

Again, bringing people in, we believe that our mission and the work that we do is such a blessing in life that if we bring those people in we're likely to keep them for longer than just a simple, short-term stint.

The CHAIRMAN. Will you have your staff look at Mr. Bird's recommendations and give us your thoughts on this?

Mr. VANDERWAGEN. Yes, sir; I will.

The CHAIRMAN. Are you aware of other federally-sponsored loan repayment programs that are tax free?

Mr. VANDERWAGEN. I believe that there have been programs funded through the Health Resources and Services Administration that has had some tax-free loan repayment components, but I may be wrong about that, but that's what comes to mind.

The CHAIRMAN. Then you do not mind if you are on a level playing field?

Mr. VANDERWAGEN. If we'd get back onto a level playing field I'd be real happy.

The CHAIRMAN. Well, Mr. Bird, it appears that you have a few allies here.

Mr. BIRD. I'm glad to hear that.

The CHAIRMAN. Now may I ask Mr. Hill a few questions. Does the Tort Claims Act provide malpractice coverage for retired providers who practice on a part-time basis for a contractor?

These questions are asked because I have had letters from Indian country.

Mr. MALCOLM. Yes, Mr. Chairman; the Federal regulations that were issued on this—it's 25 CFR, part 900, subpart M talks about the types of people, both for medical and non-medical claims, that are covered. It specifically states that temporary employees, if they are working under a self-determination contract for a tribe, would have tort claim coverage.

The CHAIRMAN. They are covered?

Mr. MALCOLM. Yes; if they are performing a service under a self-determination contract.

The CHAIRMAN. Now, does this act also provide coverage for medical specialists, as well as primary care providers?

Mr. MALCOLM. I believe so. Again, depending on—a lot of very legal technical terms apply to this area, and that's why there's a lot of confusion, and the Department of Justice basically has to make determinations on a case-by-case basis.

If the specialist, again, is working at the tribal facility, then clearly there would be that coverage. If that specialist is basically at a hospital in town that's not a tribal facility, there would be questions about the coverage in that case.

Again, it's the function that is being performed. If it's being performed under the tribal contract, there would be coverage either for full time, part time, or volunteers. When tribal members are getting care from people outside of that contract, then there would be questions about the coverage.

The CHAIRMAN. Does it make any difference as to the venue of the care in the tribal hospital or some other hospital?

Mr. MALCOLM. Yes; it would. If that person is not directly working under the contract, there would be—that would be an issue.

The CHAIRMAN. Mr. Hill, you indicated that volunteers working at a tribal facility will have tort claim coverage?

Mr. HILL. That is correct, as long as they're working under a contract.

The CHAIRMAN. Dr. Vanderwagen suggested that, because of this tort claim issue, volunteers are reluctant to sign up. How are these claims examined that involve volunteers?

Mr. HILL. I can't answer that. Of the 114 claims that we identified, none of them involved volunteers, so I'm not sure it has been tested yet.

Mr. VANDERWAGEN. If I may, Senator, it's a climate of anxiety that is not fully assuaged by Justice approach of decision on a case-by-case basis, and many providers are unwilling to accept the sort of verbal assurance that, "Oh, yes, you will be covered, but we re-

serve the right on a case-by-case to approach these issues," and it is that lack of absolute certainty that is chilling for many people, particularly in light of their private insurance carrier counseling them that they are entering into an extremely risky environment.

So the cases really have not been directly challenged. It is more a climate of concern and anxiety that we're trying to attend to on these matters.

The CHAIRMAN. Mr. Hill, do you have any response to that?

Mr. HILL. No. That's correct. We would agree with that. We would note there are some other special coverage provisions that apply. For example, in California, where you have a lot of contracting the California Indian Rural Health Board basically provides services there, and then they have subcontractors. As a general rule, under FTCA subcontractors would not be covered; however, Congress has made special provisions for California that those subcontractors will be covered.

We did find, during the 3 years we looked at, that there were 10 claims from subcontractors of the California Indian Rural Health Board that had been provided coverage. So there are other special mechanisms in there for IHS programs, and we did find that those are working as they should be.

The CHAIRMAN. Then do you feel that the problem expressed by Dr. Vanderwagen can be resolved or addressed legislatively?

Mr. MALCOLM. I don't believe so. Part of the problem is, again, as Dr. Vanderwagen mentioned, there is a large amount of confusion and misunderstanding about the coverage, and a lot of the legal questions about who is covered and who is not covered, that actually hinges on State law. So, depending on the location of where the incident occurred, the Justice Department or HHS, the Office of General Counsel, will look to the State law as far as the definition of who is an employee and what functions that person has to be performing to be considered an employee, so the State law is the controlling issue there historically, so that's what they look to and that's why there could be differences from State to State, and that's a case-by-case basis.

The CHAIRMAN. Are volunteers at VA or DOD hospitals treated the same?

Mr. MALCOLM. Our study didn't really include VA and DOD, so I'll have to—we'd have to look into that further.

The CHAIRMAN. My final question on urban Indian programs has to do with a letter that was received by the staff. Are urban in health care centers deemed to be ordering agents of the IHS for the purchase of pharmaceuticals?

Mr. VANDERWAGEN. In general they have not been direct participants in the special purchasing arrangements that we have through the VA, the prime vendor, which gets the absolute lowest cost. The 638 relationships provide us the authority to do that, and the majority—obviously, the urban programs are generally under the buy-Indian provision, and they've not been included with the VA purchasing arrangements to date.

The CHAIRMAN. Is there any reason for that?

Mr. VANDERWAGEN. Primarily revolving around the authority, in their view, being Federal, and 638 qualifying tribes as Federal, as

it does in many other environments, but the buy-Indian contracting not viewed in the same way by the Veterans folks.

The CHAIRMAN. Can this matter be resolved internally?

Mr. VANDERWAGEN. We are working on it and we think we might be able to get a solution, but that's certainly something we can report to you on.

The CHAIRMAN. Mr. Bird, are you satisfied?

Mr. BIRD. Yes.

The CHAIRMAN. Your negotiations are bearing fruit?

Mr. BIRD. We need more trees.

The CHAIRMAN. Well, we'll try our best, sir.

Mr. BIRD. Thank you.

The CHAIRMAN. We have a few more questions we'd like to submit, if we may, and receive your response.

Senator CAMPBELL. May I ask one more?

The CHAIRMAN. Yes, please.

Senator CAMPBELL. Let me ask one final question, Mr. Chairman. Since you had mentioned Peace Corps, originally when Peace Corps was set up it dealt with helping people in foreign countries. There was another program called "Vista" that was very similar, but it was more domestic oriented, and Vista workers at that time some years ago actually were working on reservations.

I don't know if Vista program is still in effect or if it has been superseded by Americorps or some of these other groups such as the National Health Care Service Corps or so on, but do any of these groups take part in the Indian health profession, Dr. Vanderwagen? Or do you work with any of those groups at all?

Mr. VANDERWAGEN. No; we really have not had formal relationships with them, and an interesting idea that we have not explored.

Senator CAMPBELL. Do you have the legislative authority now to be able to work with them, or do you need something from us in order to do it?

Mr. VANDERWAGEN. Well, I'd have to defer to our legislative people on that, but we could certainly provide an answer back to you on that question.

Senator CAMPBELL. Would you find out for us, because it seems to me that there are a lot of good-willed, hard-working people that want to help out there, and if we could get them involved with you so you could utilize some of their folks, I think it would be good for you and maybe good for Indian country, too. Find out if we need to do something legislatively or if you can just go ahead and do it. And if you can, I would encourage you to do it.

Dr. VANDERWAGEN. We'll do.

Senator CAMPBELL. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. All right. Thank you very much, gentlemen.

Mr. VANDERWAGEN. Thank you.

Mr. HILL. Thank you.

Mr. BIRD. Thank you.

The CHAIRMAN. Before I call upon the next panel, without objection the opening statement of Senator Kent Conrad will be made part of the record.

[Prepared statement of Senator Conrad appears in appendix.]

The CHAIRMAN. And now may I call upon the second panel: The president of the National Council of Urban Indian Health, Robert Hall; the health director of the American Indian Community House in New York, Anthony Hunter; the executive director of the Missoula Indian Center of Missoula, MT, Carole Meyers; the executive director of the Native American Health Center, Oakland, CA, Martin Waukazoo; and the executive director of the Denver Indian Health and Family Services, Incorporated, of Denver, Kay Culbertson.

May I call upon President Hall.

STATEMENT OF ROBERT HALL, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH, WASHINGTON, DC

Mr. HALL. Thank you, Mr. Chairman, Mr. Vice chairman, and also for the Senator of my home State, Senator Conrad, when he was in here for a while. My name is Robert Hall. I am the president of the National Council of Urban Indian Health and a member of the Three Affiliated Tribes from Fort Berthold, ND. My tribal heritage is Arikara and Hidatsa. The third tribe up there is Mandan. I also have some prepared remarks I have submitted for the record. I am also the executive director of the South Dakota Urban Indian Health Clinics. I wish to thank you for this opportunity to address the committee on the reauthorization of the Indian Health Care Improvement Act, S. 212.

I'd like to take a moment to introduce you to our new executive director for the National Council of Urban Indian Health, a lady I think you are very familiar with, Beverly Russell. We're very pleased for the training she received while she was interning with you.

The CHAIRMAN. She's a good lady.

Mr. HALL. Yes.

The CUIH is the only membership organization representing urban Indian health programs. Our members provide a wide range of health services and care, ranging from information and outreach to full clinics. We provide referral services in 34 cities, not counting the new program in Hawaii, to a population of approximately 332 urban Indians. We are often the main source of health care and health information for these urban Indians. According to the 1990 census, 58 percent of American Indians lived in urban areas. We expect that number to be well over 60 percent in the 2000 census results.

Like their reservation counterparts, urban Indians historically suffer from poor health and substandard health care services.

In 1976, Congress passed the Indian Health Care Improvement Act. The original purpose of this act, as set forth in a contemporaneous report, was to,

> raise the status of health care for American Indians and Alaska Natives over a 7-year period to a level equal to that enjoyed by other American citizens.

It has been 25 years since Congress committed to raising the status of Indian health care and 18 years since the deadline has passed for achieving the goal of equality with other Americans, and yet Indians, whether reservation or urban, continue to occupy the lowest rung on the American health care ladder.

Although the road to equal health care still appears to be a long one for Indians, the CUIH—the National Council of Urban Indian Health—believes that S. 212 is a step in the right direction. As a general matter, NCUIH supports S. 212, although we do recommend certain changes to maintain Congress' commitment to urban Indians.

The Indian Health Care Improvement Act currently provides that it is the policy of the United States to achieve the highest possible health care for both Indians and urban Indians; however, S. 212 does not contain a reference to urban Indians in its equivalent paragraphs. Deleting urban Indians from this policy statement, especially since "urban Indian" is a defined term in the legislation, could imply that the Congress no longer considers the health status of urban Indians to be a national priority.

NCUIH strongly urges the restoration of "urban Indian" to section 3, paragraphs 1 and 2, of S. 212.

NCUIH is generally satisfied with the definition of "urban Indian" in S. 212, although certain language in the definition appears to limit its coverage to title V of the legislation. Urban Indians are referred to in other titles of this legislation; therefore, this limiting language should be removed.

NCUIH supports an amendment to S. 212 that would grant urban Indian health programs the same 100 percent Federal medical assistance percentage as is currently enjoyed by IHS facilities and IHS 638 contractors.

Like IHS facilities, urban Indian programs exist because of the Federal responsibility in the Indian health care area. We should be treated the same as IHS for the purposes of FMAP, and we would like to thank the chairman for his support in introducing FMAP legislation.

NCUIH supports expanded authority in funding for urban Indian health programs in the area of pharmaceutical services. Such expanded authority would result in an immediate elevation of the quality of care for these communities, especially the elderly.

NCUIH supports the establishment of the National Bipartisan Indian Health Care Entitlement Commission. The work of this commission will help provide the basis for a rational and effective approach to Indian health care well into the 21st century.

Although addressed in other Senate legislation, we would like you to know that NCUIH strongly supports the elevation of the director of the IHS to Assistant Secretary for Indian health. Too often Native voices are lost in the national clamor over health care policy and funding. Elevating this position would greatly strengthen the voice of Indian country, whether in the halls of Health and Human Services, the corridors of Congress, or wherever the health care debate occurs.

In fiscal year 2001 urban Indian health programs received 1.14 percent of the total IHS budget, although urban Indians constituted at least 50 percent of the total American Indian population.

NCUIH acknowledges that there are some sound reasons why the lion's share of the IHS budget should go to reservation Indians; however, the health of Indian people in urban areas affects the health of Indian people on reservations and vice versa. Disease

knows no boundaries. NCUIH strongly believes that the health problems associated with the Indian population can be successfully combated if there is significant funding directed at the urban Indian population, as well as reservation population. To address this need, NCUIH has asked for a $5 million increase in the urban Indian health line item in its 2002 budget.

NCUIH also supports the establishment of a 5-percent set-aside of the IHS diabetes funding to be provided to urban Indian diabetes programs, and we would like to acknowledge the vice chairman for his strong letter directing that.

In the chart in front, you will see a history of IHS funding and urban Indian health funding from 1979. You will notice in 1979 our funding comprised 1.48 percent of the total IHS budget, and you can see from the graph we're back down into a dive in falling behind, not even maintaining. And you also are very aware that the IHS budget isn't maintaining a level track with increased cost.

America is nowhere near the lofty goals set by the Congress in 1976 of achieving equal health care for American Indians. Whether reservation or urban, NCUIH challenges this committee to think in terms of that goal as it considers reauthorization of the Indian Health Care Improvement Act.

NCUIH thanks this committee for this opportunity to provide testimony on S. 212, and we strongly urge positive action on the matters we are addressing today.

I would like to take this opportunity to thank both the majority staff in the committee and the minority staff in the committee for being very cooperative and helpful in establishing this hearing and in working with our members.

Thank you.

The CHAIRMAN. I thank you very much, Mr. Hall.

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

The CHAIRMAN. May I now call upon Mr. Hunter.

STATEMENT OF ANTHONY HUNTER, HEALTH DIRECTOR, AMERICAN INDIAN COMMUNITY HOUSE, NEW YORK, NY

Mr. HUNTER. Good morning, Mr. Chairman and members of the committee. We want to thank you for inviting us to testify at this important hearing on urban Indian health programs. We would also like to recognize and thank you for your support of our programs over the years.

With your permission, I will submit my written testimony and make additional verbal comments.

I'd like to familiarize you with the American Indian Community House because we have not only health programs but also cultural enrichment programs. We use an innovative approach in order to combine these to meet our community's needs.

The American Indian Community House is a 501(C)(3) not-for-profit organization serving the health, social service, and cultural needs of Native Americans residing in New York City. AICH was founded in 1969 by Native American volunteers as a community-based organization mandated to improve the status of Native Americans and to foster inter-cultural understanding.

Since its inception, AICH has grown into a multi-faceted social support agency, cultural center, and it has a staff of 35.

AICH membership is currently composed of Native Americans from over 80 different tribes and represents a service population, according to the 2000 census figures, of 59,000 Native Americans who reside in the greater New York City metropolitan area.

Native American migration between urban centers and reservations demonstrates the inter-relatedness of all Native Americans, and from this reality emerges the recognition that our issues and concerns are truly shared.

The AICH philosophy is that solutions can be shared, as well. AICH uses an innovative approach in combining the objectives of our social service and cultural enrichment programs to meet that community's multi-faceted needs.

AICH provides programs in job training, placement, health services referral and advocacy, HIV referral, case management, and counseling programs for alcoholism, substance abuse, and mental health. AICH also sponsors programs in cultural enrichment through a performing arts program and the only Indian-owned and -operated Native American gallery museum in New York City. These programs are important to us, because a large percent of our population comes to New York City specifically because they are involved in the performing and visual arts.

A secondary but no less important focus of AICH is to educate the general public about contemporary as well as historic American Indian issues and peoples. Some of the departments that I spoke about—and I'll give you a little more detail, if I may, on those—our HIV/AIDS project, for example. In response to the increasing numbers of Native Americans living with HIV and AIDS, the HIV/AIDS project provides community prevention, outreach, education, and information, targeted outreach to individuals at risk, and services to those infected. The project offers referral to drug and alcohol programs, sexually transmitted disease clinics, test sites, general health and mental health care facilities.

They also offer services for gay and lesbian Native people. At one of our recent community meetings, it was our understanding that we need to expand our services for gay and lesbian Native people living in New York, and that it's not just HIV and AIDS that our agency needs to be concerned about when serving that population.

Case management services are also offered and provided in New York City, as well as program offices in Buffalo, Syracuse, Riverhead, and the Akwesasne Mohawk Reservation.

AICH is actually very unique, I believe, as one of the urban programs in that we offer services also on the reservation. We have historically offered also Department of Labor services on the Shinnecock Reservation in eastern Long Island.

The employment and training funding by DOL provides educational services as well as training focused on preparing an individual for the job market. Interview skills, resume writing, computer training, referrals to outside job training facilities, limited tuition and support for higher education, and job placement assistance are among those services. We are beginning a process of becoming a training facility registered with the New York State Education Department.

Our health department is staffed by community health representatives, or CHRs, and their work includes health education,

medical and dental referrals, community outreach, and the development of Native American specific health oriented materials.

The Health Department's alcohol and substance abuse program services strongly focus on group and individual counseling. These programs offer a sense of community support as the Native American people seek to begin and maintain their recovery.

Spiritual and cultural support are integral parts of the programs, as well as our education and prevention activities, and other programs within the Health Department include mental health, the AICH Youth Council and Theater Project, our daily food and clothing bank, and hot lunches for community members.

According to our recent behavioral risk factor survey sponsored by IHS and Centers for Disease Control, prevalent in our population are risk factors associated with heavy cigarette smoking, sedentary lifestyle, acute alcohol use, and drinking while driving. Using AICH's innovative approach in combining health prevention and cultural activities, we will now design prevention programs specifically addressing these behaviors using the visual and performing arts.

As part of the Health Department, we have a Women's Wellness Circle project, and it is specifically for Native women. Utilizing innovative and cultural-specific strategies again here in this program, the project works to develop a network between AICH, health institutions, other front-line providers, and Native women in the community. The project provides accessible satellite screening and health information through mobile units, develops Native educational performance pieces, holds monthly wellness circles for Native women to share access concerns and to provide preventive health education.

The AICH gallery museum is the only Native American owned and operated gallery in New York City. It exhibits the finest in contemporary and traditional art in every media by both emerging and established Native American artists. The gallery presents a minimum of four exhibitions a year and presents artists' lectures and forums on contemporary Native arts and issues.

The artwork on exhibit is often for sale, and we charge only a small commission on those sales.

Our Performing Arts Department, which is actually part of our Department of Labor program, they've actually been very liberal with us in the way we operate and the way we combine programming, and the Department of Labor, or what is now the WIA—Workforce Investment Act program—is really the backbone of our organization over the years, since we first received Federal funding in 1975.

The Performing Arts Department coordinates various cultural activities featuring Native American performing arts and promotes and assists all Native ensembles, such as Spiderwoman Theatre, Thunderbird American Indian Dancers, Coatlicue Theatre, and Ulali. The Department provides referrals for Native storytellers, musicians, and lecturers. It acts as a non-paid booking agent for Native actors, dancers, and models, and provides rehearsal space and technical assistance to Native American artists.

We have a main stage that we have as a moveable space within our agency that seats up to 150 people during performances.

We also have a legal service project for Native Americans in our community, which is actually a joint project between AICH and the American Indian Law Alliance. The legal services project is in its fourth year of providing free legal referral services to Native Americans. The project assists with all types of legal matters for Native people in an urban environment, including but not limited to housing, Indian Child Welfare Act, and Jay treaty issues. The Jay Treaty, as a matter of fact, has been something that the American Indian Law Alliance has been looking at very closely, and they're developing further information on this.

In our population we have a large number of Indians that come from Canada, and since they are eligible to receive services in the United States, we advocate for that service for them by not only attending hearings on their eligibility requirements, but also doing outreach with departments such as Social Security Administration to educate them and their workers about the eligibility of Canadian Indians living and residing in the United States.

On behalf of the Native American community of the New York City metropolitan area, I'd like to thank you for your consideration, and as you go about considering the needs of urban Indians I'd like to just mention that some of the most important issues that we have are support of the Jay Treaty and its rights. We're also having an urban planning meeting coming up in August that will be attended by representatives of IHS, the Health Care Financing Administration, our State alcohol program, and the Bureau of Managed Care Planning to help AICH decide how it can move forward in its licensing and third-party billing process.

And, of course, the Indian Health Care Improvement Act reauthorization is an integral part of AICH's future and its ability to serve its community.

Thank you.

The CHAIRMAN. I thank you very much, Mr. Hunter.

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

The CHAIRMAN. Ms. Meyers.

STATEMENT OF CAROLE MEYERS, EXECUTIVE DIRECTOR, MISSOULA INDIAN CENTER, MISSOULA, MT

Ms. MEYERS. Thank you. Honorable Chairman, committee members, my name is Carole Meyers. I'm the executive director for the Missoula Indian Center, Missoula, MT. I am an enrolled member of the Blackfeet Tribe and a descendent of the Oneida and Seneca. I want to thank you for this opportunity to come before you today.

Missoula Indian Center is a nonprofit organization. It has been in existence in Missoula, MT, for the past 31 years. The organization has assisted with health referrals to the 3,100 Native Americans that reside in that area. We have approximately 65 tribal representation throughout the Nation that come to our community. It's also the home of the University of Montana, of which many of our Native American clients come and attend.

Montana has seven reservations, and of the reservations there are 11 different Native American tribes represented in each area.

When Native Americans leave their home reservation and move to an urban area such as Missoula, they face many obstacles. One of the most noticeable is their health coverage. Once they leave the

reservation and live in an urban area for more than 180 days, they lose their health coverage through the IHS.

Some of the programs that we provide through our program is immunization, health promotion and disease prevention, AIDS, alcohol and mental health, diabetes, and our chemical dependency programs.

Missoula Indian Center is governed by a 7-member board of directors, of which 51 percent must be Native American. Missoula Indian Center is organized under two major programs, which is our health program and our chemical dependency. We have 11 full-time staff and one part-time mental health counselor.

Health issues that surround our Native American clients range from diabetes to the common cold. With our agency as a health referral organization, many of our clients see up to three to five different health providers in the course of a year. With this inconsistency of health providers, there is not a medical health history that follows our clients as they go to their medical provider. This creates more confusion and lack of medical knowledge of a client's history. Many times, because lack of funding, clients will be referred to at a point of emergency in their situation. There is little prevention health coverage, such as yearly physicals or dental checkups.

Missoula Indian Center's health program provides quarterly clinics that cover the basic health issues, which in itself is an excellent program but a significant problem that we are faced with is if a client comes up with a problem through their medical checkup, we cannot provide the resources to do the maintenance or followup, such as when they do a blood screening. If they come back and there is an issue that they need to do followup with a medical doctor, we basically have to tell them they have to go back to the reservation or seek medical assistance on their own.

It is safe to say that 80 to 90 percent of our clients do not have health coverage or insurance.

The Missoula Indian Center had 8,865 encounters this past year. These encounters are community members who accessed the center for medical issues, drug and alcohol counseling, all the way up to utilizing the telephone. We are looked upon as a one-stop agency for many of our needs other than medical.

Other issues besides health issues that our clients face are housing, employment, school, K–12 and higher education, law enforcement, and food.

Presently, we contract with the health agencies such as Partnership Health at a reduced cost for our doctors' visits. This enables health funds to cover more clients over the course of 1 year, but this does not address the client's need for medical followup or maintenance, as I discussed earlier.

When a client needs to have a prescription filled, we are able to transport them to St. Ignatious, which is located on the Flathead Indian Reservation. This entails a 90-mile round trip. Because of the Salish and Kootenai tribal policies, clients have to physically present themselves at the pharmacy in order for their prescription to be filled. This creates hardship with our clients for two reasons: No. 1, they may not have a vehicle to transport themselves up; and, No. 2, they may not have gas to put in their vehicle to make the 90-mile round trip.

Other services that we seek for our clients to try to utilize on the Flathead Reservation is the dental clinic, but in order for a client to be seen they have to leave the Missoula area at 7 in the morning to be there at 8 a.m. to be seen in an emergency dental situation. Once again, for them to utilize it, it is an emergency, either a toothache or some type of infection. There's no or little prevention for our dental.

In our chemical dependency programs we offer intensive outpatient and standard outpatient groups and some individual counseling. Our programs are Montana State certified, so we're able to see non-Native American clients, which we do some billing with that particular population.

Our programs are spiritually and culturally themed, and many of the agencies other than our programs that provide counseling make comment that the uniqueness of the counseling sessions do help with the holistic approach with recovery of the addiction, and they have been noted for this in the State of Montana.

When clients come in to utilize these alcohol programs, they not only bring their addiction but they bring many, many health problems, and we are seeing more diabetics in this course of our target population in this area.

I want to just interject this personal note. My father who is 82 years old has been a diabetic since the mid 1970's. My mother is 79 years old and she has been diagnosed with diabetes for the last 15 years. My father is a World War II veteran, has been an admirer of yourself, Senator Inouye, and this Commission for many years and thinks of you as a champion on issues that pertain to the American Indian. He has made comment that he would like to leave the reservation, but because of the lack of health coverage in the urban areas he is unable to leave the hospital in Browning, Montana, because that is his life support for he and my mother.

I want to thank you for your time for listening and reading my testimony. It has been a privilege and an honor to come before you with my thoughts and ideas. Each and every day Native Americans are faced with issues and problems of health, employment, and education. I sincerely hope with my testimony that our issues have been personalized. Survival on a day-to-day basis for Native American people is a very real issue.

Thank you.

The CHAIRMAN. Thank you very much, Ms. Meyers.

[Prepared statement of Ms. Meyers appears in appendix.]

The CHAIRMAN. May I now recognize Mr. Waukazoo.

STATEMENT OF MARTIN WAUKAZOO, EXECUTIVE DIRECTOR, NATIVE AMERICAN HEALTH CENTER, OAKLAND, CA

Mr. WAUKAZOO. Thank you, Mr. Chairman and Mr. Vice Chairman. My name is Marty Waukazoo, and I am an enrolled member of the Rosebud Sioux Tribe in South Dakota. I was born and raised in South Dakota. I moved to California in 1973 and have been the executive director of the Urban Indian Health Board since 1982. My wife and I have three children and two grandchildren. My wife, Helen, is the executive director of the Friendship House Association of American Indians in San Francisco, which is an alcohol an drug rehabilitation center partially funded by the IHS.

The American Indian community in the Bay area organized and incorporated the Urban Indian Health Board in 1972 to open the first Native American health center in San Francisco. In 1976, a second clinic was opened in Oakland, CA. Today, the Native American Health Centers are a full-service clinic with locations in Oakland and San Francisco, dedicated to making health services available to the American Indian community of the five Bay area counties—Marin, Contra Costa, San Mateo, Alameda, and San Francisco.

The services we offer include medical, dental, mental health, nutrition, community health education, youth services, and women, infants and children program, or WIC program.

In 1983, the urban Indian Health Board had an annual operating budget of $827,000, with 17 employees. Of this amount, 90 percent was funded through grants and contracts from IHS. Today our annual operating budget is $7.1 million, with 120 employees. Of that, 14 percent or $960,000 is through grants and contracts from the IHS. Of the 120 employees we have, 65 percent are American Indian. For every dollar that the IHS invests in us, we are able to leverage six additional dollars.

We are much more than just a medical clinic. We are also the cultural hub of the Bay area. When an Indian person comes to the Bay area looking for jobs from the reservations, coming to the urban area for training, the first question they ask is where is the clinic, because they know that's where you can renew friendships, get acquainted, and find someone who can connect you up with other services.

Within the Bay area Indian community there is a social service network. When I, as a Lakota or a Sioux and someone from my State comes to visit us in the area, when they walk up to me and they find me I'm obligated to help that individual navigate through the city system or through the local health care delivery system, so it is really a point of access for our community that we serve over and beyond that of just a health clinic.

As I said, the Native American Health Center in the Bay area is one of the largest, if not the largest, employer of American Indians in the Bay area. We not only offer employment opportunities, but we also do dental assistant training, medical assistant training, clerical training. We do training within our organization. Many of our employees are former patients of our clinic. It was very important for us that we have that balance of having that opportunity and giving preference, not only Indian preference, but also preference to those people who are patients of the Native American Health Center, and we have been very successful over the years.

Just last Saturday we awarded four scholarships—not big scholarships, $1,000 each, but we made those awards by raising funds. We raised $7,000 by having the staff talent show, food sales throughout the previous year. We felt it was important that we, ourselves, award scholarships. We have two students going to junior college in the local area. One Indian student will be going to Harvard this fall. So we're very proud of what our community has done in the area of not waiting for things to happen to us, but being on the offense and doing things for our community.

Last year our medical clinic saw over 4,800 patients, with over 16,800 visits. Of our patients, 98 percent meet the Federal poverty level guidelines.

The services we provide reflect our community's expanded definition of health—that health of an individual depends upon the health of the community. If we have a healthy community, we'll have healthy individuals within our community.

I would like to outline some of the critical issues facing our clinics today—issues that ultimately impact the health of our community in the Bay area.

Back in 1985 we bought a building in east Oakland, a four-story, 20,000-square-foot building. We bought that building at a time when the market was very low. Today, we have filled up that building—four floors offering comprehensive services. Again, we also have set up a fitness center, a gym on the first floor as part of our preventive efforts.

The issues of providing health care has increased significantly over the years. Pharmacy costs for us have increased by 34 percent from fiscal year 1999 to fiscal year 2000. According to our medical director, 20 percent of our medical users are diabetic—20 percent of our medical users are diabetic. A diabetic with high sugar, high cholesterol, and high blood pressure, a very common combination, can average $3,000 per year in drug costs. Just 40 such patients for a clinic like ours can cost us $120,000 a year, or close to 13 percent of the total IHS funding that we do receive.

Capital needs for our clinic have been and continue to be a major issue for us. We have been located at 56 Julian Avenue since 1972. We lost that lease this year. Our lease rent at the 56 Julian site was $6,500 last year [sic]. We moved to a new location a 1½blocks down on Cap Street. Our rent has increased to $20,000 a year—a month. From $6,500 to $20,000 a month. The market has gone up and exploded in the urban areas.

We are currently at full or near capacity in our medical clinics and our dental clinics. Poor design, inefficient and inadequate technology has also been an issue that we have to struggle with. We've had to obtain additional funding from within private foundations and corporations in order to buy the needed computer equipment to at least continue to participate in the local health care delivery system in Alameda County and in San Francisco.

Health insurance premiums for employees—we have 120 employees. Our health insurance premiums have increased by 28 percent in the last 3 years.

The California energy crisis is also having a major impact on us. These costs have increased by 40 percent over previous years.

Another critical issue that's going to impact our ability to provide primary care in the next year or two is something very positive in our community. The Friendship House Association of American Indians will be building an 80-bed alcohol and drug treatment center in San Francisco. Through a partnership with the city of San Francisco, they were able to obtain funding to buy property in the Mission District to build this 80-bed facility. That is great. There is a need there. That 80-bed facility is going to become a regional treatment center for not only California but for the western United States.

The Friendship House already has agreements with tribes in California and throughout the western United States for those people to come into the urban area to get their treatment for alcohol and substance abuse. The problem for us is that we have to provide the health care for them, and, as you know, those people that are in recovery do need a lot of health care as they go about turning their life around. How do I know that? Because 22 years ago I went through the Friendship House. For 1 decade I was homeless on the streets of Oakland and San Francisco. I entered the Friendship House in 1980, March 12, 1980. This past year I celebrated another year of sobriety. These urban programs do work.

A financial challenge for us is to find the funding and the financing to provide care for these people. When I went to the treatment center in March 1980, I had to go next door to get my TB test and also to get screened for my physical exam, and also my dental services. I can always remember that, how they treated me there. After coming off the streets of Oakland and San Francisco and coming into the urban area, how they treated me—they treated me as if I was someone important. I was just 30 days into the program, into the treatment, having gone through detox and going through the first 30 days. My efforts today are just an attempt to repay back what they gave me as an urban program 22 years ago.

The challenge for us in urban country, again, is the challenge that we have to take on as urban Indian programs, is to build that relationship with the tribes at the reservations. There has been miscommunications, misunderstandings. We can get along individually, but somehow we don't get along as communities and groups. We need to work on that. We are uniquely positioned in the State of California, working with the California Rural Indian Health Board, trying to put together their statewide HMO plan. It is a unique opportunity for us in urban country to partner up with the tribes and urban programs.

Many of our people do return. We are young. When the relocation programs took place in the 1960's and 1970's, we were a young community. Those people in the urban areas were only in their early twenties. Today, we are seeing more grandparents, more grandfathers, grandmothers. We are seeing an elderly population starting to emerge. Those of us who are in our fifties now are grandmas and grandpas. What comes along with that is increased cost, increased needs in our community.

I'd like to thank you for the opportunity to give you my testimony and appreciate all that this committee has done for Indian people throughout the Nation—my relatives—and we look forward to improving the health care of our people together. We will work on those things and we will do everything possible in the local areas to help improve the future for the next generation.

Thank you.

The CHAIRMAN. I thank you very much, Mr. Waukazoo, for your very inspiring statement.

[Prepared statement of Mr. Waukazoo appears in appendix]

The CHAIRMAN. May I now call upon Ms. Culbertson.

STATEMENT OF KAY CULBERTSON, EXECUTIVE DIRECTOR, DENVER INDIAN HEALTH AND FAMILY SERVICES, INC., DENVER, CO

Ms. CULBERTSON. Good morning, Chairman Inouye and Vice Chairman Campbell. I'm very excited to be here, and I feel honored because I wasn't supposed to be on the presenting committee, so my testimony was very hurried.

My name is Kay Culbertson. I am an enrolled member of the Fort Peck Assiniboine/Sioux Tribes from Poplar, MT, and today I want to talk to you about Denver Indian Health and Family Services. I think I am going to show you a different perspective of urban Indian health than Mr. Waukazoo did. I didn't realize that they had 100-some employees. I knew that they had a beautiful facility but didn't realize it was so large. So, as we say in Assiniboine, I'm going to give you the "oonshaka" story.

I want to talk about Denver. Like Oakland and San Francisco, Denver was a relocation center for urban Indians or for Indians moving off of the reservation. There's also many Air Force bases and military bases in the area, so a lot of people that moved to Denver ended up staying there and raising their families there. Like San Francisco and Oakland, we also see second- and third-generation urban Indian people, but they still have their ties with their reservation, and I would like to talk about that a little bit because my family is still very close to our people back home, and I'm very anxious to go back home tomorrow because our family will be coming out of mourning on Saturday for my uncle that was killed in an accident on the Northern Cheyenne Reservation and then my grandmother that passed away last year.

One of the things that brought people to Denver was that hope for a better future. Like all of the places, you know, we all thought that—well, my parents moved there when I was 6 years old—that we'd improve our lives, that their children would grow up free from racism and grow up in a better environment and have opportunities that they didn't have on the reservation.

I want to talk a little bit about Denver. We're located right in the heart of Indian country. I mean, you fly into Denver, there's conferences there all the time. There's several national organizations with National Indian Health Board, Native American Rights Fund, the American Indian College Fund, but as far as Indian country goes we're pretty isolated.

You talked about us being 250 miles away from the Southern Ute Reservation. That's true. And we don't see very many people from Southern Ute. It's too beautiful to leave there, I think, and to come to Denver. But we primarily see Lakota people, Sioux people. That's 60 percent of our population, and another 30 percent are the Navajo people.

The closest Indian hospitals, like I said in my testimony, are in Albuquerque and probably in Rapid City, so that's quite a long haul for people to go if they need any kind of medical services that we can't handle.

We were incorporated in 1978. We started out with two employees, and they were little ladies that worked in the community and met with hospital people and when Indian people came to them and needed help they helped them get into medical appointments

or they helped them get to their medical appointment. They worked with them to find dentists. It was a very sort of hodgepodge way of providing services in the Denver area.

We started to grow. Actually, we were part of the Indian Center, Denver Native Americans United, when we started, and we moved away from the Indian Center and incorporated in 1978 as Denver Indian Health Board, now known as Denver Indian Health and Family Services. We had a full-scale clinic at one point with 21 employees, not to a point that Marty's program was, but quite, quite extensive for the Denver area. We had an agreement with the Denver Health System to provide services, and, unfortunately, a lot of the people that we see don't have health insurance. Of the population that we see now, 70 percent don't have health insurance. I'm sure that it was as high or higher then, because there weren't the Medicaid programs and the CHIP programs that they have now. And the people that were insured, the Indian people that came to our clinic actually put a burden on our clinic and we ended up having a huge debt with Denver Health and had to close our clinic operations for the organization in 1991.

We then entered into a small agreement with a community health clinic, but all along we'd hear the community people say, "This isn't our community. Where is our clinic? We want our clinic back." And so we started to work on that.

In 1998 our board had a planning retreat, and they decided that, come hell or high water, we were going to have a clinic back in our community, and so we started out really small. Very fortunately, we found this young Indian doctor that was just so excited to be providing services and was fresh out of medical school and wanted to work for us, and she came and she helped us get our clinic licensed, so that was a big step for us. She could only work for us 20 hours a week. Unfortunately, her husband was also a doctor and—well, fortunate for them, unfortunate for us—and they ended up moving to Billings, and we lost a fine doctor, a dedicated person, so we had to backtrack and start to look at how we could continue to provide services.

Eventually, we decided that we would go with the least-expensive method of providing medical services for our community, and that was through a nurse practitioner. We felt that a nurse practitioner gave us what we needed—a lot of health education—but they can do everything a doctor can do as long as they are supervised by a doctor, except for surgery, of course, and so that's the mode we are in now. We have a volunteer physician that oversees our family nurse practitioner. We do well child checks, acute emergencies, immunizations, women's health, and abuse physicals—anything that you don't have to go to the hospital for specialty care like x rays or casts or anything like that.

Let me talk about our community.

We serve people from Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, and Gilpin Counties. That's a pretty large area, if you look at Denver metropolitan area. But we do see people that come from the reservations, particularly during March Pow-wow—you know, the things that are going on in the community we seem to see a lot of people that come off the reservation, or if they're visiting their family. I can't tell you how many times people have

come and needed prescriptions through our offices or need to get something refilled because they forgot it at home or they ran out, and so they come to us looking for those services.

Denver's population is fairly young. We have a median age of 30.2. A lot of older people don't stay in Denver, and I think it has a lot to do with their health benefits and such that they move home to the reservation because it is easier for them to receive services. If they are fortunate to have health insurance, then they'll stay, but we have a very small elderly population.

The annual income of a person that comes into our organization is $7,452, and it is kind of crazy. We wonder why we have so many people that aren't on Medicaid or the other programs, but we realize that they come to us thinking that they have a right to health care—as Indian people, they have a right to health care, and that they should be able to go to any place and receive the services that they would on the reservation.

Beyond our medical clinic, we also offer a community health program that is sort of our hodgepodge of everything. It helps with getting people prescriptions. We help pay for people's prescriptions. They also work very hard to sign up people on Medicaid and CHIP, because one of the things we try to stress is that you cannot afford to live in Denver if you do not have health insurance. One trip to the hospital will wipe you out.

We have a new diabetes program, and we'd like to thank you for the additional funds. In addition to our management of glucose and keeping an eye and making sure that our diabetics are keeping their glucose levels in check, we are going to start offering new exercise programs and teaming up with different things in the community so that we have a more active community.

We also have a behavioral health program, and that's for mental health and substance abuse counseling. It's a very small program. We are in need of psychiatric backup for a lot of the things that we provide.

We have Victims of Crime Act program, where we do case management, work very closely with the area victims' programs.

Some of the challenges that I'd like to talk to you about for Denver Indian Health—and I see them as things that can't be overcome—is that one of the things, unlike Marty's program, is our board has really struggled with is entertaining becoming a 330 program or a Federally-qualified health center or a national health service core provider because we don't want to lose our identity as an Indian provider. Right now 99 percent of the people we see are enrolled members of Federally-recognized tribes, and so we are very proud of that, and we don't want to lose that. We don't want to lose that complexion of our community.

We also see that part of it would include additional things that we don't know we could handle, and that would be signing up with an HMO and having 24-hour coverage and those type of things that we haven't been able to do now, so it really limits our ability in third-party billing and we have a lot of work to go on there.

As we have said, IHS, as a whole, is funded very low, but urban programs get the bottom of the barrel. One of the things that I'd like to mention that is very important to us is dental care. There's only one urban Indian health program that has funding for the

dental program, and that's in Albuquerque, and that's just this year that they've received the funding.

We take 10 slots a month for emergency dental people, and we've got a 3-month waiting list. I mean, I don't know how many people can plan their emergencies for their dental visits, but it is very difficult. And alot of the providers in Denver don't accept Medicaid patients, so we're getting people that have the insurance but they have nowhere to go, and that has been really hard.

A little boy was in my clinic the other day and we were looking for a pedodontist to send him to because he was deathly afraid of the dentist. We don't usually deal with children. We usually refer them somewhere else. But they wouldn't accept him, either, because his family hadn't signed up for Medicaid. And so we were looking, and I think they found a pedodontist the other day for him, and hopefully his dental care is taken care of.

One of the problems we have is hiring and retaining qualified professionals. Dr. Vanderwagen talked about 30 percent lower pay rates for doctors or people that go into the tribal centers or into IHS. We can't even begin to match the salaries that IHS provides or the tribal facilities. I have calls from people calling about the diabetes positions that I have open, and they're, like, "Well, I can't afford to move there. I'd really like to move there, but you don't pay enough." And it's, like, "Well, our budget doesn't allow for us to be able to go much higher than this." And, unfortunately, we're not able to attract them because we don't have the benefits package that IHS has.

So yes, urban programs are eligible for the scholarship repayment programs, but it is very limited because they really have to take a much more decreased salary to come and work for an urban program than they do with a tribe or with a IHS facility.

I'll go very quickly now.

Denver Indian Health and Family Services would like to support the Indian Health Care Improvement Act. We've testified on that before, of our support.

We'd also like to support the elevation of the director of IHS to Assistant Secretary for IHS. We think that through his innovation we'll be able to access other grants through SAMHSA and different programs other than IHS, and hopefully, with his speaking with one voice theme for the Indian Health Care Improvement Act and working with urban programs, that we'll begin to see urban programs included in some of the funding mechanisms. Right now a lot of things are just for tribal programs or for tribal organizations.

Denver Indian Health and Family Services supports section 535 of the amendment to the Social Security Act to clarify that Indian women with breast and cervical cancer who are eligible for health services provided under a medical program of the IHS or a tribal organization are included in the eligibility category of breast or cervical cancer patients added by the Breast and Cervical Prevention Treatment Act of 2000. Again, that's an example that the urban programs will not be included in that and the urban Indians will be left out.

We'd also like to support the demonstration projects. We've heard good things. We would like to see the report. But we think that that is one way for programs that are isolated or that want to keep

their identity as Indian providers to be able to go on and do that, so we strongly support the funding of further demonstration projects.

I want to close with a story. And I want to thank you for the opportunity to provide testimony today. As I was saying, I was working on my testimony last minute. My son is very active in the local Native lacrosse program. It's a neat program. There's about 25 families that participate in this program on a regular basis.

I was sitting there at the park with my laptop out typing and working on this, and this mother that I have been friends with through the year came up to me and said, "Kay, what are you working on?" And I said, "Well, I'm working on some testimony." And I didn't want to give her a lot of information because I didn't really want to intimidate her in any way. And she said, "Are you an attorney?" And I said, "No." I said, "I'm the director of Denver Indian Health," and she said, "You are?" And I said, "Yeah." And she said, "What are you testifying on?" I said, "Urban Indian health issues." And she said, "I have a story for you."

She's diabetic and she was pregnant with a set of twins and so she was high-risk with her diabetes and also with a set of twins. Her family had told her, "Laura, go home. Go home and have your babies on the reservation because then you won't have this huge bill when you go out." Well, Laura didn't want to go home. She wanted to have her children where she lived, and so she stayed in Denver, without realizing what would happen. She had the babies. I don't know what hospital she had them at. But they were in intensive care for quite some time.

At the time they released her and her children, Laura left the hospital with a $45,000 bill, and she told me, "You know, we couldn't afford it. We couldn't do it." But she said, "I had to have my babies. They needed this care."

So they ended up filing bankruptcy, and they've never recovered. They've never recovered from this. And I'm sure that Laura is not the only person in our community that has had those problems or had to face that type of situation.

She asked me, she said, "Will you tell my story?" And I said, "Yes, I will."

I hope that in the future you will be able to give some answers to people like Laura and provide us with additional funding for urban programs.

Thank you.

The CHAIRMAN. I thank you very much, Ms. Culbertson. We will try to help your friend.

[Prepared statement of Ms. Culbertson appears in appendix.]

The CHAIRMAN. Mr. Hall, what is your definition of an urban Indian health center? What services are they required to provide? Is there any standard?

Mr. HALL. There are basically three levels currently existing, with the highest being the comprehensive like Marty's program, where you provide a multitude of services. The second level would be limited direct, much like Kay's program, where you provide partial services. And the third level is the outreach and referral, where when people come to you for advice and how to find other services that might be available.

The CHAIRMAN. How many full-service clinics are there in urban Indian health centers?

Mr. HALL. I think there's currently 14 that qualify for FQHC. There are 10 limited direct service programs and ten outreach and referral.

The CHAIRMAN. If I may ask the directors of the centers, how do you determine your beneficiaries or your clients or your members? Do they have to be enrolled members of tribes?

Ms. CULBERTSON. Every program is different. Denver Indian Health and Family Services, because we don't have a State-recognized tribe in Colorado, do not serve any State-recognized members at this time.

When people come into our clinic, we ask them to bring their documentation either of tribal enrollment, or we will tell them, because there's so much inter-marriage in the urban areas, that they are able to collect the CDIBs, and if they can come up with one-quarter degree of Indian blood from the federally-recognized tribe we will serve them.

But I know that everybody else has different——

The CHAIRMAN. Does one have to have one-quarter blood quantum?

Ms. CULBERTSON. Yes; and then we do get the people from tribes such as the Cherokee where we get in 1/124th or something like that, but we will serve regardless of blood quantum for tribal members.

The CHAIRMAN. How is it done in Oakland?

Mr. WAUKAZOO. Self-identified.

The CHAIRMAN. What?

Mr. WAUKAZOO. Self-identified.

Ms. MEYERS. In Missoula they are enrolled member of the recognized tribe or State, and are a descendent of an enrolled member. If they can prove a descendence through the lineage, then we will be able to provide services for them.

Mr. HUNTER. In New York City, Mr. Chairman, we use the definition as it is written in the Indian Health Care Improvement Act in the current legislation, and that applies to our health services. Our other programs have different requirements, but for our health services we use that definition.

We were also able to convince the State, in its managed care planning process, to accept that definition for exemptions to mandatory managed care in the State.

The CHAIRMAN. Mr. Hall, how many individuals receive services from these health centers?

Mr. HALL. In any one fiscal year it is approximately 100,000 Native Americans. If you compute that over a 3-year period, as we do for the IHS user population, it averages about 175,000.

I would like to point out that, of those 14 comprehensive clinics, we've only got two that are about the size of Marty's. Most of us are the size of mine, which is just under $1 million of total program.

The CHAIRMAN. From your experience and from statistics that you have gathered, what is the major health problem? Alcoholism?

Mr. HALL. They're very much similar with reservation. Diabetes is a very high concern. In my program we service well over 500 dia-

betics in our three urban clinics. Another high need, of course, is alcohol program, alcohol treatment money. We have high incidence of obesity and blood pressure problems. We have high incidence of other related physical structure problems because of that.

The CHAIRMAN. Now, you have been here all morning and you have listened to the testimony of the IHS. Are you satisfied with your relationship with IHS?

Mr. HALL. Are you asking anybody in particular or all of us in general?

Mr. WAUKAZOO. Could be better. Some of the—no. No, we are not. In some ways really dissatisfied with the formulas that they use. Some of the formulas that they use for additional funding, such as diabetes, was merely division. It doesn't take into account service population. It doesn't take into account level of need. Division. Diabetes funding that just came down was, as I understand it, divided by the number of programs at two levels. So our center, with two clinics, they treat us like one clinic. We have the overhead at the San Francisco clinic, overhead costs in the East Bay, and we're treated as one clinic. If both of our clinics were stand-alone, they would probably be within the top ten urban clinics in the Nation largest. But the funding that comes down comes down based on, from what I gather over my 20 years, division is the formula being used.

Mr. HALL. There are a couple of other things, as was alluded to earlier. There is direct service, IHS-provided service. There's 638-provided service by tribal groups who operate under the 638 authority. And the authority that allows us as urban programs is the buy-Indian authority. There are inconsistencies throughout IHS in how we are treated through that buy-Indian authority, and we're trying to work as a national organization in making more uniform.

We're satisfied with a lot of our relationship with IHS and being involved in consultation and having input into several of the policies, but it is still the bottom line. We are a very tiny portion of the budget process. We're a very tiny voice in any consultation issue, often one voice among up to 50, 60 representatives. And so in the end, as you can see from the recommendations, our budgets have been the last to be fully supported, and so we've got some concerns about those kinds of things.

They're fixable. We have some concerns.

Mr. HUNTER. A lot of that also has to do—and I'll refer back to Dr. Vanderwagen's testimony, in which he mentioned several times that authority is not granted. They just don't have the authority to do some of the things for urban programs that we need, and so this is why certain parts of the Indian Health Care Improvement Act are so important, because it will give the authority that we need in order to partake of some of the services and available resources that are out there.

Ms. CULBERTSON. It becomes a tenuous relationship. I don't think that anybody is saying that they want to lose their relationship with IHS, but I think that what we'd like is some of the benefits and the luxuries that tribes and IHS share in, such as the Federal Tort Claims Act. We're not eligible for that and so we have to pay for malpractice when we become direct service providers. I think that's one of the things we need to look at.

Another thing is that they expect certain things from the urban Indian health programs, and a lot of times they expect us to function like IHS facilities or tribal facilities with the limited funding that we have. My operating budget is only about $400,000, so trying to provide all the things that IHS provides, requires is sometimes overwhelming, and so I think that there needs to be some sort of different look at how the urban programs can get their funding increased, get some of the benefits the tribes have, and also provide some support for us.

The CHAIRMAN. Montana?

Ms. MEYERS. I would like to see a more workable relationship with IHS. I grew up with IHS, and I would like to see, as an urban setting—and I put it on a personal note. I've tried to convince my parents to come live with me in Missoula, but because of the limited health coverage that they would receive in Missoula their hands are tied. They would love to come and spend time with me and live in an area that they enjoy, but because of the lack of coverage of their medical needs it is totally impossible.

The CHAIRMAN. The first panel spent some time discussing tort claims, malpractice. Is that a matter of major concern to the urban Indian health centers?

Mr. HALL. If we fully participated under that protection, it would save each one of us high malpractice insurance costs. We all have to maintain high liability once we start providing direct service for that. Again, its because of the authority. Because we're not 638, it doesn't apply to a buy-Indian provider, so technically right now, according to what is legislated, we wouldn't be able to participate in it. There would have to be some enabling legislation that would allow us to be covered by that.

The CHAIRMAN. What is the cost of insurance in Denver?

Ms. CULBERTSON. Well, for us our insurance is running about $800 a year, but we have a very good relationship with a nonprofit group that provides the malpractice insurance for us. And because we have such limited services, our malpractice insurance isn't as high.

If we opened up our doors to OB, to prenatal care, our costs would skyrocket and we wouldn't be able to afford those services.

So the malpractice really determines on what you offer, and probably the best guess is Marty's malpractice, because they are a comprehensive center and are probably the closest to what an IHS facility would be, how much their malpractice insurance costs.

The CHAIRMAN. How is it in Oakland?

Mr. WAUKAZOO. I don't have that figure in front of me right now.

The CHAIRMAN. Any figures from Montana?

Ms. MEYERS. Because we are a health outreach referral, we considered and looked at when we do become a clinic—and that's one of our goals, to become a clinic for our area. That is one issue that has been discussed among staff and our board of directors is the cost of malpractice insurance, which if we don't come under this claim, the Tort Claims Act, then we will be looking at high insurance in that area.

The CHAIRMAN. Anything in New York?

Mr. HUNTER. Very similar situation in New York, sir. We are an outreach and referral. We do direct counseling services, and on oc-

casion some of our counselors in the past have insisted that there be coverage provided. We don't have it in our budgets, and so they've had to purchase their own malpractice insurance.

The CHAIRMAN. Mr. Hunter, I would gather that most of your beneficiaries are from outside New York?

Mr. HUNTER. Yes; a large segment of the population is Mohawk from the two reservations in upstate New York. A large population is from eastern Long Island from Shinnecock and the Unkechaug Reservation. Shinnecock is about 90 miles east. That's where my family is. And Cherokee people are also a large number. In our Department of Labor statistics, I just noticed in reviewing those that Navajo is also well represented in New York City.

The CHAIRMAN. And for Montana the population is from that area?

Ms. MEYERS. The biggest population that we serve are the Blackfeet, and it goes on down to the Flathead, which is Salish and Kootenai, Asinniboine. All the 11 tribes that live in the State of Montana do come to the Missoula area, plus nationwide we have Navajos from the southwest, Apache that do come up to attend the University of Montana, and we have a variety.

The CHAIRMAN. How is it in Oakland?

Mr. WAUKAZOO. The largest group of tribes that we provide service for are the California tribes. Individually largest group is the Navajo, Lakota, Pomo, Cherokee, Apache, Paiute, Blackfeet, Choctaw, and Chippewa, in that order.

The CHAIRMAN. Denver?

Ms. CULBERTSON. Well, as I said before, 64 percent of the people we see are from the Sioux tribes, and then 30 percent are Navajo, and then it is a whole mixture. The one tribe we rarely, rarely see are the Southern Utes and the people from our home State.

The CHAIRMAN. Well, I thank you.

May I now call upon the vice chairman.

Senator CAMPBELL. Thank you, Mr. Chairman. We have a conference in another 15 minutes or so, so I'm going to submit most of my questions in writing, if that's acceptable.

I might just ask Kay, does Rosalie Tall Bull work with you?

Ms. CULBERTSON. No; Gloria works for me. She's my community health specialist. But Rosalie works for National Indian Health Board.

Senator CAMPBELL. Okay. She's my sister. I don't know if you knew that.

Ms. CULBERTSON. Yes; I knew.

Senator CAMPBELL. Tell her hello for me. You see her more than I do.

Ms. CULBERTSON. I've got alot of friends that know you.

Senator CAMPBELL. Yes; alot of relatives.

Carol, does Henrietta Whiteman still run the Native American studies program up there at Missoula?

Ms. MEYERS. No; unfortunately, Bozeman got her.

Senator CAMPBELL. Bozeman? Oh.

Ms. MEYERS. And so she's down in the Bozeman area at MSU.

Senator CAMPBELL. I see. Well, she's not my sister. She's my cousin.

Ms. MEYERS. Okay. That's good.

Senator CAMPBELL. You can tell her hello if you see her, too. I don't have any relatives in anybody else's area that's testifying, but they brought up some really interesting questions, Mr. Chairman. I'm probably not going to get into them. We just won't have the time.

But Mr. Waukazoo really I thought alluded to something really important, and that is that when you talk about Indian healing it's just not a matter of giving them pills and Band-Aids. It's a form of holistic healing. So much of Indian healing has to do with their spiritual feeling and their cultural feeling about being in balance with their surroundings and so on.

I think that when you talk about all the activities you have in your center, your health center, and Mr. Hunter's too, in New York, superficially you might say, "Well, what do those have to do with health?" But they have a lot to do with health with Indians, and I think they are really worth pursuing and worth expanding, too, if you can do this.

Obviously there's a question of how to finance all those things, and that's what I wanted to ask you. You must have a pretty large staff to do all those different activities you do. Is that all done with donations and volunteerism?

Mr. WAUKAZOO. It's done with a lot of dedication and commitment on the part of the staff. And I agree with you 100 percent about health care—it's much more than just providing health care externally in the western model.

You know, when I was growing up in South Dakota my parents used to tell me, "Get out of the house. Go out and play." Today parents are saying, "Stay in the house."

Senator CAMPBELL. Yes; you'll get sick.

Mr. WAUKAZOO. "Don't go outside." So now we have a generation who is growing up. I coach the Grasshoppers. We have a tribal athletic program, part of our clinic. The Grasshoppers are first and second graders, little guys. I coach them. We haven't won a game in 2 years, but that's not important. [Laughter.]

Senator CAMPBELL. You're developing character.

Mr. WAUKAZOO. What's very important is that they're out there getting active and they're learning that they're at risk for diabetes. But they can't even run up and down the court three or four times without getting tired. We get ahead by two or three points at the end of the first quarter but we loose by the end of the game because they're all tired.

How do we do it with financing? Well, health care is local. We spend a lot of time and a lot of energy at the local level. The local level and the State and the county delivery system have a responsibility also.

Our greatest concern is we're seeing a larger and larger group of those uninsured, those individuals that are not eligible for Medicare, Medicaid, Medical in our State.

Then we also look in that other option in partnering up with different other organizations. We will be building a youth development center in the next year which will incorporate a gymnasium, performing arts studio, fitness center, and it's really about the next generation because that's our largest population. If we can get in front of this diabetes and these other health problems, you know,

instead of trying to pull them out of the stream, go upriver and build or repair that bridge to keep them from falling into that. That's the initiative that we've taken.

We're quite proud of the fact that our physicians both have been with us for over 18 years. Our dentist has been with us for 25 years. My assistant director has been with me for 16 years.

Senator CAMPBELL. That's a commitment.

Mr. WAUKAZOO. And, following my father's advice 20 years ago when I took this job, he said, "The best place to be when you don't know anything is in charge." [Laughter.]

Senator CAMPBELL. That's why we're here. [Laughter.]

Mr. Chairman, years ago I asked an old man who was a half-brother to my grandmother, I went over to visit him one time and he had a really bad cold and I asked him why Indian people have such health problems now that they didn't have in the olden days, and he gave me an interesting answer. He said, "Because look what we're living in." I don't remember the exact words, it has been so many years ago, but he pointed out in the olden times Indian people lived with nature. In the case of the Plains people, all of their structures were round. The sweat lodge, the tepee, and so on, were all round to reflect the circle of nature, the circle of life. And he said that when they were moved into square houses it was kind of an affront to the natural way of living and he thought that their health problems went up when that lifestyle changed and living in square things instead of round things.

As I began to reflect on that, almost all Indian housing, whether it was the Plains tribes or the Southwest tribes in the desert or no matter where, the northeast, their structures were round. Maybe he knew something we didn't know. But that's what his belief was—kind of an old-time belief about why health problems go up if you're out of tune with nature.

Mr. Hall, I remember we had the infamous tobacco settlement debate here a few years ago and this committee certainly went to bat for the Indian tribes being included in that tobacco settlement. In fact, the current Secretary of the Interior came back and testified. She was the attorney general for Colorado then. She testified to help us make sure there were Indian provisions in that settlement.

The thing fell apart because, typical of the Senate, we went off in 100 different directions and we couldn't get anything passed. But States did, as you know, go ahead and sue tobacco companies and reached some settlements.

Do urban Indian centers have access to any of the settlement funds that went into States? Do you know?

Mr. HALL. That varies by St. Montana I know gets a little bit per each urban center. In South Dakota we got zip.

Senator CAMPBELL. You got zip.

Mr. HALL. All of South Dakota's money went to tax relief. California—I believe you guys participated in that a little bit. But it varied by State.

Senator CAMPBELL. State by State. There was no negotiated agreement with the States and tribes.

Another question, Mr. Hall. Some Indian centers access community health center funding. Denver does not, I understand. Is the

reason because you would have to accept anyone? Oakland does, I guess. You would have to accept anyone, regardless of whether they were Indian or not if you accept those funds?

Mr. HALL. A little bit of it is that reason. The other part of it is that those clinics pretty much operate as a clinic in a dominant society. Where the access is is from our people feeling uncomfortable in those kind of environments. For example, in the State of South Dakota the family planning office has made three major efforts to reach Native American women in the past 10 years. This July 1 they finally contracted with us for a very small contract to reach out to Native American women, and in the past 10 years they haven't increased their numbers at all, and we've already submitted 25 names in less than 1 month. So it's a matter of where Indian people feel comfortable getting their service.

It's not just a matter of their being resistant. We have to understand this whole cultural history of being Indian in this country is like being an outsider in any environment, especially when you get up in places like South Dakota. So it's not just that, it's also the recognition that Indian health care is a Federal responsibility, so many State offices and stuff are not inviting to Indian people.

Another part of the issue is it is run very much in a time constrained manner. If you're late with an appointment, just like with TANF, you end up getting on sanctions, and when you don't have gas for the car or your babysitter is not there, boomadee, boomadee, boomadee, you're late. And so people get very reluctant to do that, just like a lot of our people that qualify for Medicaid. We have to push and push and push to get them to jump through the hoops of applying for it because of a perception and in many instances the reality of being discriminated against in that application process.

So when you take a full look at how our people have bumped into walls getting service in various dominant society options, it really ends up being no option.

Senator CAMPBELL. Sure.

Mr. HALL. In Sioux Falls, for example, I've had several OB/GYN people tell us that they see a young lady or a young woman when she finds out she's pregnant and again when she calls in the emergency room having a baby because of that limited sense of comfort with the dominant society's provisions.

Senator CAMPBELL. I understand that.

Mr. HALL. Sorry for the long answer, but it was——

Senator CAMPBELL. No; that's all right. I appreciate it.

Mr. Waukazoo, as I understand it, you—what did you say? The people that come into the clinic self identify? Is that the word you used?

Mr. WAUKAZOO. Yes.

Senator CAMPBELL. That means if they come in and they say, "I'm Indian and I need help," you go ahead and help them?

Mr. WAUKAZOO. Yes.

Senator CAMPBELL. You don't ask them for an enrollment number or anything?

Mr. WAUKAZOO. No; they self identify as American Indians.

Senator CAMPBELL. Dealing with health service, then, how do you handle a mixed family? A guy comes in and says, "I'm Indian."

His wife says, "I'm not." And they've got a couple of kids with them. Do you say, "Well, we can help you but not her?" How do you deal with that?

Mr. WAUKAZOO. That's what's in the family.

Senator CAMPBELL. Okay. So if he identifies, his whole family then is——

Mr. WAUKAZOO. Yes; the community—you know, in the Bay area—in urban areas the community is spread out but it is very highly connected. It's well known. It's just like on the reservation. You know who is on the reservation.

Senator CAMPBELL. You generally know because you've seen them at activities——

Mr. WAUKAZOO. Yes.

Senator CAMPBELL [continuing]. And they participate in the community.

Mr. WAUKAZOO. Yes; right.

Senator CAMPBELL. I see.

Mr. WAUKAZOO. And that decision generally is within the family as far as where the health care is going to be taken care of, so we don't get into that part of it.

Senator CAMPBELL. I see.

I think, in the essence of time, Mr. Chairman, I'll submit the rest of my questions in writing, if I could ask the panel to respond.

Thank you, Mr. Chairman.

The CHAIRMAN. I will also join you in submitting questions, if I may.

A final question. In the Native Hawaiian Health Improvement Act, there is a provision for traditional Native healers and traditional Native Hawaiian healers are officially recognized by the Government of the United States. They are compensated for their services.

Are Native American Indians interested in having this act provide for traditional Native healers? I do not want to tell you what to do, because I believe in you telling us what to do.

Mr. HALL. I just came from the Aberdeen Area Tribal Chairman's Health Board meeting, where they spoke of this very issue. They had a healer from the Navajo Reservation that is part of the Shiprock, I believe—no, excuse me, Winslow service unit. Some of the requirements you have to go through to become billable under Medicaid are so stringent that most of the healers feel they are stepping outside of their cultural powers to participate in that, so most of them, as it is now structured, are not reimbursable.

From the conversation of the Navajo people and from the Lakota people and others up in the Aberdeen area, if that provision you're describing could be applied without having to do all of the hoops, they'd very much appreciate it.

IHS, as a whole, is being very receptive to utilizing traditional healers, and I think the tribes, but we don't all speak for the tribes. I can only speak from that experience.

The CHAIRMAN. Any objections?

Mr. WAUKAZOO. I would just say that it would be a decision that I would prefer to have the tribes make, and if the decision is yes, then we would be very supportive. But, you know, sometimes we have to, in urban programs, kind of step back and follow the tribes.

The CHAIRMAN. I think your position is correct. We will most certainly discuss this matter with tribal leaders.

Before we adjourn, I would like to note the presence of Dr. Vanderwagen. He has been sitting here all morning, and if you have been to Senate hearings you will note that Government witnesses oftentimes testify and leave immediately, but he has been here and listening to your testimony, and I think all of us owe him a great debt of gratitude. I commend you, sir, for doing that.

[Applause.]

The CHAIRMAN. He was good enough to sit here to listen to your concerns, if you had any.

With that, I thank you all for patiently waiting. Your testimony is very much appreciated. It has been inspiring and moving.

Thank you.

[Whereupon, at 12:20 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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

Mr. Chairman, thank you for holding today's hearing on the personnel and urban Indian provisions of the Indian Health Care Improvement Act.

Senator Dorgan and I chaired a field hearing last August in North Dakota to consider this legislation. I can attest to the fact that tribes in my State believe changes need to be made to the way health care is delivered throughout Indian country.

This bill is one of the most important pieces of legislation being considered by this committee. Tribes in North Dakota have told me time and again that health care is their top priority. Without healthy people, all other endeavors will be less successful.

I am pleased that the committee has worked so closely with tribes in putting together this important bill. I hope we are nearly to the point where we can pass this legislation and allow health care improvements to move forward throughout Indian country.

This is especially important for the growing number of young Native Americans. We need a greater emphasis on prevention of disease and injury overall, but especially with respect to young people. Wellness and nutrition training, teaching young people to stay away from drugs, tobacco, and alcohol, and greater attention to the mental well-being of young people are all goals that I believe we should embrace. Greater access to medical care, both rural and urban, and more health care personnel throughout the system are vital to reaching those goals.

Mr. Chairman, thank you for holding this hearing today.

PREPARED STATEMENT OF HON. TOM DASCHLE, U.S. SENATOR FROM SOUTH DAKOTA

Mr. Chairman, thank you for the opportunity to testify on one of the most important issues before this committee—our commitment to provide quality health care for American Indians and Alaska Natives. As you know, the Indian Health Service [IHS] is in far too many cases unable to provide even basic health services to American Indians and Alaska Natives. We are failing to uphold a promise we made many years ago in Federal-tribal treaties as well as Federal statute.

The IHS is tasked with providing full health coverage and care for American Indians and Alaska Natives, but is so underfunded that patients are routinely denied care that most of us take for granted and, in many cases, call essential. The budget for clinical services is so inadequate that Indian patients are frequently subjected to a "life or limb" test. Unless their condition is life-threatening or they risk losing a limb, their treatment is deferred for higher priority cases; by the time they become a priority, there are often no funds left to pay for the treatment.

As devastating as the problem is for Native American patients and the tribal governments struggling to address their people's health needs, the problem does not end there. IHS often contracts with non-IHS facilities to provide care that cannot be provided at local IHS clinics and hospitals, due either to the complicated nature

of the needed service or a lack of funds. These non-IHS facilities often receive no reimbursement for the services they provide and, as a result, face serious budget shortfalls of their own. In 1999 alone, IHS issued 20,000 contract health service denials, leaving the contract facilities without any reimbursement.

A compelling example of the impact of this underfunding is the inability of many tribes to provide emergency medical services [EMS] to their residents. IHS uses its authority through the Indian Self-Determination and Education Assistance Act of 1975 to contract EMS to tribes. Throughout Indian country, however, ambulance service is funded at only 47 percent of the determined need. On the Rosebud Reservation in South Dakota, the funding for EMS is depleted by mid-year. The Rosebud Sioux Tribe's EMS contractors respond to 425 calls per month. The local IHS facility does not have an obstetrical or surgical unit, so all high-risk pregnancies and surgeries have to be transferred by the EMS providers to private hospitals located 180 to 260 miles from the reservation. When the tribe's funds for EMS are depleted, other local providers are often called to respond to emergency transport needs. Consequently, local EMS providers experience serious financial difficulties because there are no funds left to reimburse them. Ultimately, this situation can result in discontinuation of ambulance services in a rural area.

I attempted to address the crisis created by this serious, chronic underfunding of IHS by offering an amendment to the fiscal year 2002 budget resolution. The amendment called for a $4.2-billion increase for the fiscal year 2002 clinical services budget of the IHS. This amendment passed the Senate, but was not included in the bill that returned from conference. I again attempted to address this situation in the Interior Appropriations bill, but it appears that we will be unable to do that at this time due to the inadequate budget allocation facing the Interior Appropriations Subcommittee.

It seems Congress has grown so accustomed to inadequate IHS funding that we are failing to recognize the extraordinary tragedy tribal people are facing. The problem seems so big that we are almost afraid to tackle it. But we cannot afford to shirk our responsibility.

One reason the problem seems so intractable is that IHS funding—and, in turn, health care for Native Americans—depends on the vicissitudes of the appropriations process. The budget for IHS has been so underfunded for so long, our annual appropriations process may never allow us to increase it enough to adequately address the health needs of American Indians and Alaska Natives. The magnitude of the increase I requested is evidence of this point: For fiscal year 2002, I requested a $4.2-billion increase to the $1.8 billion budgeted for IHS clinical services. This 233 percent increase is based on two conservative estimates of the amount needed to adequately fund the provision of basic clinical services: The tribal needs budget and the level of need funding budget, developed by the tribes and IHS respectively.

It is time to change the way we fund our commitment to provide health services to American Indians and Alaska Natives. This Federal responsibility was codified by treaties and laws dating from 1787 and required under the trust responsibility of the United States to the tribes. It is clear that, in a historic and moral context, American Indians and Alaska Natives are entitled to receive adequate health services from the Federal Government. Why then, are they not getting it?

What some may not know is that health care for Indians is not delivered as an entitlement. I have come to believe it is time to consider changing the funding mechanism for IHS from a domestic discretionary program to an entitlement. Unless we can demonstrate a renewed commitment to Indian health care in the budget and appropriations process, granting entitlement status may be the only way we will live up to our obligation. I understand the political challenges that this entails. For Indian people, however, this is not a. question of politics. It is a question of history and obligation. It is a question of health and life.

If Indian health were moved from a domestic discretionary program to an entitlement program, it would no longer shoulder the burden of balancing the Nation's budget, along with other discretionary programs. We would have to develop a new process to quantify Indian health based on services and beneficiaries. Funding would be guaranteed.

I wholeheartedly support, therefore, the provision in the Indian Health Care Improvement Act which establishes a National Bipartisan Commission on Indian Health Care Entitlement. I look forward to the Commission's report, and to continuing the discussion of this critical issue.

I would like to bring to your attention another critical issue impacting IHS's ability to provide health care services. The IHS experiences enormous difficulties in recruiting and retaining health professionals. In 1999, in the Sisseton Indian Health Service unit, there were 34 different physicians providing medical care in four funded provider positions. This high turnover rate significantly erodes the IHS's ability

to provide high quality health care services and continuity of care. We must address this issue because, without health care professionals, health care services cannot be delivered.

The Sicangu Sioux on the Rosebud Indian Reservation in South Dakota recently built a beautiful new hospital and health care center. While in many ways they are equipped to provide state-of-the-art care, they are unable to retain health care professionals. As a result, their brand new delivery and surgery rooms stand empty, and individuals living on the reservation are forced to travel long distances to receive these vital services.

There are many documented reasons for the difficulty recruiting and retaining IHS health professionals, including low pay, lack of suitable housing, isolation, and an overwhelming workload. Some health care professionals do not want to practice long-term in chronically underfunded, crowded and outdated facilities that lack essential equipment. I am pleased that S. 212 includes an array of excellent programs to improve the ability of the IHS to recruit and retain health care professionals. There is, however, one issue that is not addressed in S. 212: Medical license reciprocity for HIS physicians.

IHS physicians, as a condition of employment, must hold a license in at lease one State. Since they are Federal employees, this license should guarantee their ability to work as an IHS physician in any State. This concept is called "reciprocity". In South Dakota, IHS physicians are granted reciprocity and allowed to practice under a license issued from a different State. Their scope of practice, however, is limited; they are not allowed to practice outside of an IHS facility. This limitation is extremely frustrating, since, due to severe underfunding of the IHS, many areas do not have IHS facilities, such as hospitals, nursing homes, or specialized clinics. Many physicians prefer to follow their patients throughout the systems of care. If an IHS patient is transferred from an IHS facility to a non-IHS facility for inpatient care, for example, the IHS physician is currently forced to turn over the care to a non-IHS physician, who may not even know the patient.

Given the many challenges IHS faces in recruiting physicians, I firmly believe we should not create another barrier. The inability of IHS physicians to practice outside the bricks and mortar of an IHS facility has led to the resignation of too many IHS physicians. I hope we can find a way to remove this barrier as we move forward with S. 212.

I was pleased to see that S. 212 continues an emphasis on programs to comprehensively address substance abuse and Fetal Alcohol Syndrome [FAS]. According to IHS, the 1994–95 age adjusted death rate for alcoholism in the IHS Service Area was more than six times that of the general population. Yet, treatment services for Native Americans remain severely inadequate.

Programs to address FAS are particularly crucial. FAS is the leading preventable cause of mental retardation in the United States and the No. 1 cause of preventable birth defects. Although the exact prevalence of this disorder is unknown, studies have estimated that 3 out of 1,000 Native American children are born with FAS, and many more with less severe alcohol-related impairments.

These statistics highlight the urgent need for increased access to residential treatment services for women of childbearing age. In the Pine Ridge area of South Dakota, there is currently a five-month wait for IHS residential substance abuse treatment programs. This means that if an alcoholic woman learns she is pregnant and is motivated enough to request treatment, she would probably be more than 6 months into her pregnancy before a bed was available. By this time, her unborn child could be severely and permanently damaged.

We need to ensure that when a pregnant woman walks in the door to ask for help with her drinking, help is available. In addition, we need to do all we can to educate Native American women, as well as professionals who serve the Native American community [as well as the non-Native community], about FAS and the dangers of drinking while pregnant. And we need to ensure that when these approaches have failed and a child is born with FAS, that child has access to the medical, educational, and social services he or she needs.

In closing, I would like to thank the chairman, the vice chairman and the entire committee for their dedication to improving the health of American Indians and Alaska Natives. S. 212 is a comprehensive reauthorization of the Indian Health Care Improvement Act, and, when enacted and if adequately funded, will go a long way toward reducing the disparities in health outcomes between Native and other Americans. It saddens me to know that the mortality rate for American Indians and Alaska Natives is higher than for all races in the United States, and life expectancy is the lowest. I commend you for your efforts to eliminate these disparities and live up to our commitment to provide health services to American Indians and Alaska Natives.

PREPARED STATEMENT OF DR. WILLIAM C. VANDERWAGEN, ACTING CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Mr. Chairman and members of the committee. I am Dr. William C. Vanderwagen, acting chief medical officer, Indian Health Service [IHS], Department of Health and Human Services.

I am pleased to be here this morning to testify before the Senate Indian Affairs Committee about two important areas within the IHS service responsibilities.

The first issue of health manpower, providing and retaining sufficient health professionals for our health care delivery system, is one shared by the country overall. The second matter concerns the operation and challenges facing the urban Indian health programs.

In meeting our goals, the IHS has adhered to its policy of working with our tribal and urban partners and constituents, on key decisions and actions. Efforts to improve program delivery of services are greatly improved by such consultation and cooperation.

The IHS health care delivery system is comprised of 49 hospitals, 219 health centers, 7 school health centers and 293 health stations. The American Indian and Alaska Native eligible population, in fiscal year 2000 was approximately 1.51 million. This service population is increasing at a rate of about 23 percent per year, and this estimate exclude's the effect of the additions of new tribes. *[Trends 1998–99]

Patient admissions into our IRS, tribal and contract general hospitals, in fiscal year 1997, were about 85,000. Main causes for admission were births and pregnancy complications. The 2 ambulatory statistics in fiscal year 1997 show over 7.3 million medical visits provided through the IHS-funded operations.

There, are additional data to be found in our IHS 1998–99 Trends publication, but the main purpose of this review is to provide the backdrop against which much of our discussions will take place this morning.

It is to the credit of our personnel, health professionals and others, that all of our IHS and tribally operated health facilities had achieved accreditation by the Joint Commission on Accreditation of Health Care, Organizations [JCAHCO]. This rating was true as of January 20, 1999.

To fulfill our primary goal of ensuring that we achieve the highest possible health status among American Indians and Alaska Natives, the health professions activities are critical but could be tested over the next 5 years. The IHS could lose a substantial number of its staff for a variety of reasons, including age-eligible retirement and the fulfillment of service obligations.

As of the end of June 2001, nearly 22 percent of our 13,000 Federal employees, throughout the whole system, had 20 or more years of service. Within the health professions, 18 percent of the 8,600 health-related employees in the 600 personnel series, in which most of the health professionals are found, are in the 20-plus years category. Finally, of the three most numerous health professions, nurses, pharmacists, and dentists, all of these groups have more than 12 percent of their staffs in this group age-eligible retirement category. Physicians have 8 percent of all of our IHS physicians are in the 20-plus years category.

Our plans for addressing this pending situation include the institution of even more vigorous recruitment efforts and a greatly increased emphasis on retention. Such activities include:

1. Increased advertising in professional journals.
2. Increased Health Educational Institution Recruitment Visits.
3. Increased web-based Advertising.

Retention has been a major factor in reaching our current status. The average length of service for all IHS employees is just over 12 years. For those in the 600 series, it is just over 11 years.

Of our four most numerous professions, nurses have the longest average length of service, at nearly 11 years. Physicians, with 8 years, have the shortest, while dentists and pharmacists average just over 9 years each. The difficulty, however, is that we lose many of our new recruits before they have served 5 years. Therefore, retention of new employees must remain a priority.

These difficulties in retention include culture and transition issues, within rural and often disadvantaged communities. Additionally, the competition for such qualified individuals is huge. Many of these professionals are often approached by other health care institutions with more attractive employee benefits packages and placements. This situation, of competing health care systems, is only going to grow in future years as our population, national and in Indian communities continue to live longer and more productive lives.

Our scholarship and loan repayment programs offer us the opportunity to attract highly qualified staff. In fiscal year 2000, 37 new scholarships were awarded to participants in two undergraduate scholarship programs in the Health Professions with 46 extensions. Forty-five new awards were made in the Preparatory Pregraduate scholarship program with 61 extensions, and 60 new awards were made to students in a health professions graduate programs with 287 extensions.

In fiscal year 1996, the average debt load of a new loan repayment program participant was S32,000. In fiscal year 2000, it was $64,000. We anticipate that this individual debt load will be even higher this year.

Such educational financial assistance, in turn, assures the IHS of a service commitment by the individual who receives such aid. Service "payback" commitment can range from 2 to 4 years. Once such commitment is completed, an individual may have private practice goals or family obligations that preclude their further employment within the Indian health care system.

Today 62.3 percent of all American Indians and Alaska Natives identified in the 1990 Census reside off-reservation. This figure represents 1.39 million of the 2.24 million American Indian/Alaska Natives identified in the 1990 Census updated by Indian Health Service. The updated 1994 Census identifies 1.3 million [58 percent] of the American Indian/Alaska Natives residing in urban areas. For comparison purposes the Indian Health Service total service population is 1.4 million with active users at 1.2 million. This figure includes 427,100 eligible urban Indian active users who reside in geographic locations with access to an Indian Health Service or Tribal facility.

In 1976 Congress passed the Indian Health Care Improvement Act [IHCIA] [Public Law 94–437]. Title V of the [IHCIA] targeted specific funding for the development of supporting health programs for American Indians/Alaska Natives residing in urban areas. Since passage of this landmark legislation, amendments to title V have strengthened Urban Indian Health programs [UIHPs] to expand to direct medical services, alcohol services, mental health services, HIV services, and health promotion and disease prevention services. [Public Law 100–713, Public Law 101–630, Public Law 102–573].

The UIHPs consist of 34 nonprofit 501 (C)(3) programs nationwide funded through grants and contracts from the Indian Health Service, under title V of IHCIA, Public Law 94–437, as amended. Sixteen [16] of the 34 programs receive Medicaid reimbursement as Federally Qualified Health Centers [FQHCs) and others receive fee for service under Medicaid for allowable services, that is, behavioral services, transportation, et cetera. The other programs are automatically eligible by law but may not provide all of the necessary primary care service requirements mandated by FQHC legislation. Over $10 million are generated in other revenue sources.

In the Omnibus Budget Reconciliation Act [OBRA] of 1993, title V of the IHCIA, and tribal 638 self-governance programs were added to the list of specific programs automatically eligible as FQHCs. The range of contract and grant funded programs below are provided in facilities owned or leased by the Urban organizations. Pursuant to title V, the Indian Health Service is required by law to conduct an annual program review using various-programs standards of Indian Health Service and to provide technical assistance to the Urban Indian Health Programs.

The range of Indian Health Service/Urban grant and contract programs services can include: Information, outreach and referral, dental services, comprehensive primary care services, limited primary care services, community health, substance abuse [outpatient and inpatient services], behavioral health services, immunizations, HIV activities, Health Promotion and Disease prevention, and other health programs funded through other State and Federal, and local resources, for example, WIC, Social Services, Medicaid, Maternal Child Health.

Sixteen [16] of the 34 programs are certified as Federally Qualified Health Centers. The other programs are automatically eligible by law but may not provide all of the necessary primary care service requirements mandated by FQHC legislation.

Today the Indian Health Service provides funding to the 36 [34 title V of the lHCIA and two demonstration programs] urban Indian health centers and to 10 urban Indian alcohol programs. The urban Indian health programs, range from comprehensive primary care centers to referral and information stations. In fiscal year 2001 Congress appropriated $29,843 million for Urban Indian Health. These centers continue to receive funding as well, from a variety of other Federal, state and private sources.

Mr. Chairman, this concludes my prepared statement, I will be happy to respond to any questions you and other committee members may have.

PREPARED STATEMENT OF MICHAEL E. BIRD, PRESIDENT, AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. Chairman and members of the committee, I am Michael Bird, president of the American Public Health Association. However, today, I am representing the Friends of Indian Health, a coalition of over 40 health organizations and individuals. The Friends were formed in 1997 to improve the funding and delivery of health services to American Indians and Alaska Natives [AVAN].

We thank you for the opportunity to testify today and to comment on health care personnel issues that we think could be addressed in the Reauthorization of the Indian Health Care Improvement Act, S. 212. While the individual members of the Friends have profession specific concerns we are united on the need to improve the recruitment and retention of health care providers in the IHS.

A member of the Friends recently sought care from the Phoenix Indian Medical Center [PIMC]. For a 1 o'clock doctor's appointment, he left his home at 11 a.m., arriving at the PIMC at noon. Having been there before, he knew that he needed to arrive an hour before his appointment because patients are seen on a "first come, first serve" basis . . . even though he had a scheduled appointment. At this facility, the patient to doctor ratio is overwhelming. Not only does it serve Indian patients from the Phoenix city limits but also patients from the adjacent reservations that do not have inpatient services are brought in by vans. The patient was eventually seen but also told that his back condition had worsened and would probably need surgery for several herniated discs. However, because of a lack of orthopedists at the PIMC he was unable to schedule a consultation until September 27. The patient's check up took all afternoon; he returned home at 5 p.m.

This experience is not unique. There is a disparity in access to care throughout the Indian health care system. For example:

- In fiscal year 1998, there were 74 physicians per 100,000 AI/AN beneficiaries, compared to 242 per 100,000 in the overall U.S. population;
- In fiscal year 1998, there were 232 registered nurses per 100,000 AI/AN beneficiaries, compared to 876.2 per 100,000 in the overall U.S. population;
- In fiscal year 1998, there were 289 public health nurses in the IHS. This represents a ratio of 19.8 per 100,000 AVAN beneficiaries;
- In fiscal year 2000, there were 21 IHS psychiatrists;
- In fiscal year 2000, there were 63 IHS psychologists;
- In fiscal year 2001, there were 19 podiatrists to treat the more than 60,000 AI/AN diagnosed with diabetes;
- In fiscal year 2001, there are 11 vacancies for optometrists. Unless these positions are filled, 27,500 patients will not receive care;
- In fiscal year 1998, the dentist to AI/AN beneficiary ratio was 1:2,793 compared to 1:1,743 for the overall U.S. population; and,
- In fiscal year 1999 there were only 20 registered dietitians per 100,000 AI/AN beneficiaries.

Another way to view this situation is to compare the IHS to the Veterans Administration. For example, the Carle T. Hayden Veterans Medical Center and the PIMC are within a mile of each other in central Phoenix. The total number of outpatient visits at the VA facility was 8,339, compared to 14,400 at the PIMC, a difference of 6,060. The VA employs 9.5 psychologists, while the PIMC employs 4 psychologists. The total number of behavioral staff at the VA was 75.5, as compared to the 17 behavioral staff at the PIMC.

While the disparity to access to care is most pronounced in the IHS, it will not be long before the rest of the country will see similar problems. Various health professions are already experiencing or expect to experience shortages in the near future. For example:

- According to the American Hospital Association's June 2001 *TrendWatch,* 126,000 nurses are currently needed to fill vacancies at our nation's hospitals. Today, fully 75 percent of all hospital personnel vacancies are for nurses;
- According to a study by Dr. Peter Buerhaus and colleagues published in the Journal of the American Medical Association [June 14, 2000], the United States will experience a 20-percent shortage in the number of nurses needed in the United States health care system by the year 2020. This translates into a shortage of more than 400,000 RNS nationwide;
- In the next 20 years, 85,000 dentists will retire and only 81,000 will replace them;

- The June 2001 *TrendWatch* also reports that hospitals have a 21-percent vacancy rate for pharmacists; and
- Podiatry has experienced a nearly 50 percent reduction in its applicant pool since the 1990's. In addition, the number of graduates is also dropping. This is occurring when most States have only 1 to 4 podiatrists per every 100,000 citizens. Federal estimates recommend 6.2 podiatrists per 100,000.

The *Friends* believes that by improving access to treatment and preventive services the IRS will be able to make significant strides in reducing health disparities and morbidity and mortality rates in the AI/AN population. Evidence of this was demonstrated by the placement of a full time podiatrist with the Winnebago and Omaha tribes. During his 4-year tenure, the average annual 16 leg amputations fell to zero. Not only did this improve the daily living and quality of life for tribal members and their families but there was a considerable cost savings also. On the average, medical and surgical costs associated with leg amputations can average $40,000 a piece. This one podiatrist saved the tribes over $2 million in surgical expenses during his tenure.

But the IHS needs to move quickly to better recruit and retain health care providers now. If the Administration waits too long then in the near future when competition for health care providers throughout the country becomes more intense, the IRS will not be able to compete for these workers. In order for that to happen, Congress needs to make it easier for the IHS to recruit health care providers.

Suggested Solutions;

1. Loan Repayment

The most successful recruiting tool that the IHS has is loan repayment. A few years ago, following recruitment visits to dental schools, the IHS dental branch received 100 calls from interested graduating seniors. However, almost every caller asked about the availability of loan repayment. When they learned that it was minimal, actual applications fell to just over 30. Loan repayment is an excellent recruiting tool. Of the 19 podiatrists serving in the IHS, 13 are receiving loan repayment. Most health professionals have incurred heavy debt loads during their education. The average debt load of the 272 people entering the IHS last year was $64,000. But that figure understates several individual professions:

- The average student debt for physicians is $95,000;
- The average student debt for optometrists is over $100,000;
- The average student debt for dentists is $100,000 [this does not include undergraduate debts]; and
- The average student debt for podiatrists is $110,000.

As part of the *Friends* fiscal year 2002 appropriations request, we requested that the IHS loan repayment budget be raised to $34 million. This is an increase of $17 million and would allow the IHS to double its workforce. The IHS could further extend this funding if Congress were to make these loans tax-free. Under the current system, Congress not only pays health care providers an annual sum of $20,000 but also pays an additional 20 percent of that amount for taxes. Therefore, $3.4 million goes to the Internal Revenue Service. If the loans were tax free, this would allow the IHS to hire 170 more providers. Just doubling the number of IHS dentists getting loan repayment would mean that 53,000 more dental visits could be scheduled each year. The *Friends* recommends that the committee include a provision in S. 212 to make the loans tax-free.

2. Loan Deferment

Under the Higher Education Act, volunteers or members of various health and Federal programs do not have to repay the principal of, or the interest on, any student loan under the Act for 3 years. This includes members of the

- Armed Forces,
- Peace Corps,
- Domestic Volunteer Service,
- Full time nurse or medical technicians providing health services, or
- Full time employees of a public or private nonprofit child or family service agency who is providing, or supervising services to high-risk children from low-income communities.

Health care personnel working in the IHS or for tribes are noticeably absent from this list. Consequently, recent graduates must begin immediate repayment of debt upon graduation, when their net incomes are at their lowest. For some, that monthly payment can be over $1,000. Faced with this burden, many health care professionals cannot afford to join the IHS, whether as Commissioned Corps, Tribal hires or urban hires. For those who do take the risk of joining while waiting to be accepted for loan repayment, many soon discover that they cannot make ends meet be-

cause of their enormous debt load and leave the IHS to accept more lucrative opportunities. Therefore, the *Friends* recommends that the Committee correct this omission in S. 212 in order to improve the recruitment and retention of IHS health professionals.

The need for a robust loan repayment and deferment program is especially critical when one considers that the IHS pay scale lags far behind the private sector. For example, in 1998, the average net income among general practice dentists that graduated less than 10 years ago was $141,690, while the newly graduated dentist in the Commissioned Corps earned slightly more than $50,000. Similarly, the average annual income for IHS pediatricians is nearly $40,000 less than for pediatricians in the private practice. This occurs despite the fact that one-third of the AI/AN population is under the age of 15.

3. Housing for Health Care Providers

Another important aspect of recruiting health care personnel is adequate housing. At some sites, health care providers have reported it is discouraging to have to live in housing that is "worse than college dorms." The American Dental Association reported to Congress, following a 1997-site visit, that a dentist was leaving a remote site because of the unlivable conditions of her mobile home. No suitable housing could be found to retain her services. In some areas, health care providers are forced to live miles away, often in other States, in order to find decent housing for themselves and their families. The Friends believes that the IHS needs to assess its staff quarters and develop a consistent approach to replacing or building new staff quarters. Therefore, the *Friends* recommends that committee include a study of staff quarters and a proposal for addressing the situation in S. 212.

4. Exit Interviews:

As the IHS approaches the next decade and must compete for health personnel with the rest of the country, the *Friends* believes that it would be very helpful to require exit interviews of departing employees. Determining whether staff are leaving because of non-competitive salaries, high debt burden, inadequate housing, spousal needs or a lack of an "esprit de corps" would be essential to quickly making corrections to prevent others from leaving. The *Friends* has heard anecdotal stories that because of the Government Performance and Results Act [GPRA] that midlevel support personnel have been lost and paperwork burdens have increased. These changes directly impact on patient care. They decrease the number of patients that can be treated and reduce prevention education programs which help to keep down the level of disease. Health care providers feel overburdened which leads to bum out and retention problems. For example, the financial resources in the IHS are at 40 percent of that need to provide mental health services. Most Service Units and Tribal programs are operated with one or two providers, who provide primarily crisis-related services with little backup due to the isolated, rural nature of their practice. Not surprisingly, professional burnout leads to rapid turnover, adversely affecting the availability of a single backup psychiatrist, let alone the essentials of an adequate, cost-effective mental health program. Maintaining strong patient-provider relationships is essential to good care, but if the provider doesn't stay long enough to form such a bond, it undermines the care and prognosis of the patient.

Increasing the Use of Students and Volunteers

The IHS employs approximately 500 pharmacists. Many of them joined the IHS after completing a residency at IHS sites. The pharmacists have 11 IHS sites where students can do their residencies. Interestingly, new pharmacist hires have a better retention rate than other health care professionals during the first 5 years of working for the IHS. While the Friends cannot state for sure that this is due to the students' early exposure to the IHS we recognize that such a program offers great opportunities. We would like to see the IHS work with other professional organizations and education groups to create similar programs. We believe that this would help to ease the provider shortage on a short-term basis when the students are at the sites and possibly in the long run for recruitment efforts.

In addition, the *Friends* would like to see the IHS explore ways to recruit active and retiring health care professionals interested in providing care on a part-time or temporary basis. For example, the American Academy of Pediatrics has received more than 300 requests from active physicians for information about its Locum Tenens program, a national initiative that identifies short-term pediatric opportunities at IHS sites. Additional, we believe that many other providers are not ready to completely retire and would be willing to volunteer a week, a few days a month or even 6 months of their services. Their experience and expertise, particularly specialists like OB/GYNs, psychiatrists, oral surgeons, and orthopedic surgeons are in high demand. However, in order to make use of these professionals the IHS needs to create a program where such volunteers can be recruited, enter easily without a lot of paperwork, provide adequate housing and assure the volunteers that liabil-

ity would not be problem. The *Friends* recommends that the committee include in S. 212 a pilot project to create such a program in consultation with professional organizations. Individual members of the *Friends* would be pleased to work with the IHS on such a project.

Thank you Mr. Chairman and members of the committee for offering the *Friends of Indian Health* the opportunity to testify today on the Indian Health Care Improvement Act. We hope we have provided the committee with thoughtful suggestions and we will try to answer any questions you might have.

FRIENDS OF INDIAN HEALTH

AIDS Action
American Academy of Child & Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American Academy of Pediatric Dentistry
American Academy of Physicians Assistants
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Colleges of Podiatric Medicine
American Association of Dental Schools
American Cancer Society
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Physicians
American Dental Association
American Diabetes Association
American Dietetic Association
American Geriatrics Society
American Hospital Association
American Medical Association
American Nurses Association
American Occupational Therapy Association
American Optometric Association
American Osteopathic Association
American Pharmaceutical Association
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Public Health Association
Arizona Academy of Family Physicians
Association of Schools of Public Health
Friends Committee on National Legislation
National Kidney Foundation
National Rural Health Association
National Native American AIDS Prevention Center
George Blue Spruce, D.D.S.
Ward Robinson, M.D.
William Treviranus, D.O.
James Zuckerman, M.D., Harvard Medical School

PREPARED STATEMENT OF CAROLE MEYERS, EXECUTIVE DIRECTOR, MISSOULA INDIAN CENTER, MISSOULA, MT

Honorable Chairman and committee members, my name is Carole Meyers, executive director for the Missoula Indian Center, Missoula, MT. I am an enrolled member of the Blackfeet Tribe and also a descendent of the Oneida and Seneca Tribes. I would like at this time and thank you for this opportunity to testify before your committee on the issues of urban health problems in Missoula, MT.

The Missoula Indian Center is a Non-Profit 301 c. (3) organization and has been in existence in Missoula, MT since April 1970. This organization has assisted the Native American community in Missoula for thirty-one (31) years as a health referral agency. The population of Native American's in the Missoula Community is approximately 3,100 people with, 65 tribal representations from across the Nation. Missoula, MT has a population of 74,000, home of the University of Montana, which

many of the Native American people who move to Missoula attend the University system. Montana has seven (7) reservations and there are eleven (11) different tribes that live in each area. When Native American's leave their home reservation and move to an urban area, such as Missoula, they face many obstacles. One of the most noticeable is their health coverage. Once they live in an urban area for 180 days, they loss all of their Indian Health Service coverage.

I want to go on record that I fully support the passage of Indian Health Care Improvement Act Reauthorization of 2001 S. 212. This reauthorization of this bill would allow Native American people to receive the necessary health coverage to enjoy a long and healthy life.

The definition of "Urban Indian" means any individual who resides in an urban center and who-(A) regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands or groups that are recognized by the States in which they reside, or who is a descendant, in the first or second degree, of any such member.

This definition needs to part of the Indian Health Care Improvement Act. In order for the Urban Indians to receive adequate funding; we need to be recognized as our own unique group of Indian people. Living away from the reservation does create different situations.

Below is a listing of the program the Missoula Indian Center provides:

Indian Health Service
- Immunization Health Promotion/Disease
- Prevention AIDS
- Alcohol
- Mental Health
- Diabetes
- Adolescence Substance Abuse Program
- Health
- Chemical Dependency Program

Missoula County
- Alcohol

State of Montana
- Alcohol
- Tobacco

The Missoula Indian Center is governed body by a 7-member Board of Directors, of which, 51 percent, must be Native American. The Missoula Indian Center is organized under two major programs; the Health Programs and the Chemical Dependency Programs. There are 11 full-time staff and one part-time Mental Health Counselor.

The health issues that surround the Native American population range from diabetes to the common cold.

With our agency as a health referral organization, many of our clients may see as many as three (3) to five (5) different health providers in a course of 1 year. With this inconsistency of health providers, there is not a medical history that follows the clients. This creates more confusion and lack of medical knowledge of the client's history. Many times, because of lack of funding, clients will be referred to at the point of emergency medical attention. There is very little prevention health care, such as a yearly physical or dental check-ups.

The Missoula Indian Center's Health program provides quarterly clinics that cover basic health issues. Which, in itself is an excellent program activity. But a significant problem the Health program faces is, if a client has a medical problem we do not have the resources to provide the medical follow up that is necessary. For example, at our quarterly, clients are provided with a blood screening, this is a very through medical screening. If a client's medical report comes back as an issue, they are basically on his or her own to seek medical assistance. It is a safe estimate that 80 percent to 90 percent of our clients do not have medical insurance so they look to us for their medical needs but we do not have the funding resources to help them in their crisis. The only thing we can advise them if to go back to their home reservation to seek medical help but some require a 6-month waiting period for residency purposes.

The Missoula Indian Center had 8,865 encounters this past year. These encounters are community members who access the center for medical issues, drug and alcohol counseling to utilizing the telephone. We are looked upon as a "One-Stop" agency for many needs other than medical. Other prevalent issues besides the health are: No. 1, housing; No. 2, employment; No. 3, school (K–12 and Higher Edu-

cation); No. 4, law enforcement and; No. 5, food. These are a few that we see on a daily base if not weekly.

The center staff networks with other agencies within the Missoula community, such as Office of Public Assistance, Casey Family Foundation, Youth Court, Adult Parole and Probation, Pre-Release Center, Missoula County School District, Missoula Food Bank, Public Health Clinic, Now Care, Missoula Housing Authority, Human Resources, City Police Department and Missoula County Sheriffs Department, just to mention a few. Networking within the community is important because many of our Native American clients utilize those agencies and if there are issues that clients face, we can advocate for them. The Missoula Indian Center offers "In-Service" training for those agencies that want a better understanding the type of services we provide.

Presently, we contract with other health agencies, such as Partnership Health Clinic at a reduced cost for a doctor's visit. This enables Health funds to cover more clients over the course of a year. But this does not address a client's need for medical followup or maintenance.

When a client needs to have a prescription filled, we are able to transport them to St. Ignatius on certain days, located on the Flathead Indian Reservation, which is a 90-mile round trip. Because of the Salish and Kootenia Tribal policies, clients have to physically present themselves to pick up their medication. This creates some hardship on our clients due to the fact that they may not have transportation to drive to St. Ignatius or money to purchase gas for their car. When the health staff transports, this takes them away from their regular workday.

The other service clients can utilize is the dental clinic. But in order for a client to be seen, it has to be an emergency and they have to be at the dental office by 8 a.m. in order to be seen by a dentist. This means, the client has to leave Missoula by 7 a.m. in order to have dental care. And once again, by the time they need emergency dental, it is a tooth ache or some type of infection and it is in a crisis setting. Plus, this trip can and is often dangerous drive to St. Ignatius because of the hazardous weather conditions Montana has during the winter months.

As you can read in my testimony, there are many factors that play in to affect when it comes to the health issues of Native Americans living in an urban area. Native American's leave their home reservation for many reasons. The most prevalent is education. Trying to achieve a higher education degree is of the utmost importance from many. This enables individuals to have a better life style, achieve a goal not too many Native Americans have been able to accomplish in the past. But in order for them to achieve this goal, they have to move to an urban area to attend a 4-year higher education institution. At times, it can be very difficult in the sense they experience "culture shock" when they move to an urban location. The transition period for adjustment can be up to 1 year to feel comfortable and cope with many of the difficulties they encounter. Within the capacity of my job, I have seen many Native American's try to better themselves and their families but at times when they are faced with medical problems or other issues and no where to turn, the only alternative would be for them to move back home and at times, the cycle poverty or frustration continues.

The Chemical Dependency programs the center offers are Intensive Outpatient and Standard Outpatient with some group/individual counseling sessions. Since these programs are Montana State Certified that enables them to apply for other funding through State and County programs. Not only the Native American clients utilize these programs, the non-Native American's attend these sessions. The type of programs the center offers has a Native American/spirituality theme and many of the clients who participate have commented that a "wholelistic" approach to their addictive issues has benefited them with their recovery. The Missoula Indian Center is the only program in the Missoula area that offers this type of services. Other programs in the Missoula area have recognized the spirituality of these Chemical Dependency counseling sessions and have commented the uniqueness of them.

The health programs assist with the Chemical Dependency clients. They offer HIV testing and counseling, Hepatitis-C testing, and encourage them to attend the quarterly clinics they offer. Many of them not only come in with an addiction problem but as well noted stems into many health issues.

Diabetes is a prevalent health issue that is on the rise with many of the recovery alcoholic. One incident that comes to mind is a pre-release client utilizing the Chemical Dependency program complained of having a blister on his foot. The pre-release staff accompanying him that day thought it was not a big deal but I told her that a blister on a diabetic could be fatal. She was not aware of the significant problems that Native American diabetics face everyday with their disease. I offered to have the health staff come to the Pre-Release Center and provide their staff with an "In-Service" on the health issues of diabetic clients.

I want to thank you for your time for listening and reading my testimony; it has been a privilege and honor to come before you with my thoughts and ideas. Each and everyday Native American's are faced with issues and problems of health, employment, and education. I sincerely hope with my testimony that our issues have been personalized and "survival" on day-to-day bases for the Native American people is a very real issue.

PREPARED STATEMENT OF MARTIN WAUKAZOO, EXECUTIVE DIRECTOR, URBAN HEALTH BOARD, INC., NATIVE AMERICAN HEALTH CENTERS SAN FRANCISCO AND OAKLAND, CA

Although the majority of Native Americans live in urban settings, most Federal funding for Native health care and community initiatives goes to those who continue to live on reservations. The basic medical and dental needs of urban Indians are unmet in addition to other areas including mental health, substance abuse, HIV/AIDS prevention and treatment, diabetes prevention and treatment, and capital needs. Urban Indian Health Board, Inc. was established in 1972 to address the health needs of the urban Indian population of the San Francisco Bay Area. In that year, Indian Health Services [IHS] funding comprised ninety percent of our operating budget. Today, IHS grants amount to only 14 percent of our total funding. Our success in fundraising and in service delivery can be attributed to decades of sacrifice and persistence. However, consistent funding is becoming more difficult to achieve when costs rise faster than the needs of our service population.

Our service area is the five counties of the San Francisco Bay Area including Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties. Preliminary Census 2000 figures show nearly 80,000 Native American/Alaska Native and multirace/Native individuals reside in these five counties. The Bay Area has one of the largest concentrations of urban Indians in the country.

Urban Indian Health Board, Inc. is a nonprofit 501(c)(3) community health care provider operating two licensed clinics, one in San Francisco, since 1972, and one in Oakland, since 1983. We employ 120 health workers. Our operating budget for the current year is $7.1 million. The Board of Directors is composed entirely of Native Americans and serves on a volunteer basis.

Ninety-eight percent of Native American patients served meet the Federal poverty level guidelines. In 2000, the medical clinic saw over 4,800 patients with over 16,800 visits. Many of our patients are members of tribes from across the United States with the largest number representing California tribes, Navajo, Lakota, Pomo, Cherokee, Apache, Paiute, Blackfeet, Choctaw, and Chippewa.

Our services reflect our expanded definition of health: The health of an individual depends upon the health of a community. Since our agency is one of the few Native organizations in the Bay Area, we are in a unique position to directly impact our community's health. Thus, we function as far more than a medical clinic. As part of our mission to contribute to the health and growth of our community, we offer adult and pediatric services in our two clinic settings; women's health care; prenatal care; a WIC program; comprehensive dental care; mental health services including substance abuse counseling; fitness and nutrition counseling; health education and outreach; and a variety of youth initiatives through our Native American Youth Services program.

We believe health is whole-body and community-based. Urban Indians feel a sense of isolation and disconnect from the broader community. As a health service provider, we step in to try to ameliorate that feeling of isolation among our community members. Our clients are disproportionately young, poor [nearly every client in 2000 was below the poverty line, with fully 13 percent at 200 percent or more below poverty level], and impacted by physical and mental health issues specific to a people that has suffered cultural and physical dislocation and decades of poverty. Disparities have arisen in disease and mortality rates between Native peoples and the general population. We believe these disparities are due to the consequences of poverty and cultural dislocation, with urban environments like our own only exacerbating the lack of family and traditional support systems.

We face several overlapping challenges: Those specific to urban Native populations, and those specific to the Bay Area. For instance, the rate of substance abuse is higher for urban Native Americans than for any other ethnic group, while the rate of HIV/AIDS among Native Americans is higher in the Bay Area than in any other Native service area. In the five counties, we estimate that over 75 percent of Native American families suffer from substance abuse, domestic violence, and mental illnesses. Additionally, we believe that over 50 percent of urban Native American children are emotionally disturbed or at high risk for mental illness, substance

abuse, and delinquency. The suicide rate for Native American teenagers is higher than for any other group.

Another challenge we face is a disproportionate rate of diabetes. In a local study we conducted last year, we found that two-thirds of the adults and youth in the study group fell into the nutritionally poor to very poor category. This correlates with our experience that the most common physical problems facing our patients are diabetes, heart disease, obesity and chemical dependency. Poor dietary practices and lack of exercise contribute directly to heart disease and the development of diabetes.

Urban Indian Health Board's operates two licensed clinics but we are treated by Indian Health Services as one entity for funding, programmatic and evaluative procedures. Although there are 34 urban Indian clinics in the nation, our clinics are counted as one site. Funds for urban clinics for some programs are distributed now via a simple method of division between the 34 urban sites across the country that serve Native Americans.

We advocate that the formula for distribution be redrawn to coincide with the number of Native people in the service area and that area's cost of living. This determination would far more accurately reflect the costs of providing care to those in need. For instance, additional money for diabetes care was recently distributed, yet our clinics received only a tiny portion of that funding despite the fact that a full twenty percent of our 18,000 patient visits were due to diabetes.

There is no urban clinic IHS funding available for capital needs. Our agency is stretched beyond our limits as we struggle to meet the increasing demand for services. Presently, we are at full capacity and need immediate capital funds. Existing facility problems such as poor design, insufficient exam rooms, inadequate information systems and technology, and limited access for the handicapped result in the inefficient provision of services. Capital investments in urban Indian health centers will increase access to primary and preventive health care.

The cost of providing health has increased significantly over the years. Pharmacy costs, which accounted for 44 percent of health care costs nationwide last year, is growing much faster than other components of health care. Providing this benefit for indigent patients has become an overwhelming financial drain on our clinics. Our clinics' pharmacy costs increased by 34 percent from fiscal years 1998–99 to 1999–2000. Pharmacy costs have skyrocketed so significantly that they directly reduce our ability to provide primary care services, as we must devote more of the IHS funding to cover the cost of prescription drugs.

Health insurance premiums for our employees have also increased dramatically over the past 3 years. The premium rate for our clinic has increased by 28 percent in the past 3 years. The increase in health insurance premiums directly reduces the clinics' ability to provide primary care services. As we spend more money to provide health insurance for our employees, there are fewer funds available to provide care.

The California energy crisis is also having a major impact on our clinics. Our clinics' utility costs have increased by approximately 40 percent this fiscal year. Finally, workforce issues have also had a tremendous impact on our clinics. Our clinics' ability to provide quality health care is limited by the number of health care professionals that we are able to hire and retain. Often, salaries are not competitive enough to attract various health care professionals. In addition, vacancies directly limit the resources that we have to serve our community.

A disproportionate number of Native Americans are ineligible for any subsidized insurance programs. Our clinic has struggled to respond to the ever-increasing demand for our services, particularly by uninsured patients who have no other system of health care to utilize. Furthermore, as we enroll more children into health insurance programs, we are seeing changes in the patient mix that reflect an older population facing more chronic diseases, with the need for acute care and a greater number of pharmaceuticals. We are now seeing a greater number of patients with chronic conditions requiring more than one visit and a greater amount of health care services resulting in increased costs. Because the number of uninsured patients seeking care at our health centers continues to increase, urban Indian health clinics need additional funding to cover the ongoing health costs of serving more indigent patients and patients that have more expensive health care needs.

Ninety-eight percent of our clinic patients are low-income and approximately 60 percent are uninsured. In the past 3 years, we have seen a 10-percent increase in older uninsured patients. This older population faces a greater amount of chronic conditions, requiring more acute care, a greater number of pharmaceuticals and more than one visit. Our data also shows a 30-percent increase in patient visits per year in the last 3 years. This data likely reflects an increase in clinic patients that are needlessly suffering from chronic conditions/diseases.

In response, our clinics for the past 2 years have been working on a diabetes management initiative. While physicians play a key role in diabetes management, other

health care professionals including health educators, community health workers, nurses, case managers, and nutritionists are crucial to assisting patients in their disease management by helping individuals learn self-management skills and assisting patients to make behavioral changes in their lifestyle.

In conclusion, our community clinic is a strong and vibrant organization committed to providing the highest quality of care for our community. As an urban Indian clinic we must be creative and resourceful to weave available funding opportunities to address the need of our community. We have developed linkages with the system of health care in the broader community in the San Francisco Bay Area while at the same time build alliances with other IHS funded urban programs. For example, we have a working partnership with the Friendship House of American Indians of San Francisco who is developing an 80-bed residential treatment facility, the first major development project in the Indian community of the Bay Area. We are also working with Friendship House to build a 75,000 square foot Youth Development Center in Oakland, a project which is in pre-development with anticipated site control within the next 30 days.

These projects in our community continue to underscore the need for greater investment in our community. Many times we fall through the cracks and remain unrecognized within the broader discussions of Indian issues. Although I.H.S. funding only composes 14 percent of our total operating budget, for every one dollar invested by IHS we are able to leverage another $6 from other sources.

We have several recommendations which address the level of need in our community and will ultimately increase the level of care for our patients. A funding augmentation is required to provide immediate "pharmacy relief to allow the our clinics to maintain their capacity for primary care visits. A special augmentation is also required that would provide our clinics with relief from health insurance premium increases. With soaring energy costs already making a tremendous impact upon our operating costs, we would recommend and allocation to offset increased energy costs and provide our clinics with additional funds to address the shortage of health care professionals in our clinics. The demographics of our patient population is ever-changing along with the cost of care. We recommend an adjustment in the funding formula that would take into consideration the higher health care costs to clinics given the changing patient mix. With an increasingly older patient population, we require Increased funding to cover costs for patients participating in chronic disease management initiatives. Although we strive to provide a high level of care, capital needs in our facilities is at an all-time high, we strongly recommend allocations of funding to address greatly needed capital and facility improvement needs. Finally, we recommend funding for regional and culturally competent approaches to diabetes prevention and treatment, substance abuse prevention and care, youth violence prevention and HIV/AIDS prevention and treatment.

We would like to thank the committee for allowing us this opportunity to share with you our concerns, our successes and our recommendations. Our ability to provide quality care for our unique community is directly affected by your work and your commitment. We are fortunate for the opportunity. Thank you.

PREPARED STATEMENT OF KAY CULBERTSON, EXECUTIVE DIRECTOR, DENVER INDIAN HEALTH AND FAMILY SERVICES

Good morning Chairman Inouye, Vice Chairman Campbell and other distinguished committee members. My name is Kay Culbertson, I am an enrolled member of the Fort Peck Assiniboine/Sioux Tribes located in Poplar, MT. I serve on the board of directors for the National Council of Urban Indian Health and I am the Executive Director for Denver Indian Health and Family Services [DIHFS] located in Denver, CO. On behalf of the Denver Indian Community, I would like to thank you for the opportunity to provide testimony regarding health issues of Indians who reside off reservation and the Urban Indian Programs that serve them. There are currently 34 urban Indian health programs located throughout the United States, with each program offering a variety of medical service through many creative and innovative delivery types. Today, my focus will be on Denver Indian Health and Family Services.

In the past, Denver attracted Indian people for a variety of reasons. Denver was one of the original sites for relocation of Indian people from their home reservations. A segment of Denver's Indian population is a result of Indian men and women who settled here after serving in the armed forces. Another segment came to Denver because there was a Bureau of Indian Affairs office located in the area. Many Indian people moved from the reservation to the Denver area with the hope of attaining the "American Dream". And today, Denver continues to be a hub for Indian people.

Denver's Indian population is estimated at 25,000 and is comprised of people who have lived in Denver for over 30 years producing second and are third generation Denver natives as well as those who are transient and move to and from the reservation on a regular basis. The universal reason for moving continues to be "Hope for a better future".

Although Denver is centrally located within "Indian country" and many national Indian organizations are headquartered in Denver, it is isolated from tribal health and Indian Health Service services, the closest Indian health facility in Colorado is located on the Southern Ute Reservation, an 8-hour, drive. The nearest Indian Health Service Hospitals are in Rapid City, SD and Albuquerque, NM. Unlike other urban health programs we do not have the ability to utilize other Indian health facilities to meet the gaps in services.

Denver Indian Health and Family Services was created as the result of a needs assessment conducted by the Denver Native Americans United. Denver Indian Health and Family Services was incorporated in 1978, as a non-profit Indian organization and received funding from the Indian Health Service to provide outreach and referral services to the Indian community. With a staff of two people, the agency gathered and provided information to Indian people in accessing health care in the Denver metropolitan area. Eventually, DIHFS began to provide limited health care through volunteer nurses and doctors and grew into a full scale clinic entering into an agreement with Denver Health and Human Services. The number of uninsured and the inability to charge American Indian patients placed a much larger financial burden on the organization and clinic services were discontinued in 1991. Unfortunately, the health care needs of the community exceeded the funding limits of the agency. In 1996, DIHFS entered into an agreement with a local community clinic to provide services at a limited cost; however, the agency could only allow two visits per year and the patients were responsible for their own laboratory and x ray costs. This arrangement made it difficult to provide health care to persons with chronic medical problems such as diabetes. The community voiced the need for additional health care. Not just any health care but health care that was culturally sensitive and available through an Indian organization or provider.

At a 1998 strategic planning retreat the DIHFS board of directors planted the seeds to begin the process of providing medical services to the Indian community onsite. The board of directors stressed the importance of taking slow steps to providing health care. The board of directors insisted that the services be provided by DIHFS, that patients would receive more health education, that the delivery of services be provided in a manner that was comfortable to Indian patients, that the financial pitfalls of the past be avoided and that we maintain our identity as an Indian provider and an Indian clinic. In March 1999, a young Indian physician, Dr. Lori Kobrine, took on the task of laying the foundation for our clinic. Through her efforts our clinic met the requirements for state licensure. She worked 20 hours a week providing limited medical services to the community. Now our clinic continues to grow. Since May 2000 our clinic has been staffed with a full time nurse practitioner and a volunteer physician who provide medical services on a full time basis to the community. The medical services include immunizations, acute emergencies, well child physicals, physicals, women's basic health, diabetes management and screening and other health services that do not require a specialist or that are not life threatening. DIHFS also provides mental health and substance abuse counseling, substance abuse prevention, case management services for victims of crime, energy assistance, diabetes case management, prescription assistance, emergency dental, and referrals to meet other community health needs.

The cachement area for DIHFS includes Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, and Gilpin counties. However, we also serve people who travel from as far as Pueblo and Aspen. There is also an increase in services during peak months of March, June, July, and August for persons who are visiting during the annual March Pow-wow or who are staying with relatives over the summer. DIHFS is located in southwest Denver near the old Fort Logan facility. Although located outside of central Denver, DIHFS is conveniently located near the Denver Indian Center and Denver Indian Family Resource Center, making referrals to other Indian organizations and coordination of case services much easier for Indian clients.

The Denver Indian community is fairly young population with the median age of 30.2 as compared to 34.5 for all other races. The majority of DIHFS clientele are single parent heads of household. The average income reported by DIHFS patients is $621 per 4 month or $7,452 per year. Seventy-three percent of DIHFS patients do not have health insurance.

The Medical Clinic provides onsite services through a family nurse practitioner. Appointments are scheduled for 1 hour at time to allow for intense patient education regarding their presenting problem. The most common diseases treated in the

clinic are diabetes, hypertension and dental pain. Wellness screening services include women's health, family planning, men's health, well child checks and education.

The Community Health Program is the most often utilized program is the agency. DIHFS assists with prescriptions purchases, energy bills, adult emergency dental through a contract dentist, referrals for denture purchases, transportation, tribal enrollment for patients, optical exams and glasses and many other health related problems. Education regarding the importance of health insurance [private or public] is stressed in the Community Health Program. We currently have a Denver Health Authority navigator stationed at our office to assist Indian people with access the Denver Health system and walk clients through the enrollment procedure for the State Child Health Plan and Medicaid.

Our Diabetes Program is staffed by a Certified Diabetes Educator and has focused on bringing traditional foods back into our diets. The focus has been on the Plains Indian diet with additional research on Southwest Indian traditional diet. Diabetic patients are provided with free glucometers, and strips to encourage regular checking of glucose levels. The project also assists diabetic patients with special eye exams, podiatry checks, shoe inserts, shoes, glasses and medications.

Behavioral Health services include mental health and substance abuse counseling and youth substance abuse prevention support in area schools. The program assists with antabuse physicals and medication, psychological evaluations and court support. The outpatient and women's counseling program are the only American Indian programs in the Denver area that are licensed through the Colorado Department of Health, Alcohol and Drug Abuse Division.

Victims of Crime Act funds a small case management project for Indian victims of crime. The Bureau of Justice Statistics released a report in February 1999 detailing the rates of victimization for Indian people. The study found that American Indians were victims of violence at twice the rate of the U.S. population, that rates of violence are higher than any other group in every age group, and that alcohol was more often involved in crimes against American Indian persons at double the rate of any other race. These are sobering statistics.

As you can see DIHFS has accomplished a great deal with the limited amount of funding; that is received and the limitations of our community. We have learned to build relationships with other programs and meet some but not all of the gaps in service delivery to American Indian people living in the Denver area.

In providing services we have encountered barriers that tribes may not face. If we accept Medicaid, become a National Health Service Corp provider, federally Qualified Health Center or a 330 Community Health Center our services must be open to all people. This places a strain on our identity as an Indian clinic.

Seventy-three percent of the patients seen in our clinic do not have insurance because they are underemployed, have recently moved to the area, the employer does not provide health benefits or they do not qualify for any other health benefits. Often Indian people who come to an urban area have a misconception that urban Indian health programs are virtually the same as the Indian Health Service or tribal health programs on the reservation and may not elect to sign up for health care benefits. Indian people assume that IHS is everywhere. DIHFS does not currently have an affiliation with a health maintenance organization [HMO] because we have neither 24 hour coverage nor hospital admission privileges. These issues also do not allow us to generate third party billing from Medicaid because the State of Colorado contracts with HMO's to provide services to the Medicaid beneficiaries. The patients who have health insurance do not utilize their providers due to the expense of copay amounts or deductibles, they enjoy receiving services at the Indian clinic or wait times for visits are not as long.

Indian Health Service is severely under funded as a whole, but urban Indian programs receive the least amount of funding. If urban programs were f1mded at the same amount and provided the core services of a tribal or IHS facilities, American Indians living off reservation would have access to comprehensive health care.

Dental services are limited. DIHFS is limited to 10 emergency dental appointments a month. The dental waiting list is months long. Affordable dental care is difficult to find, even for persons with private or public insurance. Very few dentists accept Medicaid patients. Only one urban program has received funding from the Indian Health Service for dental services.

Hiring and retaining quality professionals has been difficult. DIHFS has an operating budget of $430,000. The medical field is highly competitive in the Denver area and we are not always able to compete with other health facilities for staff. DIHFS does have the opportunity to provide IHS scholarship recipients with payback opportunities and although there has been much interest to work in Denver, we are not

able to provide them with a salary and benefit package that is commensurate with tribal and IHS staff positions of the same level.

Denver Indian Health and Family Services supports S. 212 a bill to amend the Indian Health Care Improvement Act. We strongly support inclusion of urban Indian health programs in title IV, Access to Health Care.

Denver Indian Health and Family Services also supports S. 214 a bill to elevate the position of Director of Indian Health Service to the Assistant Secretary for Indian Health. Through the leadership of Dr. Michael Trujillo and his concept of "Speaking with One Voice" there has been an increase in support from both tribal leaders and Indian Health Service professionals to address the needs of tribal members who live off reservation. The elevation of the Director to Assistant Secretary will benefit both tribes and urban programs in their ability to access other Department of Health and Human Service programs as well as to bring to the forefront the severe disparities in health for Indian people as a whole.

Denver Indian Health and Family Services also supports S. 535 a bill to amend the Social Security Act to clarify that Indian women with breast or cervical cancer who are eligible for health services provided under a medical care program of the Indian Health Services or a tribal organization are included in the eligibility category of breast or cervical cancer patients added by the Breast and Cervical Cancer Prevention and Treatment Act of 2000. We recommend that urban Indian health programs also be included in the eligibility category. During my testimony to the Senate Committee on Indian Affairs in March 2000 regarding the Indian Health Care Improvement Act, I relayed a story of a woman with breast cancer who did not have insurance and had no way of receiving services. Her only option was to return to the reservation and hope that Indian Health Service would extend coverage to her. We may be able to avoid these scenarios if urban Indian health programs are included in S. 535.

Denver Indian Health and Family Services also strongly recommends that the feasibility of additional demonstration projects such as those located in Tulsa and Oklahoma City be funded. We recommend that one site be funded in an area that is isolated from other IHS or tribal facilities. It is recommended that the project include provisions for comprehensive medical, dental, and hospital services.

Once again, thank you for the opportunity to testify on behalf Denver Indian Health and Family Services. I would like to close my testimony with the following story:

My son is active with the local Native Lacrosse Program. There are approximately 25 Indian families who regularly participate in this most worthwhile sport. The program not only promotes exercise and culture but also serves as an informal social support system for parents while the youth practice. I was writing my testimony for today when a young mother named Laura inquired about my work. I told her that I was working on addressing urban Indian health issues to the Senate Committee on Indian Affairs. She became very excited and went into great length about the need for more comprehensive health care for Indian people in Denver. She told me of the birth of her twin children and how her diabetes had caused complications in the pregnancy. The young family did not have health insurance because of layoffs and they were not eligible for other services. She was told by her family to go home to Oklahoma and have her twins at the Indian hospital but she chose to stay because they could not afford to travel back home. She gave birth to her children at an area hospital. The twins were kept in intensive care for an extended amount of time. After the twins were released from the hospital the family was presented with a $45,000-hospital bill, a bill that they would never be able to satisfy. The family had to file for bankruptcy and today continues to suffer from the effects of that action. Laura asked me why she was not allowed to have the same medical care as her brothers and sisters who live on the reservation, why was there not an IHS facility for people in Denver? She asked that I tell you this story today. I hope that in the near future I will be able to tell Laura that you heard her questions and provided the Denver Indian community with additional health care resources.

PREPARED STATEMENT OF WAYNE TAYLOR, JR., CHAIRMAN, HOPI TRIBE

Thank you, Chairman Inouye, Vice Chairman Campbell, and other distinguished members of the Senate Committee on Indian Affairs for allowing the Hopi Tribe to provide testimony on S. 212, legislation to reauthorize the Indian Health Care Improvement Act. We are grateful for your continued attention to improving health care services for all Native Americans.

The Hopi Tribe looks to Congress as the ultimate Federal trust authority. Vested in your authority is the ability to ensure the provision of quality health services for

all Native Americans. We value your counsel and depend in no small measure on your assistance in establishing an array of health services of critical importance to all tribes.

I would like to provide the Hopi Tribe's comments on four provisions of title II of S. 212 dealing with medical services covered by the Indian Health Service [IHS]. Each of these four provisions addresses a service area that is critical for the improvement of the health status of the Hopi people, and we strongly urge the committee to enact the strongest possible provisions in these areas during the 107th Congress.

The Hopi Tribe strongly supports requiring the Secretary of Health and Human Services, through the IHS or Indian tribes or tribal organizations, to provide mammography screening for Indian women at an appropriate frequency under national standards and consistent with those established for the Medicare program. It is essential to the improvement of the health and survival of Indian women that the IHS and tribes be able to significantly increase the availability of early screening, diagnosis and treatment.

One- and 5-year breast cancer survival rates are significantly lower among Southwestern American Indian women compared with non-Hispanic whites, despite the lower rates of breast cancer observed in the Indian population. One of the major factors contributing to this poor rate of survival is the later stage at which breast cancer is diagnosed in the Indian population.

The reduction in breast cancer mortality when screening mammography is available to American Indian populations is estimated at 27.9 percent. Among populations whose disease is more advanced when it is first diagnosed, as among Southwestern American Indian women, the reduction in mortality with screening mammography increases another estimated 26.4 percent.

The 1993 "Healthy Hopi Women Survey" of 559 women on the Hopi Reservation confirmed the lack of knowledge about breast cancer screening. Only 55.7 percent of these women had knowledge of a mammogram procedure, and less than 20 percent knew when women should begin to have screening exams. Only 61 percent of the women surveyed reported having annual clinical breast exams as recommended by the American Cancer Society—less than one-half of the women 40 years and older had ever had a mammogram and only 26.4 percent had one in the 2 years preceding the survey. The results were similar for women age 50 and older—less than 25 percent of those women had both a mammogram and a clinical breast exam in the 2 years preceding the survey. The survey confirmed that the proportion of women receiving screening mammography and clinical breast examinations is significantly lower than the rate proposed in the Year 2000 goals.

The Hopi Tribe Breast and Cervical Cancer Early Detection Program currently provides breast screening services to women 40 years and older. The program works in collaboration with Indian Health Service to provide mammography services to women who are seen through the program or through Indian Health Service. At this time, Indian Health Service is unable to cover the cost of services for mammography services and will provide women with mammography service only when it is necessary. Often times, many women who are covered under Indian Health Service for mammography services are already at high risk for cancer. The Hopi Tribal Breast and Cervical Cancer Early Detection Program currently covers the cost of mammography service for all women who reside on the Hopi Reservation and who are eligible through the program. Women who are not eligible through the program are unable to receive a mammogram unless they pay for the cost or have private insurance to cover the cost.

To date, 48 percent of enrolled Hopi women ages 40 and over have been screened through the Hopi Tribal Breast and Cervical grant program. Although nearly one-half of the women in this age category have been screened, there is still a need to screen the other 52 percent of the population. While the Breast and Cervical Early Detection provides breast and cervical screening to all women, services are limited due to the lack of a full-time women's health provider as well as the availability of space for services.

With additional funds available to provide screening services, the Hopi Tribe will be able to screen all women regardless of their eligibility through the program. The program will also be able to hire a full-time physician to provide screening services to women on a daily basis and eliminate the waiting time of 3 months for a women's health exam. Outreach and awareness in the community is essential, as many Native American women do not understand the importance of early detection. The Hopi Tribe needs additional funding to increase our ability to provide preventative breast and cervical cancer services, thereby decreasing the cancer rate for native women and improving the chance of survival for women who suffer breast or cervical cancer.

The Hopi Tribe also strongly supports the "Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001" introduced by Senator Jeff Bingaman [D–NM], which would correct an oversight made by Congress when it enacted the Breast and Cervical Cancer Prevention and Treatment Act of 2000. Senator Bingaman's bill [S. 535] would ensure that Indian women with breast and cervical cancer who are eligible to received health services from the IHS or a tribe or tribal organization will be included in the optional Medicaid eligibility category of breast and cervical cancer patients added by the 2000 legislation. Without this legislation, Indian women who are diagnosed with breast or cervical cancer through the CDC program may still find themselves ineligible for coverage of any treatment services. We strongly urge the committee to support the prompt enactment of this legislation.

The Hopi Tribe is also strongly supportive of the provisions of S. 212 to require the Secretary, acting through the IHS or tribes or tribal organizations, to provide funds for appropriate patient travel costs, including transportation by ambulance, specialized vehicle or private vehicle, or by air transportation or such other means as may be available when ground transportation is infeasible.

We have presented testimony to the committee in the past regarding the difficulty of providing necessary emergency medical transportation services on geographically remote reservations such as ours. Insufficient funding for adequate staffing and outdated equipment has left our existing emergency medical service [EMS] team constantly struggling to provide services. While they do a wonderful job, our EMS personnel are stressed for time and lack the equipment necessary to perform certain lifesaving functions. Our program lacks the resources to staff the program according to industry standards for the time and distances involved in rural transport.

The closing of reservation hospitals in Indian country and replacing them with ambulatory care centers and consolidating medical services adds to the burden on emergency medical services teams and magnifies the importance of providing necessary emergency and non-emergency transport. Patients must now travel longer distances for necessary inpatient care, requiring highly trained personnel as escorts and more advanced equipment. Thus, the change health care system itself is increasing the critical role of emergency transportation and advanced life support care yet the system has failed to provide the financial resources necessary to meet the need, resulting in a growing gap in the continuum of health care.

We applaud the committee's effort to require the Secretary to provide funds for patient travel costs. However, we remain concerned that our tribe and others will have difficulty purchasing the high-cost emergency vehicles and equipment needed to provide these services. Further, given the historical under-funding of IHS contract health services, we are very concerned that simply requiring the Secretary to pay for these added costs from already inadequate funds would ultimately fail to address the problem. We urge the committee to address these concerns as it addresses the legislation.

We are very pleased that the committee bill recognizes the need to address health care related services such as long-term care, home- and community-based services including homemaker/home health aide services, and assisted living services. The Hopi Tribe, like many others, faces serious challenges in providing necessary health care for our aging population.

Respect and care for our elders is one of the fundamental elements of Hopi culture and heritage. As a result, the traditional Hopi concept of family care-giving includes a cohesive community that emphasizes the desire to keep all members at home—where elders are able to remain active members of the community and participate in the care of close and extended family members. Since 1978, IHS and Bureau of Indian Affairs [BIA] statistics indicate that Hopi has maintained the lowest nursing home placements of all the 19 Arizona Tribes. In this context, it is critical for the tribe to establish and maintain services that are locally available and accessible to our elders.

Currently, about 25 to 30 Hopi members reside in respite care facilities located in Phoenix, Flagstaff, and Payton. It is difficult for family members to travel these significant distances to visit their elders, and the elders themselves feel cutoff from their family and community. To remedy this situation, the tribe is seeking funding support from the State of Arizona to establish Senior Centers in 3 of the 12 Hopi reservation villages. We have also initiated planning for an on-reservation long-term and respite care facility. However, there remains a significant need for planning, design, engineering and construction funding.

The geographical remoteness of our reservation and language barriers have also made it difficult to access many State services. Service providers must currently travel 4 hours from their Phoenix office to provide care for Hopi seniors, and even then they are available for a limited time. All of our elderly are Hopi-speaking with

limited proficiency in English, and they are often discouraged from applying for state or Federal services because of the communications barrier that exists between them and their service providers. We are investigating the possibility of establishing a local, on reservation office in partnership the State agencies and recruiting and training Hopi-speaking providers to reach a broader client population.

Since 1978 the Hopi Tribe has contracted with the IHS to participate in the Community Health Representative [CHR] program. There are currently more than 325 Hopi seniors in all 12 reservation villages receiving services ranging from patient care and monitoring to case management, education and counseling, and disease prevention. It is crucial that Congress continue to support and increase funding for this important support program.

In conclusion, thank you again for allowing the Hopi Tribe to present this testimony. We look forward to working with you during the course of your deliberations on legislation reauthorizing and enhancing the programs provided through Indian Health Care Improvement Act. I would be pleased to respond fully to any request for additional information.

United States General Accounting Office

GAO

Testimony

Before the Committee on Indian Affairs,
U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.,
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FEDERAL TORT CLAIMS ACT

Coverage and Claims for Tribal Self-Determination Contracts at the Indian Health Service

Statement of Barry T. Hill, Director,
Natural Resources and Environment

GAO-01-1001T

Mr. Chairman and Members of the Committee:

The Indian Self-Determination and Education Assistance Act was passed in 1975 to encourage tribes to participate in and manage programs that for years had been administered on their behalf by the Department of Health and Human Services and the Department of the Interior. The act authorizes tribes to take over the administration of such programs through contractual arrangements with the agencies that previously administered them: Health and Human Services' Indian Health Service and Interior's Bureau of Indian Affairs.[1] For the Indian Health Service, the programs include mental health, dental care, hospitals, and clinics, and for the Bureau of Indian Affairs, the programs that can be contracted by tribes include law enforcement, education, and social services.

Under the first 15 years of the Self-Determination Act, tribal contractors generally assumed liability for accidents or torts (civil wrongdoings) caused by their employees. However, in 1990, the federal government permanently assumed this liability when the Congress extended Federal Tort Claims Act (FTCA) coverage to tribal contractors under the Self-Determination Act. Originally enacted in 1946, FTCA established a process by which individuals injured by federal employees could seek compensation from the federal government. As a result of extending this coverage to tribal contractors, individuals injured by tribal employees may, under certain circumstances, seek compensation from the federal government. For example, if a patient receives negligent care at a tribal health facility, administered under a self-determination contract, the injured party may be able to seek compensation from the federal government for their personal injuries.

[1]Throughout this statement, the term "tribes" will refer both to tribes and tribal organizations eligible to contract programs under the Indian Self-Determination and Education Assistance Act. Also, the term "contracts" will refer to contracts, grants, self-governance agreements, cooperative agreements, or annual funding agreements entered into pursuant to the Indian Self-Determination and Education Assistance Act, as amended.

To gain a better understanding of how this coverage works, you asked us to review and report on various aspects of it. We provided this Committee with our report on July 5, 2000.[2] We testified before this Committee last year on the combined FTCA claims history for tribal self-determination contracts at the Indian Health Service and the Bureau of Indian Affairs and FTCA legal issues that are unique to tribal contractors.[3] Our testimony today will focus solely on the Indian Health Service. Specifically, our testimony will (1) describe the process for implementing FTCA coverage for tribal self-determination contracts and (2) present the FTCA claims history for tribal self-determination contracts at the Indian Health Service for fiscal years 1997 through 1999. The status of the FTCA claims presented in this testimony has been updated since our July 2000 report and is current as of July 15, 2001.

In summary:

- Federal regulations implementing FTCA prescribe the process that federal agencies must follow in resolving claims arising from the negligent or wrongful acts of federal employees. With the extension of FTCA coverage to tribal contractors, tribal employees or volunteers under a self-determination contract are considered federal employees for the purpose of FTCA coverage. According to FTCA regulations, claims are subject first to an administrative review and determination by the federal agency whose actions gave rise to the claim. At the administrative level, the Department of Health and Human Services handles these claims for the Indian Health Service. If a claim is not resolved administratively, a lawsuit may be filed in federal court, where the Department of Justice would defend it. Administrative and legal settlements may be paid from agency funds, the U.S. Treasury, or tribes' private liability insurance if duplicative coverage exists.

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[2]*Federal Tort Claims Act: Issues Affecting Coverage for Tribal Self-Determination Contracts* (GAO/RCED-00-169, July 5, 2000).

[3]*Federal Tort Claims Act: Claims History and Issues Affecting Coverage for Tribal Self-Determination Contracts* (GAO/T-RCED-00-234, July 12, 2000).

- Data on FTCA claims involving tribal contractors are not readily available because the Department of Health and Human Services is not required to track these claims separately from FTCA claims involving federal employees. However, in response to our request for claims data, the department identified 114 claims, filed from fiscal years 1997 through 1999, that arose from programs contracted from the Indian Health Service. Total damages claimed were $487 million. Patient care activities and vehicle accidents of a few tribes gave rise to most of the claims. Although about half of the claims remain open, 58 (involving $230 million in claimed damages) have been brought to closure at a cost of less than $700,000. Of the claims brought to closure, 40 resulted in settlement payments and 18 were denied.

Background

The Federal Tort Claims Act was enacted in 1946 and provides a limited waiver of the federal government's sovereign immunity. It specifies the instances in which individuals injured by the wrongful or negligent acts or omissions of federal employees can seek restitution and receive compensation from the federal government through an administrative process and, ultimately, through the federal courts. The Department of Justice handles lawsuits arising from FTCA claims.

The Indian Self-Determination and Education Assistance Act of 1975 allowed Indian tribes to contract for administration of certain federal Indian programs. As originally enacted, tribal contractors assumed liability for torts caused by tribal employees performing official duties. The act authorized the Secretaries of Health and Human Services and the Interior to require that tribal contractors obtain private liability insurance. People injured by the actions of tribal contractors could file claims against tribal employees or their tribes.

By the late 1980s, the Congress recognized that some tribes were using program funds to purchase private liability insurance, which reduced the funds available to provide direct program services. Thus, the Congress amended the act in 1988 and required that

beginning in 1990 the Secretaries of Health and Human Services and the Interior obtain or provide liability insurance or equivalent coverage for the tribes. Also in the late 1980s, the Congress began to enact statutes extending FTCA coverage to tribal self-determination contracts. In 1990, this coverage was extended permanently, thus giving injured parties the right to file tort claims against and recover monetary damages from the federal government for injuries or losses resulting from the negligent actions of tribal employees.

Federal Indian programs that tribes can contract under the Self-Determination Act fall under the jurisdiction of the departments of Health and Human Services and the Interior. Within these departments, the primary agencies responsible for administering Indian programs are the Indian Health Service and the Bureau of Indian Affairs, which have a combined annual appropriation exceeding $4 billion. Indian tribes administer about one-half of these programs, or about $2 billion annually. As of March 2000, there were 556 federally recognized tribes. Agency officials estimate that nearly all of the federally recognized tribes administer at least one contract from the Indian Health Service or Bureau of Indian Affairs, either directly or as a member of a tribal consortium.

The Indian Health Service and the Bureau of Indian Affairs programs administered by a tribe under the Self-Determination Act may represent only a portion of that tribe's total activities. The other programs tribes operate outside of the Self-Determination Act may include other federal programs, such as federal housing assistance for Native Americans under the Department of Housing and Urban Development, early childhood educational and care programs under the departments of Education and of Health and Human Services, and tribal enterprises, such as gaming operations and smokeshops or convenience stores. These programs have generally not been extended FTCA coverage. The tribes themselves are liable for any injuries or damages caused by these programs, and they may choose to protect themselves against this liability by purchasing private liability insurance.

FTCA Regulations Prescribe Administrative and Judicial Review of Claims

The federal regulations implementing FTCA prescribe the process that federal agencies must follow in resolving claims arising from the negligent or wrongful acts of federal employees. With the extension of FTCA coverage to tribal contractors, tribal employees or volunteers under a self-determination contract are considered federal employees for the purpose of FTCA coverage. According to FTCA regulations, claims are subject first to administrative review and determination by the federal agency whose actions gave rise to the claim. Claims must include evidence and information about the actions giving rise to the injury and the injury sustained, and must be presented in writing to the responsible agency within 2 years. The claim must also request a specific amount of compensation. Once a claim has been filed, the agency has 6 months in which to review the claim before the claimant may file suit in federal court. The administrative review can result in a claim's being denied, settled, or undecided.

Claims arising from Indian Health Service programs are filed with the Department of Health and Human Services' Claims Branch in Rockville, Maryland. The Claims Branch reviews all claims for completeness and requests additional documentation as necessary. For nonmedical claims of $10,000 or less, the Claims Branch can issue the initial administrative determination; those claims over $10,000 are forwarded to the Office of General Counsel for a determination. A more rigorous review process exists for medical claims. Each medical claim must undergo three reviews: (1) a site review at the facility where the incident occurred; (2) an independent medical review from an off-site provider(s) in the pertinent field; and (3) a review by the Public Health Service's Quality Review Panel. The recommendations of the Quality Review Panel on the medical merits of the claim are then returned to the Claims Branch. The Claims Branch can issue the initial administrative determination for medical claims of $10,000 or less, while claims over this amount are forwarded to the Office of General Counsel.

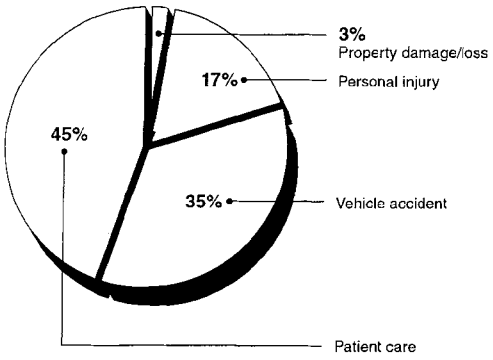
The claimant must go through the administrative claims process before filing suit in federal court. The Department of Health and Human Services can approve settlements of less than $25,000. The Department of Justice must approve larger settlements. Settlements of $2,500 or less are paid directly from agency funds, and larger settlements are paid from the Judgment Fund in the U.S. Treasury.[4] Ultimately, if the claimant is dissatisfied with the administrative determination, the claimant may file suit in federal court. The Department of Justice handles lawsuits arising from FTCA claims. FTCA claims involving tribal contractors may be turned over, or "tendered," to private insurers when tribes have private liability insurance policies that provide coverage for the same incidents covered under FTCA.

Over One Hundred Claims Have Been Filed;
Most Involve Patient Care and Vehicle Accidents

Data on FTCA claims involving tribal contractors are not readily available because the Department of Health and Human Services is not required to track these claims separately from FTCA claims involving federal employees. However, in response to our request for claims data, the department identified 114 claims filed from fiscal years 1997 through 1999 for programs contracted by tribes from the Indian Health Service. Total damages claimed were $487 million. Patient care claims accounted for about 45 percent of all claims involving tribal contractors (51 out of 114 claims) filed during this period. Claims involving vehicle accidents constituted about 35 percent of the total, and personal injuries, about 17 percent (see fig. 1).

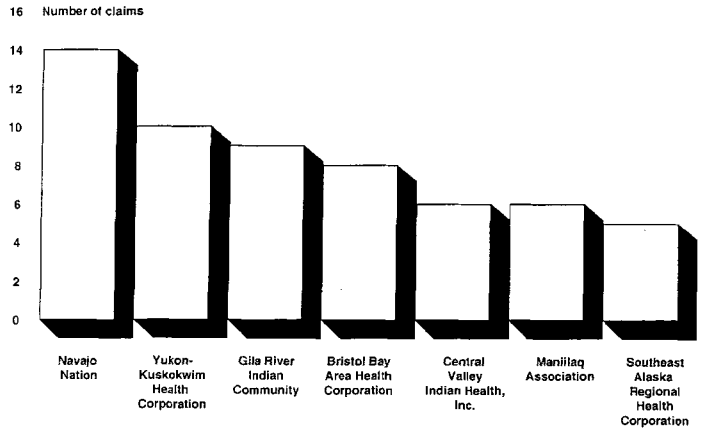
[4]The Judgment Fund is a permanent indefinite appropriation available to pay certain settlements and judgments against the federal government.

Figure 1: Claims Arising from Tribally Contracted Programs From the Indian Health Service by Type of Claim, Fiscal Years 1997-99



These claims involved tribally contracted programs for 40 contractors. The Indian Health Service contractor with the most claims—the Navajo Nation—had 14 claims, about 12 percent of the total. Seven contractors were involved with five or more claims during the 3-year period (see fig. 2).

Figure 2: The Seven Indian Health Service Contractors Involved With the Most Claims, Fiscal Years 1997-99



One of the reasons why so few of the 556 tribes had claims involving their self-determination programs is because FTCA coverage is still not well-known or understood by attorneys, tribes, or potential claimants, according to the agency officials that process these claims. Also, to the extent that tribes continue to carry duplicative private liability insurance, claimants may be referred to private insurers rather than to the federal government for compensation.

The damages claimed ranged from a low of $75 to a high of $100 million, with a median claim amount of $1 million. The $75 claim involved damages to a car that was parked adjacent to a tribally contracted facility. A tribal contract employee was treating a wooden fence with water sealant when some of the overspray damaged the finish on the claimant's car. The $75 claim to remove the spray and to wax the car was paid in full. The $100 million claim involved an alleged misdiagnosis that resulted in delayed treatment for breast cancer. This claim was denied because the evidence failed to establish that the claimant's condition was due to an act or omission of the tribal physician.

As of July 15, 2001, for the 114 FTCA claims filed from fiscal years 1997 through 1999 involving tribal self-determination contracts 40 resulted in settlement payments, 18 were ultimately denied and the final outcome of 56 claims is still pending either administratively or in litigation. The status of the claims filed changes frequently as new administrative determinations are made, lawsuits are filed, or settlement agreements are reached. The figures presented in this testimony have been updated since our July 2000 report. Overall, for the 40 claims that resulted in settlement payments 31 were settled administratively and 9 through litigation. Including the 18 claims that have been denied, a total of 58 claims have been brought to closure, or about 51 percent of the 114 claims. These 58 claims have been closed at a cost of about $680,000 out of the $230 million claimed in these cases. According to agency officials, the small, simple claims for minor incidents, such as a "fender bender," are generally resolved quickly, while the large, complex claims may take longer to resolve. Although $680,000 has been paid to date to resolve claims involving tribal contractors filed from fiscal years 1997 through 1999, this figure will likely increase as the remaining claims are resolved. For example, since our July 2000 report the total settlement amount has increased by about $90,000. In aggregate, the percentage of tribal claims approved and the amount awarded are comparable with the resolution of other FTCA claims at the Department of Health and Human Services.

Mr. Chairman, this concludes my statement. We would be pleased to respond to any questions that you or other Members of the Committee may have at this time.

Contacts and Acknowledgments

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URBAN INDIANS AND HEALTH CARE IN AMERICA

Testimony of

Robert Hall, President
National Council of Urban Indian Health

before the
Senate Committee on Indian Affairs

on S. 212
Indian Health Care Improvement Act
Reauthorization

July 31, 2001

Introduction. Honorable Chairman and Committee Members, my name is Robert Hall. I am the president of the National Council of Urban Indian Health (NCUIH) and a member of the three affiliated tribes of North Dakota: Arkara and Hidatsa. I am also the Executive Director of the South Dakota Urban Indian Health Clinic. On behalf of NCUIH, I would like to express our appreciation for this opportunity to address the Committee on the reauthorization of the Indian Health Care Improvement Act (S. 212) and its impact on the urban Indian communities that have formed in many of America's cities.

Founded in 1998, NCUIH is the only membership organization representing urban Indian health programs. Our programs provide a wide range of health care and referral services in 34 cities to a population of approximately 332,000 urban Indians. Our programs are often the main source of health care and health information for urban Indian communities. In this role, they have achieved extraordinary results, despite the great challenges they face. According to the 1990 census, 58% of American Indians live in urban areas, up from 45% in 1970 and 52% in 1980. We expect that the 2000 census will show that over 60% of American Indians now live in urban areas. Like their reservation counterparts, urban Indians historically suffer from poor health and substandard health care services.

Indian Health Care Improvement Act. In 1976, Congress passed the Indian Health Care Improvement Act. The original purpose of this act, as set forth in a contemporaneous House report, was "to raise the status of health care for American Indians and Alaska Natives, *over a seven-year period*, to a level equal to that enjoyed by other American citizens." House Report No. 94-1026, Part I, p.13 (emphasis added).[1]

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

The Senate has also recognized that Congress has an obligation to provide health care for Indians, including providing health care off the reservation.

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

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).

It has been twenty-five years since Congress committed to raising the status of Indian health care to equal that of other Americans, and eighteen years since the deadline for achieving it has passed. And yet, Indians, whether reservation or urban, continue to occupy the lowest rung on the health care ladder, with the poorest access to America's vaunted health care system.

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attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."

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

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

Although the road ahead to equal health care still appears to be a long one for Indians, including urban Indians, NCUIH believes that S. 212 is a step in the right direction. As a general matter, NCUIH supports S. 212, although we do recommend certain changes to maintain Congress' commitment to urban Indians in S. 212.

Proposed Amendment: Declaration of Health Objectives. S. 212, although addressing urban Indian issues in some areas, appears to diminish the commitment of the Congress to the improvement of urban Indian health in general. In a 1976 report, the House noted that the Congress has "a responsibility to assist" urban Indians in achieving "a life of decency and self-sufficiency" and has acknowledged that "[i]t is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities." Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652 at P. 2754. Consistent with that report, the Indian Health Care Improvement Act currently provides that it is the policy of the United States to achieve the highest possible health status for both "Indians *and urban Indians*". The current law goes on to say that it is the intent of the Congress that the United States meet certain health objectives with respect to both "Indians *and urban Indians*" by the year 2000. This is current law. However, S. 212 does not include a reference to urban Indians in its equivalent paragraphs (Section 3, "Declaration of Health Objectives"). Deleting "urban Indians" from this policy statement, especially since "urban Indian" is a defined term in the legislation, could imply that the Congress no longer considers the health status of urban Indians to be a national priority. NCUIH strongly urges the restoration of "urban Indian" to Sections 3 (1) and (2) of S. 212.[2]

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[2] NCUIH seeks restoration of language as follows (text to be restored is underlined):

"SECTION 3. DECLARATION OF HEALTH OBJECTIVES

"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people--

"(1) to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

"(2) to raise the health status of Indians and urban Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010, or any successor standards thereto;"

Proposed Amendment: Definition of "Urban Indian." NCUIH is generally satisfied with the definition of "urban Indian" in S. 212 which is essentially consistent with current law. However, the definition contains language that appears to limit its coverage to Title V of the legislation. Urban Indians are referred to in other titles of this legislation, as well, therefore this limiting language should be deleted.[3]

Proposed Amendment: Federal Medical Assistance Percentage (FMAP) should be 100% for Urban Indian Health Programs. The Federal government pays a share of the medical assistance expenditures under each State's Medicaid program. If an American Indian or Alaska Native who is eligible for Medicaid receives primary care services covered by Medicaid at an outpatient facility operated by the Indian Health Service or by a tribe or a tribal organization under contract with the Indian Health Service, the Federal government will pay 100% of the cost of that service. However, for urban Indian health programs, the Federal government only pays at the state's regular Federal Medicaid matching rate (FMAP), which typically ranges from 65% (as in Arizona) to 73% (as in Montana). The same policy rationale that justifies a 100% FMAP for IHS-related facilities -- that Indian health care is a federal responsibility -- also applies to urban Indian health programs. Therefore, NCUIH strongly urges that the Congress provide the same FMAP to urban Indian health programs. Specifically, NCUIH recommends the following amendment to section 1905(b) of the Social Security Act (*new language in italics*):

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[3] NCUIH's proposed deletion from the definition of "Urban Indian" is set forth below (language to be deleted is struck through):

> ***"SECTION 4. DEFINITIONS.***
>
> *"(22) URBAN INDIAN - The term "urban Indian" means any individual who resides in an urban center and who—*
>
> *"(A) ~~for purposes of title V and~~ regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands or groups that are recognized by the States in which they reside, or who is a descendant, in the first or second degree, of any such member;"*

"Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian health service facility *or program* whether operated by the Indian Health Service or by an Indian tribe or tribal organization *or by an urban Indian health program* (as defined in section 4 of the Indian Health Care Improvement Act)."

Proposed Amendment: Pharmaceutical Services. Currently, urban Indian health programs are limited in the range of pharmaceutical services that they can provide to urban Indian communities. NCUIH supports expanded authority and funding for these programs to offer a broader range of pharmacy services. Such expanded service will result in an immediate elevation of the quality of care for these communities, as well as an increased efficiency in the provision of health care services.

National Bi-Partisan Commission on Indian Health Care Entitlement. NCUIH strongly supports the establishment of the National Bi-Partisan Indian Health Care Entitlement Commission as provided for in Section 814 of S. 212. The work of this commission will help provide the basis for a rationale and effective approach to addressing the Indian health care crisis well into the 21st Century.

NCUIH strongly supports the elevation of the Director of the Indian Health Service to Assistant Secretary for Indian Health as provided for in S. 214 and H.R. 293. One reason why the status of Indian health has improved so slowly since Congress announced its commitment in 1976 is that Indian people do not have sufficient influence in the health care debate. Too often, our voices are literally drowned-out by the cacophony of other health care interests. For example, when we hear that the Director of IHS cannot attend certain meetings because of his lesser position, it is time for a change. Protocol should never come at the price of common sense and the health needs of Americans, Indian or otherwise. Elevating the position of the Director of Indian Health Service to Assistant Secretary for Indian Health will greatly strengthen the voice of Indian country, whether in the halls of the HHS, the corridors of Congress, or wherever the health care debate occurs and decisions are made.

Urban Indian Health Programs are funded within the Indian Health Service budget at a small fraction of the percentage of urban Indians in the Indian population. In FY 2001, Urban Indian Health Programs received 1.14% of the total Indian Health Service budget, although urban Indians, according to the 1990 census constituted 58% of the total American Indian population. Urban Indian programs are slated to receive 1.11% in the President's FY 2002 budget. In 1979, at a time when urban Indians made up a smaller percentage of the overall Indian population, the urban Indian programs received 1.48% of the Indian Health Service budget.

NCUIH acknowledges that there are some sound reasons why the lion's share of the IHS budget should go to reservation Indians. However, we believe that the disparity is too great. All Indian people are connected. There is substantial movement back and forth from reservation to urban Indian community. The health of Indian people in urban areas affects the health of Indian people on reservations, and visa versa. Disease knows no boundaries. With the 1990 census showing that 58% of the Indian population now resides in urban areas, we strongly believe that the health problems associated strongly with the Indian population can only be successfully combated if there is significant funding directed at the urban Indian population, as well as the reservation population.

NCUIH has asked for a $5 million dollar increase in President Bush's proposed FY 2002 budget for Urban Indian programs from $29,947,000 to $34,947,000 as a first-step towards redressing this situation. While this cannot address the total need, it will make a huge difference in access to and quality of care for urban Indians and begin to address the funding gap.

Diabetes Funding. NCUIH also supports the establishment of a five-percent (5%) set-aside of IHS diabetes funding to be provided to urban Indian diabetes programs. Diabetes has reached epidemic proportions, not only for reservation Indians, but also for the urban Indian community. For example, the prevalence level of diabetes mellitus among the urban Indian community served by the Boston urban Indian health program is 10.4%; for the Portland, Oregon urban Indian community it is 10%. It is important to educate and address the entire Indian

community on this issue if true progress is going to be made.

Federal Responsibilty for Urban Indians. NCUIH believes that there is a Federal obligation to urban Indians. Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided:

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

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

The Supreme Court and other Federal courts have also acknowledged that there is a Federal responsibility towards Indians, both on and off their reservation. "The overriding duty of our Federal Government to deal fairly with Indians *wherever located* has been recognized by this Court on many occasions." *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); and *Board of County Comm'rs v. Seber*, 318 U.S. 705 (1943). In areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian

housing rather than dismantle it where it exists. The Court generally agrees." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987).[4] "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members living collectively or individually, on or off the reservation.*" *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987)(emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising *that it can extend to Indians individually*, as well as collectively, *and off the reservation*, as well as on it." *St. Paul Intertribal Housing Board v. Reynolds*, 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

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

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[4] Congress enunciated its objective with regard to urban Indians in a 1976 House Report: "To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cond Cong. & Admin. News (USCAN) 2652, 2657.

Id. At 1414-1415 (emphasis added).

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

The Federal courts have also found, that the United States can have an obligation to state-recognized tribes under Federal law. See *Joint Tribal Council of Passamaquoddy v. Morton*, 528 F.2d 370 (1st Cir. 1975). Congress has provided, not only in the IHCIA,[5] but also in NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

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

In the context of all of this law, NCUIH strongly believes that the Federal government's trust obligation to protect American Indians does not stop at the reservation boundary.

The urban Indian community has developed principally as a result of misguided Federal programs or actions, such as the Bureau of Indian Affairs relocation program, which relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians are still in the cities. They maintain their Indian identity even if, in some cases, they have been unable to re-establish ties, including formal membership, with their tribes. While most, but not all, urban Indians are enrolled in federally recognized tribes, all are Indian. They are recognized as Indian by their community; their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.

There are a number of Federal programs and policies which have led to the formation of the urban Indian population, including:

(1) the BIA relocation program which relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians are still in the cities.
(2) the failure of Federal economic policies on reservations which has forced many Indians to become economic refugees in the cities;
(3) the Federal policy of "terminating" tribes in the 1950s and 1960s, many of which have not yet been restored to recognition;
(4) The marginalization of tribal communities such that they exist but are not federally recognized;
(5) Indian service in the U.S. military which brought Indians into the urban environment;
(6) the General Allotment Act, which resulted in many Indians losing there lands and having to move to nearby cities and towns;
(7) court-sanctioned adoption of Indian children by non-Indian families; and
(8) Federal boarding schools for Indians.

Some of these federal policies were designed to force assimilation and to break-down tribal governments; others

may have been intended, at some misguided level, to benefit Indians, but failed miserably. One of the main effects of this "course of dealing," however, is the same: the creation of an urban Indian community.

Conclusion. America is nowhere near the lofty goal, set by the Congress in 1976, of achieving equal health care for American Indians, whether reservation or urban. NCUIH challenges this Committee to think in terms of that goal as it considers reauthorization of the Indian Health Care Improvement Act. NCUIH thanks this Committee for this opportunity to provide testimony on S. 212. We strongly urge your positive action on the matters we have addressed today.

Urban Indian Health Care in the City of New York

Testimony of

Anthony Hunter

Health Director

American Indian Community House, Inc.

Before the

United States Senate

Committee on Indian Affairs

Respectfully Submitted

July 31, 2001

Good Morning Senator Inouye and members of the committee. We want to thank you for inviting us to testify during this most important hearing on urban Indian Health programs. We would also like to recognize and thank you for your support of our programs over the years.

The American Indian Community House (AICH) is a 501(c)(3) not-for-profit organization serving the health, social service, and cultural needs of Native Americans residing in New York City.

AICH was founded in 1969, by Native American volunteers as a community-based organization, mandated to improve the status of Native Americans, and to foster inter-cultural understanding.

Since its inception, AICH has grown into a multi-faceted social support agency and cultural center with a staff of 35. AICH membership is currently composed of Native Americans from over 80 different tribes, and represents a service population area of 59,000 Native Americans in the greater New York City metropolitan area.

Native American migration between urban centers and reservations demonstrates the inter-relatedness of all Native Americans, and from this reality emerges the recognition that our issues and concerns are truly shared. The AICH philosophy is that solutions can be shared as well. AICH uses an innovative approach in combining the objectives of our social service and cultural enrichment programs to meet our community's multi-faceted needs.

AICH provides programs in job training and placement; health services referral and advocacy; HIV referral and case management services; and counseling programs for alcoholism and substance abuse. AICH also sponsors programs in cultural enrichment through a performing arts program and the only Indian owned and operated Native American gallery/museum in New York City. A secondary but no less important focus of AICH is to educate the general public about contemporary as well as historic American Indian issues and peoples.

AICH consists of the following departments:

HIV/AIDS Project
In response to the increasing numbers of Native Americans living with HIV/AIDS, the HIV/AIDS Project provides community prevention education and information, targeted outreach to individuals at risk, and services to those infected. The project offers referrals to drug and alcohol programs, sexually transmitted disease clinics, test sites, general health and mental care facilities, and services for gay and lesbian Native people. Case management services are also provided here in New York City as well as at program offices in Buffalo, Syracuse, Riverhead and the Akwesasne Mohawk Reservation.

Employment & Training (E&T)
The E&T Program provides educational services as well as training focused on preparing an individual for the job market. Interview skills, resume writing, computer training, referrals to outside job training facilities, limited tuition and support for higher education, and job placement assistance are among the services available to all Native Americans

who meet the eligibility requirements. We are beginning the process of becoming a training facility registered with the New York State Education Department.

Health Services
Staffed by Community Health Representatives (CHRs), their work includes health education, medical and dental referrals, community outreach, and the development of Native American specific health oriented programs. The Health Department's Alcohol/Substance Abuse program services strongly focus on group and individual counseling. These programs offer a sense of community support as Native people seek to begin and maintain their recovery. Spiritual and cultural support are integral parts of the programs, as well as our education and prevention activities. Other programs within the Health Department include: Mental Health, AICH Youth Council and Theater project, Food and Clothing banks, and free daily hot lunches during the weekdays for all community members.

According to our recent Behavioral Risk Factor Survey, sponsored by the Indian Health Service and the Centers for Disease Control, prevalent in our population are risk factors associated with heavy cigarette smoking; sedentary life style; acute alcohol use; and, drinking while driving. Using AICH's innovative approach in combining health prevention and cultural activities, we will now design prevention programs addressing these behaviors using visual and performing arts.

The Women's Wellness Circle Project
The Women's Wellness Circle Project is under our Health services division and addresses barriers to health care for Native women. Utilizing innovative and cultural specific strategies, the project works to develop a network between AICH, health institutions, other front-line providers and Native women in the community. The project provides accessible satellite screening and health information through mobile units, develops Native educational performance pieces, and holds monthly wellness circles for Native women to share health access concerns and to provide preventative health education.

Gallery and Museum
The AICH Gallery/Museum is the only Native American owned and operated art gallery in New York City. It exhibits the finest contemporary and traditional art, in every media, by both emerging and established Native American artists. The Gallery presents a minimum of four exhibitions each year and presents artists lectures and forums on contemporary Native arts and issues. The artwork on exhibit is offered for sale with only a small commission retained.

Performing Arts Department
The Performing Arts Department coordinates various cultural activities featuring Native American performing artists, and promotes and assists all-Native ensembles such as Spiderwoman Theatre, Thunderbird American Indian Dancers, Coatlicue Theatre Company and Ulali. The department provides referrals for Native storytellers, musicians and lecturers. It acts as a non-paid booking agent for Native actors, dancers and models. AICH provides rehearsal space and technical assistance to Native American artists and has a main stage called The Circle which seats up to 150 people.

Communications and Information Department
The main tasks of this department are promoting Native culture, publishing the quarterly AICH Community Bulletin each year, and correcting the constant flow of misinformation about Native people and culture. C&I maintains research files, a video library, pow wow listings, and an events listing, all of which are available to scholars, students and educators at minimal or no charge. A library of Native periodicals, guide to genealogical research, U.S. reservations lists, and a bibliography of Native books are some of the other resources that are available.

Legal Services Project
A joint project with the American Indian Law Alliance, the Legal Service Project is in its fourth year of providing free legal referral services to Native Americans. The project assists with all types of legal matters for Native people in an urban environment including but not limited to housing, criminal, the Indian Child Welfare Act, and the Jay Treaty.

On behalf of the Native American community of the New York City metropolitan area, we thank you for your consideration of our health care needs.

NEWSDAY, SUNDAY, APRIL 22, 2001

City's Influx of Indians

Attracted by jobs, population growing quickly in the city

By Mae M. Cheng
STAFF WRITER

Irwin Wesley Pashagameskum traded the big city life for bigger city life five years ago.

Pashagameskum, 29, was raised on a Muskogek Cree American Indian reservation in Attawapiskat, Ontario, Canada and lived in Toronto for 19 years before he moved to Manhattan, where he now lives in a studio apartment with a view of the Empire State Building.

"I was attracted by the media, the way they portrayed New York City," said Pashagameskum, who was able to take advantage of U.S. immigration laws that allow many American Indians from Canada to come to the United States and work without a visa.

"I wanted to learn about the diverse cultures here, sample different foods," said Pashagameskum, a community health representative at The American Indian Community House in Manhattan.

He is among the hundreds of American Indians who, in the last decade, moved to New York City, making American Indians and Alaskan Natives one of the fastest growing racial groups in the five boroughs, according to Census 2000 data.

Over the last decade, the American Indian/Alaskan Native population in New York City grew at least 30 percent, from 27,531 in 1990 to 41,289 in 2000. When taking into account the number of people who checked American Indian/Alaskan Native and at least one other race, the rate of population increase skyrocketed to 217 percent, or 87,241 people. This surpasses the growth rate of any other racial group in New York City, Census data show.

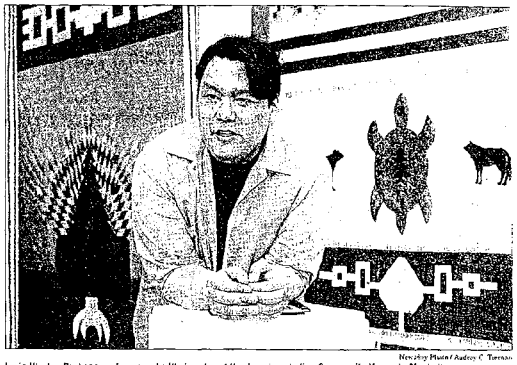
"We've known for many years that Indian people are moving to urban areas in increasing numbers," said Anthony Hunter, the health director at the Community House.

American Indians come to New York for better employment and educational opportunities and to get away from poverty that may exist on their reservations, Hunter said.

"They come to the city in hopes of bettering their lives in some way," he said.

In Queens, where the largest population of non-Hispanic American Indians or Alaskan Natives in New York City live, there still exists a bit of suburbia that attracts families from reservations, said Regla Winter Flower Gibson, who, as Earth Mother, is one of the leaders of the Northeastern Native American Association based in Hollis.

"Queens is still a little bit of country," Gibson said. "You can see a tree, go to a park. It's not all that concrete and maze you get in the city."



Newsday Photo / Audrey C. Tiernan

Irwin Wesley Pashagameskum speaks Wednesday at the American Indian Community House in Manhattan.

Census 2000 data also show that the American Indian/Alaskan Native population is growing nearly twice as quickly in New York City as on neighboring Long Island or even nationwide. Between 1990 and 2000, it grew by at least 27.7 percent on Long Island, with 5,913 people identifying themselves solely as American Indian or Alaskan Native in the 2000 census.

Nationwide over the last decade, the population grew by at least 26.4 percent. About 2.48 million people in the United States identified themselves as being only American Indian or Alaskan Native last year.

Curtis Zunigha, a member of the Census Bureau's Ethnic Advisory Committee who is from the Delaware Indian tribe in Oklahoma, said that for four decades, American Indians have been migrating to cities, with Los Angeles having the largest urban Indian population.

"They're still going to where the jobs are," Zunigha said.

In New York City, immigration has also bolstered the numbers, community leaders said. Some recent Central and South American immigrants probably identified themselves as American Indian/Alaskan Native on the census forms, they explained.

Gibson said that in recent years, Honduran craft vendors have increasingly been attending her organization's powwows.

"More and more people are comfortable identifying themselves as Native American," said Gibson, who is mainly Cherokee.

Community leaders say the American Indian population is moving to New York City from all parts of the country, including upstate and Long Island, and the majority is no longer the transient population it once was. In the middle of the last century, most American Indians in New York were iron workers who returned on weekends to reservations upstate and in Canada.

About four times a year, Pashagameskum makes it a point to leave his Empire State Building view and visit relatives living on the reservations, where hunting, fishing and canoeing are part of everyday life. But he has no desire to move back to the reservation, explaining that the energy and diversity in the city is a great source of attraction for him.

In New York City, Pashagameskum said he blends in well in the diversity, so much so that at times, people have approached him speaking Spanish or an Asian language. But despite the openness many New York City residents have for all races, he said he finds they know little about the American Indian population.

"In New York, some people haven't heard of us or think we're extinct."

Robert Fresco contributed to this story.

American Indian Community House, Inc. **New York City, New York**

2000 Census - Native American Population

NEW YORK STATE		82,461
AICH Service Unit Population Area *(All New York and New Jersey Counties)*		59,000
New York City		41,289
Richmond County (Staten Island)	1,107	
New York County (Manhattan)	7,617	
Kings County (Brooklyn)	10,117	
Queens County	11,077	
Bronx County	11,371	
Greater Metropolitan Area *(Outside New York City)*		17,711
New York State Counties	10,752	
Dutchess	609	
Rockland	676	
Orange	1,205	
Nassau	2,112	
Westchester	2,343	
Suffolk	3,807	
New Jersey		19,492
Northern New Jersey Counties	6,959	
Union	1,215	
Bergen	1,336	
Essex	1,861	
Hudson	2,547	

- 50.1% of all Indians living in New York State, live in New York City.
- 63.1% of all Indians living in New York State, live in the New York City Metropolitan Area.
- 35.7% of all Indians living in New Jersey, live in the New York City Metropolitan Area.

2000 Census data are from U.S. Census Bureau. Census 2000 Redistricting Data (P.L. 94-171) Summary File. This report was prepared by A. Hunter, AICH Health Director.

Admin/Profile Dem Info/2000 Census.xls

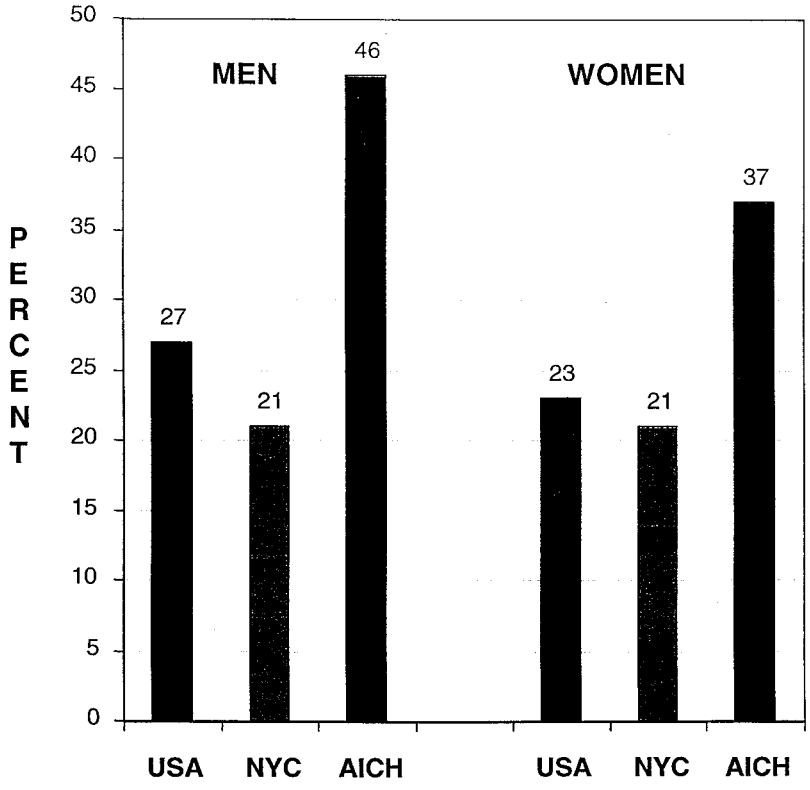
American Indian Community House, Inc. **New York City, New York**

1990 & 2000 Census Comparison Native American Population	1990 Census	2000 Census	Numerical Difference	Percent Change
NEW YORK STATE	62,651	82,461	19,810	31.6%
AICH Service Unit Population Area *(All New York and New Jersey Counties)*	40,463	59,000	18,537	45.8%
New York City	27,531	41,289	13,758	50.0%
Richmond County (Staten Island)	715	1,107	392	54.8%
New York County (Manhattan)	5,728	7,617	1,889	33.0%
Kings County (Brooklyn)	7,969	10,117	2,148	27.0%
Queens County	7,050	11,077	4,027	57.1%
Bronx County	6,069	11,371	5,302	87.4%
Metropolitan Area *(Outside New York City)*	12,932	17,711	4,779	37.0%
New York State Counties	7,893	10,752	2,859	36.2%
Dutchess	374	609	235	62.8%
Rockland	654	676	22	3.4%
Orange	824	1,205	381	46.2%
Nassau	1,642	2,112	470	28.6%
Westchester	1,405	2,343	938	66.8%
Suffolk	2,994	3,807	813	27.2%
New Jersey	14,970	19,492	4,522	30.2%
Northern New Jersey Counties	5,039	6,959	1,920	38.1%
Union	880	1,215	335	38.1%
Bergen	1,060	1,336	276	26.0%
Essex	1,639	1,861	222	13.5%
Hudson	1,460	2,547	1,087	74.5%

2000 Census data are from U.S. Census Bureau, Census 2000 Redistricting Data (P.L. 94-171) Summary File. This report was prepared by A. Hunter, AICH Health Director.

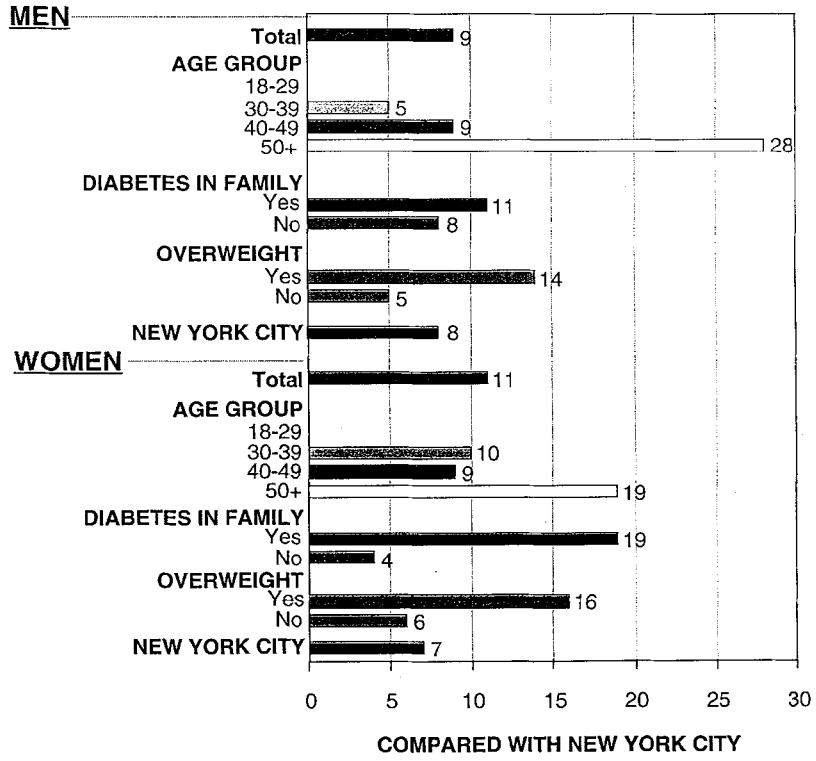
Admin/Profile Dem Info/2000 Census.xls

PERCENT OF MEN & WOMEN 18 AND OVER WHO CURRENTLY SMOKE COMPARED WITH USA AND NEW YORK CITY



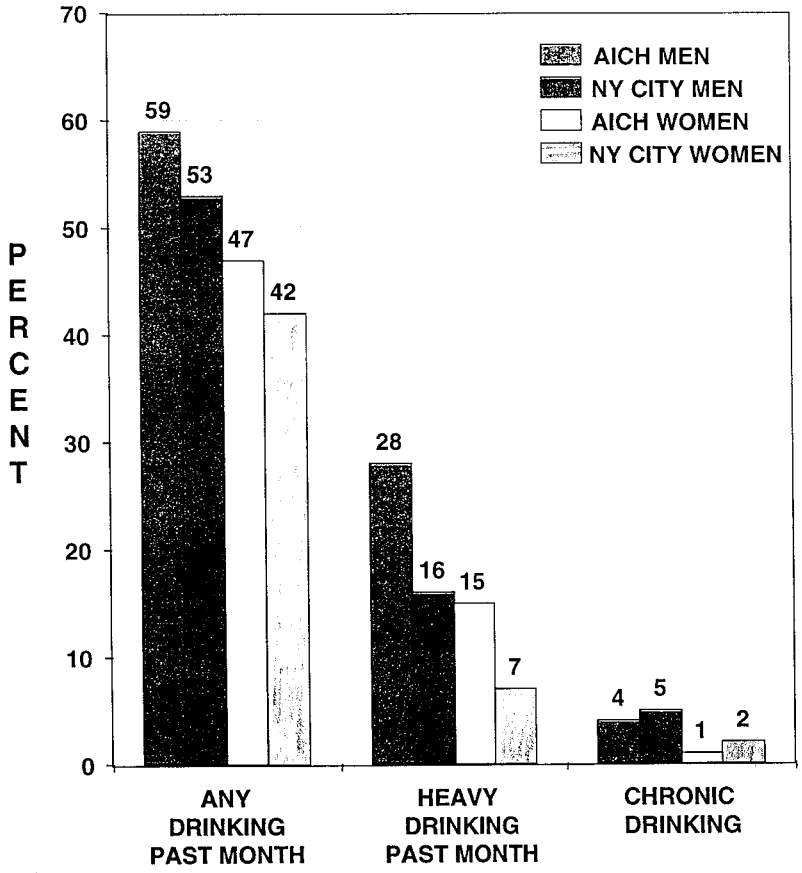
2000 AICH HEALTH BEHAVIOR SURVEY

PERCENT OF MEN & WOMEN WHO HAVE BEEN TOLD THEY HAVE DIABETES BY DIABETES RISK FACTORS



2000 AICH HEALTH BEHAVIOR SURVEY

PERCENT OF MEN AND WOMEN WHO DRINK ALCOHOL TO VARIOUS DEGREES COMPARED TO NEW YORK CITY



CDC 2000 AICH HEALTH BEHAVIOR SURVEY

TESTIMONY FOR
SENATE COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE
Health Care for Urban American Indians

July 2001

Chairman Inouye and members of the Senate Committee on Indian Affairs, my name is Ralph Forquera. I am a member of the Juaneño Band of Mission Indians, Acjachemen Nation, a California state-recognized Indian tribe whose historic homelands are the San Juan Capistrano region of Southern California.

I am the Executive Director for the Seattle Indian Health Board in Seattle Washington, one of the 34 non-profit health programs that contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act. Prior to this appointment, I was Executive Director for the San Diego American Indian Health Center, also a Title V contractor. I have served in a leadership capacity addressing the health needs of urban American Indians and Alaska Natives through these two urban Indian health programs for a total of 19 years of service. I continue to be dedicated to improving the lives of Indian people now living in American cities.

This hearing is to address the continuing health disparities that afflict urban Indian people and to review proposed changes to Title V through the reauthorization of this important legislation. I am pleased to express support for reauthorization with some additional thoughts and recommendations.

Little is known about the overall health status of urban Indians, in large part, because no one has taken the initiative or allocated the resources to provide for such information. My agency, the Seattle Indian Health Board, is one of the few community-based organizations serving urban Indians to attempt to understand and report on the health status of urban Indians and to publish our findings for public review. In FY-2001, we were awarded a cooperative agreement with the Indian Health Service to establish an urban Indian epidemiology center in recognition of our previous work and the need to define the health disparities that exist for urban Indians. We are currently developing the infrastructure to allow us to begin creating a national data base on the health of urban Indians.

We first described the health of urban Indians in a study published in the *Journal of the American Medical Association* in March of 1994. The findings helped document the array of health problems faced by urban Indians compared to local residents and Indians in 7 rural counties in Washington State (article attached). In May of 2001, in cooperation with the local Seattle/King County Department of Public Health, we have updated some of these findings and have expanded this report summarizing the health of Indians in this urban county; findings that show a lingering health disparities gap (copy attached).

The Seattle Indian Health Board, and its Indian-majority Board of Directors, fully embraces the principles of self-determination espoused for Indian tribes. In so doing, we recognize that our role in addressing health disparities means dealing with highly complex social and cultural factors as well as historic experiences, both on and off-reservation that serve to reinforce negative perceptions toward organized approaches to care. Additionally, we understand how the historic mistreatment of Indian people through the ill-fated termination and relocation policy, as well as through the continued underfunding of both Indian Health Service and Bureau of Indian Affairs programs reinforces the neglect that many urban Indians feel undermines their success. The feeling of being slighted experienced by many urban Indians and the continuing lack of adequate support for agencies established to serve their needs is itself a barrier to improving the health of this population, one that can only be resolved by the Congress through improved appropriations.

Urban Indians are truly the forgotten souls in our society. Often rejected by their own tribes and abandoned by a government which claims an obligation to their welfare, improving access to health care is only a first step in improving the health status of the people and closing the disparities gap. The scars of social and cultural abuse and neglect are deeply embedded in the attitudes and behaviors of urban Indians. The effects are often seen in a state of overall poor health as demonstrated in the 1994 and 2001 reports.

The Indian Health Service was never envisioned to serve the broader, non-reservation Indian population. Created as a separate and distinct program, Title V was never fully developed and today fails to recognize that the bulk of urban Indian health services are driven by local rather than national priorities. The fact that more than 60% of all Indian people now live in American cities, yet only 1% of the Indian Health Service budget is directed to provide assistance, is a reflection of this lingering problem.

In the recent report for the Seattle/King County region, we include data from a Seattle Public School survey that provided some disturbing results. The report illustrates that poverty, single parent household, and exposure to risky health behaviors such as stress, living in dangerous surroundings, exposure to and reinforcement of alcohol and drug use, smoking, and a lack of motivation and relevance of formal education play a significant role in the overall picture of the health of urban Indian youth. Institutions like the Seattle Indian Health Board and our Title V colleagues across the nation play an important safety net role for urban Indians. Whether providing direct care or assisting in finding acceptable health car alternatives, the urban Indian health programs are a vital link in the social fabric for urban Indians. In many instances, urban Indian health programs are the only cultural link available to urban Indians struggling to find their place in the larger society. For this reason alone, the need to sustain and grow this system of care is a worthwhile investment.

Unlike the IHS and tribal programs, urban Indian health programs are not government institutions and are thus subject to differing rules, many which add new costs. For example, clinics must acquire and maintain state-licensed for each clinical service provided. Providers must likewise be state-licensed or certified. With the advent of managed care and the consolidation of health care systems in most cities, competition for providers and support staff has driven salaries and benefits beyond the

modest increases allocated by the Congress for Title V programs. Managed care itself has severely reduced reimbursement sources from private insurers, and changes in the Medicaid system have caused confusion and frustration for many urban Indians who, although eligible for aid, choose not to be further subjected to demonstrating their poverty and social condition to enroll in these government-sponsored programs. Their choices have further reduced operating revenue for the urban program.

As with all health care, the cost of prescription medications is having a severe impact on the ability of urban Indian health programs to assure effective treatment. Many new and increasingly effective medications are beyond the financial reach of most patients, and our limited budgets preclude our adding these drugs to our internal pharmacies. Managed care has disrupted the delicate network that use to exist for specialty and hospital care provided to the poor and uninsured. Title V programs, like our community health center relatives, provide only primary care services; yet at the same time, our populations are also aging and the extent of early onset chronic conditions effecting urban Indians increases our need for specialty and hospital care for a growing number of our patients. For Indian people, this need starts at a younger age with chronic conditions like type II diabetes being seen in older teens and young adults.

Because urban Indian health programs have not received sustained and appropriate support over the years, many programs are now in jeopardy of losing services. The lack of scientifically-valid data further reduces the competitive edge needed to attract new resources at the local, state, and national levels. At this same time, the population of urban Indians continues to grow.

The Seattle Indian Health Board remains a beacon of hope and a source of caring for thousands of Indian people each year here in Washington State. Our colleagues play an equally important role in assuring that culturally-competent help is available to an increasingly fragile group of Americans.

While urban Indians are citizens of the United States, and have been for almost eight decades, many still believe themselves first citizens of their tribes. This world view influences many not to fully participate in the services offered to the vulnerable members of society (Medicare, Medicaid, TANF, etc), due in large part to past abuses and the fear of continued reprisal. Urban Indian health programs are an important safety net provider for this overlooked and underserved population. We believe that our work adds value to the overall society by helping rectify the failure of government policies in the past that deeply disrupted the lives of America's first residents. We hope that the Congress recognizes the importance of assuring that sufficient support is granted now and into the future if this pattern is to ever be improved.

With regard to the bill under consideration, the Seattle Indian Health Board endorses the changes proposed. We especially support the inclusion of urban Indian health programs under the Federal Medical Assistance Percentage (FMAP) provision for Medicare and Medicaid. State changes in Medicaid reimbursement and the imposition of managed care is reducing this important revenue stream for urban programs that provide direct Medicare and Medicaid services. Support under FMAP will help us sustain this important adjunctive source of funding.

We also wish to endorse the provision to allow for programs to manage multiple urban Indian programs rather than requiring local governance. This is a practical approach to the current health environment which demands economies of scale in the financial viability of institutions. To assure that quality services are maintained for urban Indians, new and collaborative approaches are needed. This provision opens the door for more regional systems of care, still Indian controlled, but more in keeping with the external health care environment.

Last, we wish to support the preservation of the definition of urban Indian that is in S-212. This definition allows the urban Indian health programs to perform perhaps the most important healing act needed by urban Indians, e.g. the act of acceptance. In many instances, our ability to accept one's indianness is the critical step needed to get an urban Indian involved in their own health and welfare. Without this important federal statement of recognition, our efforts would be for naught.

Thank you for the opportunity to provide this written testimony to the Senate Committee on Indian Affairs. I will be happy to provide additional information at your request.

Respectfully submitted:

Ralph Forquera, M.P.H.
Executive Director
Seattle Indian Health Board
July 2001

Copies enclosed:
"Health Status of Urban American Indians and Alaska Natives" - 1996
"The Health Status of American Indians and Alaska Natives Living in King County" - 2001

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March 16, 1994 Volume 271

Health Status of Urban American Indians and Alaska Natives

A Population-Based Study

David C. Grossman, MD, MPH; James W. Krieger, MD, MPH; Jonathan R. Sugarman, MD, MPH; Ralph A. Forquera, MPH

Objective.—To use vital statistics and communicable disease reports to characterize the health status of an urban American Indian and Alaska Native (AI/AN) population and compare it with urban whites and African Americans and with AI/ANs living on or near rural reservations.

Design.—Descriptive analysis of routinely reported data.

Setting.—One metropolitan county and seven rural counties with reservation land in Washington State.

Subjects.—All reported births, deaths, and cases of selected communicable diseases occurring in the eight counties from 1981 through 1990.

Main Outcome Measures.—Low birth weight, infant mortality, and prevalence of risk factors for poor birth outcomes; age-specific and cause-specific mortality; rates of reported hepatitis A and hepatitis B, tuberculosis, and sexually transmitted diseases.

Results.—Urban AI/ANs had a much higher rate of low birth weight compared with urban whites and rural AI/ANs and had a higher rate of infant mortality than urban whites. During the 10 years, urban AI/AN infant mortality rates increased from 9.6 per 1000 live births to 18.6 per 1000 live births compared with no trend among the other populations. Compared with rural AI/AN mothers, urban AI/AN mothers were 50% more likely to receive late or no prenatal care during pregnancy. Relative to urban whites, urban AI/AN risk factors for poor birth outcomes (delayed prenatal care, adolescent age, and use of tobacco and alcohol) were more common and closely resembled the prevalence among the African-American population except for a higher rate of alcohol use among AI/ANs. Compared with urban whites, urban AI/AN mortality rates were higher in every age group except the elderly. Differences between urban whites and AI/ANs were largest for injury- and alcohol-related deaths. All-cause mortality was lower among urban AI/ANs compared with rural AI/ANs and urban African Americans, although injury- and alcohol-related deaths were higher for AI/ANs. All communicable diseases studied were significantly ($P<.05$) more common among urban AI/ANs compared with whites. Tuberculosis rates were highest in the urban AI/AN group, but rates of sexually transmitted diseases were intermediate between urban whites and African Americans.

Conclusions.—In this urban area, great disparities exist between the health of AI/ANs and whites across almost every health dimension we measured. No consistent pattern was found in the comparison of health indicators between urban and rural AI/ANs, though rural AI/ANs had lower rates of low birth weight and higher rates of timely prenatal care use. The poor health status of urban AI/AN people requires greater attention from federal, state, and local health authorities.

(*JAMA*. 1994;271:845-850)

From Harborview Medical Center (Drs Grossman and Krieger), the Departments of Pediatrics (Dr Grossman), Medicine (Dr Krieger), and Family Medicine (Dr Sugarman), School of Medicine, the Department of Health Services, School of Public Health (Dr Grossman), and the Native American Center of Excellence (Drs Grossman and Sugarman and Mr Forquera), University of Washington; the Seattle-King County Department of Public Health (Dr Krieger); the Division of Research, Evaluation, and Epidemiology, Portland Area Indian Health Service (Dr Sugarman); and the Seattle Indian Health Board (Mr Forquera), Seattle, Wash.

The views expressed in this article do not necessarily represent the views of the Nesholm Family Foundation or the Indian Health Service.

Reprint requests to Harborview Medical Center, 325 Ninth Ave, ZX-10, Seattle, WA 98104-2499 (Dr Grossman).

IT IS generally known that the health status of American Indians and Alaska Natives (AI/ANs) is far below that of other Americans.[1] However, this conclusion is based on statistical reports from the Indian Health Service (IHS), an agency of the Public Health Service, and tribally owned health programs on or near Indian reservations or Alaska Native lands. Little is known about the health status of urban AI/ANs despite the fact that 56% of the AI/ANs identified in the 1990 US Census now reside in urban areas.[2] The IHS was created by Congress and is currently directed to "assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy."[2] Congress recently established health status objectives specifically for AI/ANs that are to be accomplished by the year 2000.[3] Funding and politics have restricted most IHS activities to tribal members living on or near Indian reservations or Alaska Native lands.

Very little health information is available regarding AI/ANs in urban areas.[4] Most published studies of urban Indian health are based on data from clinics and hospitals and cannot be generalized to an entire urban AI/AN population.[5] In a comprehensive report on Indian health published in 1986, the Office of Technology Assessment concluded that "the IHS does not collect diagnostic patient care information from urban programs and does not analyze or publish vital statistics or population characteristics for urban AI/ANs except when these data are included with national level data on the reservation states."[6] Since the publication of this report, there have not been any large population-based studies that broadly describe the health status of any urban Indian population.

The purpose of this study was to use available vital statistics and health data to characterize the health status of the AI/AN population in the largest metropolitan county within the state of Wash-

ington and to compare its health status with three reference populations. The comparison populations are the white and African-American populations within the same metropolitan county and the AI/AN population living in rural Washington counties with tribal reservations.

METHODS

Site

According to the 1990 US Census, the Seattle, Wash, metropolitan area has the seventh largest concentration of urban AI/ANs in the United States. King County, Washington, is a large metropolitan region with a population of 1 507 319.[2] There are three cities with more than 50 000 residents, the largest of which is Seattle. The 17 305 AI/AN residents comprise 1.1% of the King County population and 21% of the state's AI/AN population. Of the King County AI/AN residents, 1461 (8.4%) reported that they were of Eskimo or Aleut ancestry on the census. Data sets from which numerator data were derived do not allow stratification of Alaska Natives from American Indians. Within King County, there is one small reservation with a tribally operated clinic. The Seattle Indian Health Board, one of 34 nonprofit organizations partially funded by the IHS, operates a comprehensive community-based primary care program that cares for AI/ANs.

Comparison Groups

First, we compared the health status of AI/ANs with that of whites and African Americans within King County. Second, we compared health status indicators of the King County AI/ANs ("urban" AI/ANs) with those of AI/AN residents of rural Washington counties with tribal reservations, a population traditionally served by the IHS. These seven counties are classified by the Washington State Department of Health as "rural" (15 to 100 persons per square mile) or "remote rural" (<15 persons per square mile) counties and have reservation land belonging to federally recognized tribes. King County and the rural reservation counties account for 40% of the state's total AI/AN population. The remainder of the state's AI/AN residents live in other urban/metropolitan counties or rural counties without reservations.

Data Sources

Three main data sources were used to generate numerator data for vital statistics rate calculations. These included birth certificates, linked infant birth and death certificates, and death certificates from 1981 through 1990 from the Center for Health Statistics of the Washington State Department of Health. Communicable disease data were obtained from the Centers for Disease Control and Prevention and the Epidemiology Office of the Washington State Department of Health. Data from the 1980 and 1990 editions of the US Census provided the denominator and socioeconomic data for each of the comparison groups. Population estimates for urban and rural AI/ANs between 1980 and 1990 were generated by linear interpolation between 1980 and 1990 US Census counts while estimates for urban whites and African Americans were based on Washington Office of Financial Management demographic estimates. These Office of Financial Management estimates were unavailable for all counties in the study, so all AI/AN denominator estimates were derived using linear interpolation. The differences between the two denominator estimates (for the intercensus period) were quite small. The interpolation method gave a slightly higher number for each of the years, with a range of ratios from 1.02 to 1.06. This method consistently exceeded the Office of Financial Management estimate and resulted in a probable underestimate of mortality rates of urban AI/AN residents compared with other races.

We used the post-1989 National Center for Health Statistics definition of race for all infant birth and death rate calculations in the study. The National Center for Health Statistics currently defines an AI/AN birth as an infant born to a mother identified in the birth record as AI/AN, regardless of the father's race. We used linked birth and death certificates for infants, in which the mother's race at birth defines the race at birth and death. Individuals self-report their race to the US Census.

Table 1.—Demographic Characteristics of Study Populations

Characteristic	Urban			Rural AI/AN
	AI/AN*	White	African American	
1990 population	17 305	1 255 339	72 463	15 054
Older than 25 years without high school diploma, %	24	10	21	34
Unemployed, %	8.4	3.7	11.3	21
Below 100% of federal poverty level, %	26	8.1	22	35

*AI/AN indicates American Indian and Alaska Native.

Health Status Measures

The health status indicators used in this study were derived from routinely collected population-based health status data for which race-specific information was available. Mortality rate calculations included infant mortality, age-specific mortality rates in six age groups, cause-specific mortality, and alcohol-associated mortality. To assess alcohol-associated mortality, alcohol-related disease impact software was used.[7] This methodology, developed by the Centers for Disease Control and Prevention, uses the attributable risk from alcohol use for each cause of death to derive a composite rate of alcohol-associated mortality.

Maternal and infant health measures included the proportion at birth of preterm births (<37 weeks' gestational age), of low (<2500 g) and very low (<1500 g) birth weight, of unmarried mothers, of mothers who started prenatal care in the first trimester (on time care) or who had late (third trimester) or no prenatal care, and of mothers who smoked tobacco or consumed alcohol during pregnancy, and the school-age (ages 10 through 17 years) fertility rate. The data source for information on smoking and alcohol use during pregnancy and prenatal care was the birth certificate. Smoking data from 1986 through 1988 were used (question wording on Washington State birth certificates was changed in 1989). Assessment of alcohol consumption was added to the birth certificate in 1989. Maternal drug-use data are not routinely collected on Washington State birth certificates.

Because the AI/AN population is small, only reportable communicable diseases of high frequency were compared. These included sexually transmitted diseases (gonorrhea, syphilis, and chlamydia), tuberculosis, and hepatitis A and hepatitis B. Because detailed data for sexually transmitted diseases were unavailable for rural counties, these data were used for comparisons within King County only.

We used the following *International Classification of Diseases*[8] codes as definitions for cause-specific mortality: heart disease, 391 through 392.0, 393 through 398, 402, 404, 410 through 416, 420-429; cancer, 140-208; unintentional injury, E800 through E949; liver disease, 571; cerebrovascular disease, 430 through 434, 436-438; pneumonia and influenza, 480 through 487; homicide, E960-E969; diabetes, 250; chronic obstructive pulmonary disease, 491, 492, 496; suicide, E950 through E959; and all firearms, E922, E955.0 through E955.4, E965.0 through 965.4, E970, E985.0 through E985.4.

All disease and death rates were age-adjusted to the 1940 US population for

Table 2.—Prevalence of Risk Factors for Poor Birth Outcomes Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

	Average Rates 1988 Through 1990 (Total Births)*			
	Urban			
Risk Factors	AI/AN (n=994)	White (n=52 261)	African American (n=4100)	Rural AI/AN (n=1051)
Low birth weight (<2500 g)	9.5 (7.7-11.5)	5.0 (4.8-5.2)†	13.0 (12.0-14.1)†	5.6 (4.3-7.2)†
Very low birth weight (<1500 g)	1.6 (1.0-2.7)	0.8 (0.7-0.9)†	2.8 (2.4-3.4)	0.8 (.35-1.7)
Preterm births (<37 wk gestation)	15.9 (13.5-18.6)	8.1 (7.9-8.4)†	17.7 (16.5-19.1)	13.0 (10.9-15.5)
Mother 10-17 y of age	9.1 (7.4-11.1)	1.7 (1.6-1.8)†	9.8 (9.0-10.8)	10.2 (8.5-12.2)
Single mother	59.1 (56.0-62.1)	15.7 (15.4-16.0)†	65.1 (63.6-66.6)†	64.6 (61.6-67.5)
Consumed alcohol‡	20.1 (16.3-24.4)	6.2 (5.9-6.5)†	11.0 (9.5-12.7)†	16.2 (13.5-19.3)
Smoker§	38.2 (34.7-41.7)	20.0 (19.7-20.4)†	33.5 (31.9-35.0)	40.6 (37.5-43.8)
Received first-trimester prenatal care	56.5 (53.1-60.0)	83.9 (83.6-84.2)†	59.2 (57.5-60.8)	64.0 (61.0-67.0)†
Received late or no prenatal care	15.9 (13.5-18.5)	3.4 (3.2-3.6)†	12.7 (11.6-13.9)	10.0 (8.3-12.0)†

*Data expressed as percentage (95% confidence interval). Infant race determined by mother's race on birth certificate. Urban AI/ANs are the reference group for all statistical comparisons.
†Significantly ($P<.05$) different from urban AI/AN rate.
‡Two-year average rates, 1989 through 1990.
§Three-year average rates, 1986 through 1988.

two reasons. A recent Centers for Disease Control and Prevention conference on age adjustment concluded that the 1940 US population would continue to be recommended by the National Center for Health Statistics as the standard population for US mortality data (primarily for purposes of comparability to historical national data).[9] Also, IHS uses the 1940 population as the reference in its annual statistical publications, widely cited sources for AI/AN health data; thus, use of the 1940 population will facilitate comparisons. Confidence intervals (CIs) for age-adjusted rates were compiled using the method of Chiang,[10] and CIs for proportional rates were calculated by the method of Fleiss.[11] Three- or 5-year rolling averages were used to assess trends, depending on the frequency of the outcome. Chi-square test for trend was used to determine the statistical significance of rate trends over time.

To determine whether the difference in low–birth-weight rates between urban and rural AI/AN populations could be entirely explained by differences in known behavioral and biologic risk factors, we conducted a logistic regression analysis to determine the model that best explained low–birth-weight variation. The outcome variable was defined as the presence or absence of low birth weight. The main independent variable was whether the birth occurred in an urban or rural location. The covariates included known maternal risk factors for low birth weight, including smoking, alcohol use, adolescent age, prior pregnancies, and the interpregnancy interval.

RESULTS

Socioeconomic Characteristics

Data from the 1990 US Census revealed that, compared with whites, the urban AI/AN population had fewer high school graduates and higher rates of unemployment and poverty (Table 1). However, rural AI/ANs appeared to be the most disadvantaged group in the study. A third of those older than 25 years living in rural counties were without a high school diploma. Unemployment (21%) and poverty rates (35%) were also highest among rural AI/ANs.

Birth Outcomes

The prevalence of low birth weight (<2500 g) was considerably higher among urban AI/ANs compared with urban whites and rural AI/ANs, but was lower than the rate of low birth weight among urban African Americans (Table 2). The prevalence of very low–birth-weight (<1500 g) births and premature deliveries shared similar patterns, although only the differences between urban AI/ANs and whites were significant.

Using low birth weight as the dependent variable and urban or rural status as the main independent variable, we found that after adjustment for the interval between births, history of prior pregnancy, adolescent age, use of prenatal care, and maternal smoking, the difference in low–birth-weight risk between the rural and urban groups was no longer statistically significant (odds ratio, 0.90; 95% CI, 0.56 to 1.4; $P=.66$). Thus, it appeared that most of the variation was attributable to differences in risk profiles of each group and not to a community risk or protective factor represented by the urban/rural variable.

Like low birth weight, the infant mortality rate averaged over 10 years was 80% higher among urban AI/ANs than among whites (Table 3). Neonatal and postneonatal mortality rates were higher among the urban AI/ANs (data not shown). Infant mortality rates among the urban AI/ANs were not significantly different than those among African Americans or the rural AI/ANs.

A significant increase in the urban AI/AN infant mortality rate occurred during the decade starting in 1981 (Figure). Five-year rolling average rates increased consistently every 5-year period from 9.6 per 1000 live births during 1981 through 1985 to 18.6 per 1000 during 1986 through 1990 (χ^2 test for trend, 5.1; $P<.05$). This decade-long trend was not evident among the other county residents or the rural population. The apparent upward trend among African Americans was not significant.

Prenatal Risk Factors for Poor Birth Outcomes

Rural and urban AI/AN mothers shared a similar prenatal risk profile (adolescent age, single marital status, and use of tobacco and alcohol during pregnancy) for poor birth outcomes (Table 2). However, urban AI/AN women were less likely than rural AI/AN women to initiate prenatal care in the first trimester (56.5% vs 64.0%; $P<.05$) and more likely to have late (third trimester) or no prenatal care (15.9% vs 10.0%; $P<.05$).

Urban AI/AN mothers had a much higher risk profile in comparison with urban white mothers (Table 2). Births among mothers aged 10 to 17 years, mothers who were single, or mothers who used tobacco or alcohol during pregnancy were all more common among AI/ANs. Similarly, the lower rates of first trimester prenatal care and high rates of late (third trimester) or no prenatal care seemed to place AI/ANs at higher risk of poor birth outcomes. This risk profile closely resembled that of African-American mothers across all variables except for prenatal alcohol consumption, where the risk among AI/ANs was significantly higher.

Table 3.—Urban American Indians and Alaska Natives (AI/AN) Mortality Rates Compared With Other Races and Rural AI/ANs by Age Group and Cause, 1981 Through 1990*

Mortality Rate	Urban			Rural AI/AN
	AI/AN	White	African American	
Infant (age 0-1 y), 10-y average rate, per 1000 live births (95% CI)†	14.7 (10.6-20.3)	8.0 (7.6-8.4)‡	17.5 (15.3-20.0)	23.2 (18.4-29.2)
Age-specific, y, 10-y average rate per 100 000 population (95% CI)				
1-14	56 (35-87)	29 (26.4-31.2)‡	39 (29.8-49.7)	62 (42-92)
15-24	162 (121-217)	83 (78.4-86.9)‡	131 (111.2-153.8)	265 (208-337)
25-44	335 (288-389)	127 (123.8-130.6)‡	279 (258.1-302.1)	386 (327-454)
45-64	1122 (992-1269)	693 (682.4-703.9)‡	1303 (1231.8-1378.8)	1092 (950-1255)
65-99	3099 (2685-3573)	4949 (4912.4-4984.9)‡	5158 (4951.3-5373.2)‡	5124 (4650-5643)‡
Total deaths	727	93 048	4525	921
Cause-specific, 10-y age-adjusted [to 1940] rate per 100 000 population (95% CI)				
All causes	597 (557-638)	473 (469.4-475.5)‡	729 (710.5-748.3)‡	747 (702-791)‡
Alcohol related	149 . . .	82 . . .	105 . . .	182 . . .
Heart disease	141 (120-163)	139 (137.1-140.3)	207 (195.8-217.6)‡	168 (164-212)‡
Cancer	76 (57-92)	127 (124.8-128.2)‡	175 (164.4-185.3)‡	93 (75-110)
Unintentional injury	69 (56-83)	29 (27.6-29.5)‡	39 (34.5-44.4)‡	118 (99-136)‡
Liver disease	50 (37-62)	9 (8.3-9.4)‡	15 (12.0-18.7)‡	44 (31-56)
Cerebrovascular	26 (18-35)	28 (27.7-29.1)	48 (42.5-53.1)‡	56 (42-70)‡
Pneumonia and influenza	22 (14-31)	12 (12.0-12.6)‡	13 (10.2-15.7)	15 (8-22)
Homicide	21 (14-28)	4 (3.8-4.5)‡	30 (25.7-34.0)	20 (12-27)
Diabetes	19 (11-27)	8 (7.8-8.7)‡	30 (25.4-34.3)	20 (12-29)
Chronic obstructive pulmonary disease	18 (10-26)	19 (18.5-19.9)	19 (15.1-22.1)	24 (15-33)
Suicide	17 (10-23)	14 (12.8-14.1)	9 (6.8-11.4)	26 (18-35)
All firearms	15 (9-21)	8 (7.9-8.9)‡	21 (17.3-24.2)	34 (24-45)‡

*CI indicates confidence interval. Ellipses indicate data not available.
†Based on linked birth and death files where mother's race is AI/AN.
‡Significantly different from urban AI/AN rate.

Age-Specific Mortality

Urban AI/AN age-specific mortality rates were higher in almost every age group compared with urban whites. The only exception was among the elderly (older than 65 years), in which the AI/AN rates were lower (relative risk [RR], 0.65; 95% CI, 0.56 to 0.75). The biggest difference was evident in the 25- to 44-year age group, though rates in the 1- to 14-year and 15- to 24-year age groups were nearly twofold higher than among whites. The only significant ($P<.05$) difference between urban AI/ANs and African Americans was in the oldest age group, in which rates for African Americans were higher.

Similarly, a comparison of death rates between urban and rural AI/ANs appeared to demonstrate slightly lower rates among urban AI/AN residents, although only the difference among the elderly (older than 65 years) reached statistical significance (RR, 0.60; 95% CI, 0.51 to 0.72; $P<.05$).

Cause-Specific Mortality

The overall age-adjusted mortality rate among urban AI/ANs was higher compared with whites, but lower compared with African Americans and rural AI/ANs (Table 3). Injuries and alcohol-related deaths accounted for the majority of excess mortality among AI/ANs. Urban AI/ANs had significantly ($P<.05$) lower age-adjusted all-cause mortality rates than rural AI/ANs as well as for heart disease, unintentional injury, cerebrovascular disease, and firearm injury. Rates for other specific causes of death (cancer, liver disease, pneumonia and influenza, homicide, suicide, diabetes, and chronic obstructive pulmonary disease) were not significantly different between the groups.

Within the urban county, the most striking differences in cause-specific mortality rates between AI/ANs and whites were for chronic liver disease and cirrhosis, unintentional injury, and homicide. Of the leading causes, only cancer was lower in the AI/ANs compared with whites. Compared with African Americans, the urban AI/ANs had lower all-cause death rates and lower rates from heart disease, cancer, and cerebrovascular disease, but higher death rates from unintentional injury and liver disease.

Communicable Diseases

Among communicable diseases, the prevalence of reported hepatitis A and hepatitis B was higher among urban AI/ANs than among rural AI/ANs, urban whites, and African Americans (Table 4). Similarly, urban AI/ANs also experienced a much higher reported prevalence of tuberculosis compared with all three other population groups. Reported prevalence rates of chlamydia, syphilis, and gonorrhea were much higher among urban AI/ANs compared with urban whites, but considerably lower than rates among urban African Americans. Race-specific rates of sexually transmitted disease were not available for rural AI/ANs.

COMMENT

The findings of this study confirm the existence of great disparities between the health of AI/ANs and whites living in one large metropolitan area. Urban AI/ANs have poorer health across almost every indicator we examined. The gap appears across almost all age groups and most causes of death. Many of the indicators were similar to those among urban African Americans, a group whose health status has repeatedly demonstrated the health inequities between whites and minorities in the United States.[12]

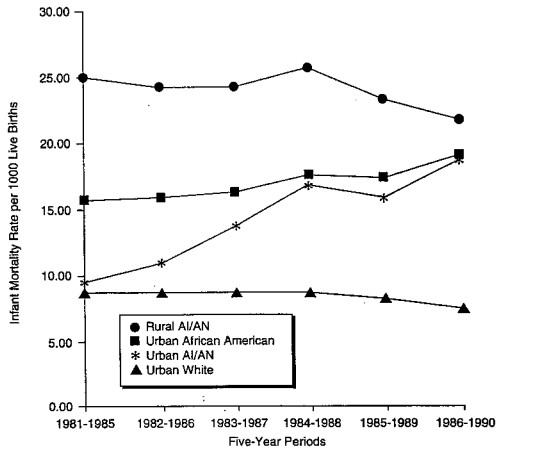
Our systematic comparison of health status indicators between urban and rural AI/ANs did not reveal a consistent pattern. Our most disturbing finding was the significant decade-long rise of the urban AI/AN infant mortality rate, a trend not shared by any of the other study populations. Rural AI/AN moth-

ers of newborn infants were more likely to have early and adequate prenatal care and were less likely to deliver a low–birth-weight infant than urban AI/AN mothers. This may be a result of access to comprehensive maternal and child health services offered by the IHS that include extensive public health nursing outreach systems. Access to these services in the rural IHS clinics may have led to earlier initiation of and follow-up with prenatal care. Though the earlier use of prenatal care and the lower rate of low birth weight appeared to demonstrate better maternal and infant health in the rural population, rural AI/AN infant mortality (including both neonatal and postneonatal mortality) was not lower in the rural counties. This surprising relationship between low birth weight and infant mortality rates may be a reflection of superior access to neonatal intensive care in the urban county.

The AI/AN mortality rates tended to be higher within the rural counties than within the urban area. The most striking age-specific difference was among the population older than 65 years. The higher rate of unintentional injury fatalities is not surprising since the incidence of fatal motor vehicle crashes is known to be higher in rural areas, especially among AI/ANs.[13] Almost all of the overall mortality difference can be explained by higher rates of the four leading causes of death (heart disease, cancer, injury, and cerebrovascular disease) among rural AI/ANs, compared with their urban counterparts.

Several limitations may have affected the results of this study. Although undercounting of AI/ANs in the census would have the effect of inappropriately increasing morbidity and mortality rates when the census population is used as the denominator, data from the 1980 and 1990 censuses suggest that the problem of undercounting of AI/ANs has diminished in comparison with earlier censuses.[14] Misclassification of race in vital records can result in substantial underestimates of mortality rates among AI/ANs.[15-17] We estimate that this differential misclassification affects mortality data by artificially minimizing some of the true disparity between whites and urban AI/ANs, ie, a conservative bias. We attempted to minimize the effects of racial misclassification for infant mortality rates and the prevalence of birth risk factors by using linked birth and death certificates and the current National Center for Health Statistics designation of race. However, estimates of AI/AN mortality rates for ages beyond infancy were not derived from linked files, raising the potential for significant racial misclassification and underestimation of the AI/AN rates. If misclassification of AI/ANs as other races was less likely to occur in rural areas (perhaps because morticians and coroners are more sensitive to the presence of a large AI/AN population), then urban rates would be selectively underestimated, thus accounting for some of the differences between urban and rural AI/ANs observed in this study. Indeed, in a study of racial misclassification of clients of the Seattle Indian Health Board, almost one third of persons who identified themselves as AI/AN to the clinic while living were classified as other races on death certificates, compared with approximately 12% inconsistent classification among primarily rural, IHS-registered AI/ANs in Washington.[18] Because the direction of this potential bias is known, study conclusions or policy implications should not be significantly affected. Data from birth certificates may be less susceptible to this potential bias.

In addition to racial misclassification on vital records, several studies in the Pacific Northwest have shown that morbidity rates calculated from registries of cancer,[16] AIDS,[19] end-stage renal dis-



Five-year rolling averages for infant mortality trends of urban American Indians and Alaska Natives (AI/ANs) compared with other races and rural AI/ANs. Data derived from linked birth and death certificates. Race classified according to maternal race.

Table 4.—Incidence of Communicable Diseases Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

Disease	Urban			Rural AI/AN
	AI/AN	White	African American	
Hepatitis A†	151 (123-178)	42.0 (39.8-44.1)‡	43.4 (34.9-52.0)‡	106 (85-128)
Hepatitis B†	47 (31-63)	10.8 (9.7-11.8)‡	25.3 (18.8-31.9)	25 (14-35)
Tuberculosis§	60 (47-74)	3.0 (2.7-3.3)‡	16.8 (13.5-20.0)‡	20 (12-28)‡
Sexually transmitted diseases‖				
Chlamydia	516 (460-573)	255.5 (250.0-261.1)‡	1472.6 (1432.9-1512.2)‡	NA
Gonorrhea	298 (253-342)	81.0 (77.9-84.2)‡	2055.5 (2008.5-2102.5)‡	NA
Syphilis	47 (28-66)	4.9 (4.2-5.6)‡	183.7 (166.0-201.4)	NA

*All rates age-adjusted to 1940 US population. NA indicates not available. Data expressed as mean rates per 100 000 population (95% confidence intervals).
†Average rate, 1987 through 1990.
‡Significantly ($P<.05$) different from urban AI/AN rate.
§Ten-year average rate, 1981 through 1990.
‖Three-year average rate, 1988 through 1990.

ease,[20] and injury[21] may be underestimated among AI/ANs because of racial misclassification. Reporting bias is another potential concern in this study, primarily in the rates of communicable diseases. Care providers in the public sector, where indigent patients are more likely to seek care, may be more likely to report cases of communicable diseases to health authorities than private practitioners. The effect of this bias would be to overestimate the differences noted between whites and urban AI/ANs with respect to communicable diseases such as gonorrhea.

Should urban AI/ANs receive attention as a population with special health needs? More than half of AI/ANs now live in urban areas, but only a few of these areas, such as Albuquerque, NM, Phoenix, Ariz, and Anchorage, Alaska, offer direct IHS services. Title V of the Indian Care Improvement Act of 1976 was the first federal government recognition of the health needs of urban AI/ANs. Despite this recognition, few resources have been allocated to address these needs. The initial 1976 authorization called for a $15 million allocation for urban Indian communities to organize programs to "facilitate access to and, when necessary, provide health services to urban Indian residents."[22] In 1992, only $17 million was appropriated to urban Indian programs in cities where an IHS facility was not present, representing 1% of the total IHS budget. Because eligibility for the full scope of IHS services has been reserved for "persons of descent belonging to the Indian community served by the local facilities and program," it effectively excludes rural AI/AN residents who move to an urban area without an IHS direct care facility, perhaps in search of employment or family reunification.[5] Though the reasons for the presence of large urban AI/AN populations are not completely known, many urban AI/AN residents were coercively relocated from reservations by the federal government to the cities during a period in the 1950s known as the "termination era" in the history of relations between US Indians and whites.[23] This relocation policy separated AI/AN people from tribal land and culture, exposing them to the harsh social and economic conditions of the urban poor. Others migrated to the cities in search of employment and education. Many of these individuals and their families never returned to their reservations. Whatever the reason, many AI/AN people are firmly rooted in the cities.

The allocation of IHS funds to the urban Indian program has been a source of controversy between urban Indian and tribal leaders. Concerned that scarce resources would be redirected from the reservations to the cities, some tribal leaders have opposed the expansion of urban programs. Our data do not support the redirection of funds previously designated for rural AI/ANs living on native lands, since it appears that both populations are vulnerable and in similar great need of health services, epidemiologic surveillance, and prevention activities. The recent drive for health system reform may benefit the health concerns of the urban AI/AN population. Under President Clinton's proposed Health Security Act of 1993 (section 8302), urban AI/ANs will be eligible for the same full health care benefits extended to rural AI/AN residents. Under this plan, all AI/AN enrollees could receive their care in an IHS, a tribal, or an urban Indian facility. Until a solution is reached in the context of health system reform, the responsibility for the health needs of urban AI/ANs must continue to be addressed at local, state, and federal levels in consultation with existing urban Indian programs.

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References

1. Rhoades ER, Hammond J, Welty TK, Handler AO, Amler RW. The Indian burden of illness and future health interventions. *Public Health Rep.* 1987; 102:361-368.
2. US Bureau of the Census. *1990 Census of the Population: General Population Characteristics—United States.* Washington, DC: US Bureau of the Census; 1990.
3. Pub L No. 102-537. Amendments to the Indian Health Care Improvement Act of 1992.
4. Kramer BJ. Health and aging of urban American Indians. *West J Med.* 1992;157:281-285.
5. Taylor TL. Health problems and use of services at two urban American Indian clinics. *Public Health Rep.* 1988;103:88-95.
6. *Indian Health Care.* Washington, DC: Office of Technology Assessment; 1986. US Dept of Health and Human Services publication OTA-H-290.
7. Shultz JM, Rice OP, Parker DL, Goodman RA, Stroh GJ, Chalmers N. Quantifying the disease impact of alcohol with ARDI software. *Public Health Rep.* 1991;106:443-450.
8. World Health Organization. *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Based on the Recommendations of the Ninth Revision Conference, 1975.* Geneva, Switzerland: World Health Organization; 1977.
9. *Reconsidering Age-Adjustment Procedures.* Washington, DC: US Dept of Health and Human Services publication PHS 93-1446.
10. Chiang CL. Standard error of the age-adjusted death rate. *Vital Stat Special Rep.* 1961;47:275-285.
11. Fleiss JL. *Statistical Methods for Rates and Proportions.* New York, NY: John Wiley & Sons Inc; 1981.
12. Dept of Health and Human Services. *Report of the Secretary's Task Force on Black and Minority Health, I: Executive Summary.* Washington, DC: US Dept of Health and Human Services; August 1985.
13. Baker SP, O'Neill B, Ginsburg MJ, Li G. *The Injury Fact Book.* 2nd ed. New York, NY: Oxford University Press; 1992:224.
14. Passel JS, Berman PA. Quality of 1980 census data for American Indians. *Soc Biol.* 1988;33:163-182.
15. Hahn RA, Mulinare J, Teutsch SN. Inconsistencies in coding of race and ethnicity between birth and death in US infants: a new look at infant mortality, 1983 through 1985. *JAMA.* 1992;267:259-263.
16. Frost F, Taylor V, Fries E. Racial misclassification of Native Americans in a surveillance, epidemiology, and end results cancer registry. *J Natl Cancer Inst.* 1992;84:957-962.
17. Centers for Disease Control and Prevention. Classification of American Indian race on birth and infant death certificates—California and Montana. *MMWR Morb Mortal Wkly Rep.* 1993;42:220-223.
18. Sugarman JR, Hill G, Forquera R, Frost FJ. Coding of race on death certificates of patients of an urban Indian health clinic, Washington, 1973-1988. *IHS Provider.* 1992;17:113-115.
19. Hurlich MG, Hopkins SG, Sakuma J, Conway GA. Racial ascertainment of AI/AN persons with AIDS, Seattle/King County, WA 1980-1990. *IHS Provider.* 1992;17:73-74.
20. Sugarman JR, Lawson L. The effect of racial misclassification on estimates of end-stage renal disease among American Indians and Alaska Natives, Pacific Northwest, 1988-1990. *Am J Kidney Dis.* 1993;21:383-388.
21. Sugarman JR, Soderberg R, Gordon JE, Rivara FP. Racial misclassification of American Indians: its effect on injury rates in Oregon, 1989 through 1990. *Am J Public Health.* 1993;83:681-684.
22. Pub L No. 94-437. Indian Health Care Improvement Act of 1976.
23. Prucha FP. *Documents of United States Indian Policy.* Lincoln: University of Nebraska Press; 1990:237.

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Cover Artwork: Åldigâws (Hummingbird) by Joyce Troyer-Willson who is a member of the Tsimshian Tribe from Ketchikan, Alaska. She belongs to the Gishbuwidwada (Blackfish) Clan. Ms. Troyer-Willson served as a member of the SIHB Board of Directors for 10 years and served as Board President from 1985 to 1990. Her portfolio includes a totem pole raised in her ancestral village of Metlakatla, Alaska.

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Foreword

Several studies conducted by Public Health - Seattle & King County show that not all residents of this region enjoy good health. One often overlooked group is urban American Indians and Alaska Natives.

During the 1950s, Seattle was designated a relocation center for thousands of Indian people displaced by the ill-fated Indian relocation and termination policies of the federal government. Indians from across the nation were sent to Seattle with promises of housing, education, and jobs. While many succeeded in making the transition to urban life, others remain mired in poverty, struggling to find their way in the new environment.

Urban Indians now represent the largest segment of Indian people in the nation. However, federal policies regarding Indian health are generally directed at Indians living on or near the 226 Indian reservations scattered across the United States. Indians who leave reservation homes frequently find themselves without access to health care or lack an understanding of how the mainstream health system operates.

The Seattle Indian Health Board (SIHB) and Public Health - Seattle & King County have provided primary health care for Indian people and other low income residents for many years. This report is a result of the partnership that has evolved between Public Health - Seattle & King County and the SIHB on behalf of Indian people who now call King County home.

Understanding health disparities is the first step in developing effective interventions to correct these differences. We thank all of our community partners for their continuing support and efforts. We hope that this report will be a catylst for both dialogue and action as we address the health concerns of the continent's first residents.

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Health Status of American Indians and Alaska Natives in King County Report Highlights

In the 2000 U.S. Census 33,000 King County residents reported that they were of American Indian or Alaska Native (AI/AN or Indian) heritage. Together with Indians living in Pierce County, they comprise one of the largest concentrations of Indian people in the nation. Indians in King County have diverse ethnic identities; members come from hundreds of federally-recognized tribes and from tribes not officially recognized by the U.S. government.

The health status of Indians living in King County presents a varied picture with both notable improvements over time and a number of new or continuing challenges.

Progress toward better health:

- **Decreasing mortality:** The total mortality rate has decreased and is nearly 20% lower than the rate in 1980. With respect to specific causes, there have been decreases in mortality due to unintentional injuries, chronic liver disease and cirrhosis, and homicide. Since 1994, however, overall mortality has begun to increase.

- **Improved maternal and prenatal care:** Since 1980, the timely use of prenatal care (within the 1st trimester of pregnancy) has increased significantly to 91% of all births to AI/AN women. Decreases in maternal smoking and alcohol use have also been observed in recent years.

- **Decreasing communicable disease:** Substantial decreases in sexually transmitted diseases such as gonorrhea and chlamydia have occurred in the last decade.

Continuing and new health challenges:

- **Serious disparities in health indicators continue:** While some health concerns have decreased significantly in past years, these decreases have not kept pace with advances for all King County residents.

- **Increase in some rates and risk for serious disease:** Mortality overall has increased from 1994 to 1998. Increases are evident with respect to lung cancer, unintentional injury, diabetes, and drug-related causes.

- **High prevalence of some risk factors for disease:** Among adults, smoking (37%) and overweight status (60%) are higher than countywide rates (19% and 46%, respectively). The same indicators among AI/AN youth attending Seattle Public Schools (grades 7 through 12) were lower than the rates for AI/AN adults, but higher than the rates for all youth attending these schools. This was especially true among high school students. Similarly, other indicators with respect to carrying weapons, gang involvement, being the target of a weapon, and drug and alcohol use were also higher than for all students in the district.

- **Poverty:** Over one third of AI/AN children and over one quarter of adults lived in poverty in 1990. While more recent data are not available for children, surveys of adults, as recent as 1998, indicate that up to 41% of AI/AN live below 200% of the federal poverty level.

- **Lack of health insurance:** Up to 23% of adults report having no health insurance compared to 12% of all county residents.

Notes about using this report

In general the health indicators included in this report which pertain to the health of American Indians and Alaska Natives living in King County are compared to rates for all King County residents. Some national data on American Indians and Alaska Natives has also been included for comparison purposes when available. It should be noted that this report uses the terms "American Indian/Alaska Native," "AI/AN" and "Indian" interchangeably.

On rates and statistical significance: *The term "significant" when comparing numerical data is used to imply a statistically significant difference in rates. A rate in this report is usually expressed as the number of events per 100,000 population per year. When this applies to the total population (all ages), the rate is called the crude rate. When the rate applies to a specific age group (e.g., age 15-24), it is called the age-specific rate. The crude and age-specific rates present the actual magnitude of an event within a population or age group.*

When comparing rates between populations, it is useful to calculate a rate which is not affected by differences in the age composition of the populations. For example, if one population has a higher death rate and more older people, it will not be easy to determine if its rate is truly higher or just reflects the high death rate among older people. The age-adjusted rate is a rate that mathematically removes the effect of the age composition. By convention, we adjust the rate to the age distribution of the 1940 U.S. population.

When comparing rates between different groups with bar graphs, the "95% confidence interval" or margin of error is shown for each rate to assess how much the rate is likely to vary due to chance. For each estimated rate, one would expect the rate to fluctuate, but to remain within the confidence interval 95% of the time. The larger the population under consideration, the smaller the confidence interval, and thus the more reliable the rate. When comparing two rates, if the confidence intervals do not overlap, the difference in the rates is considered "statistically significant," that is, chance or random variation is unlikely to be the reason for the difference.

I. Introduction and Overview

More American Indians and Alaska Natives (AI/AN or Indians) now live in major metropolitan regions of the nation, like King County, than on Indian reservations. The 1990 Census found that over 60% of Americans who self-identify as American Indian or Alaska Native were living outside of reservations, with the majority of all Indians (56%) living in major metropolitan centers. In spite of this geographic shift and because the urban Indian populations in these areas are small and geographically dispersed, little is known about their general health status.

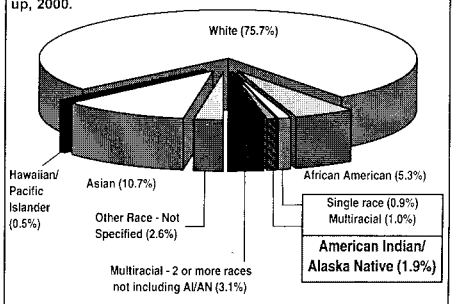
The Seattle/Tacoma metropolitan area had the 7th largest concentration of Indian people in the United States, according to the 1990 Census. In the 2000 Census, slightly more than 33,000 residents (1.9%) out of a total of 1.7 million people living in King County indicated that they were of American Indian or Alaska Native heritage **(Figure 1)**. While nearly half (15,922) of these residents identified themselves solely as AI/AN, the remaining 17,100 reported mixed heritage. These figures when taken together probably represent an increase in the number of AI/AN living in King County when compared to the 1990 Census **(see box at right for a more details).**

Ethnic diversity among Indians living in King County is also quite great. A recent study performed for the Seattle Indian Health Board (SIHB) found that Indian people from 238 federally-recognized Indian tribes were served by this community health center in the past decade. Indians from dozens of non-federally recognized tribes also receive their care at the SIHB.

An earlier mapping study of clients of the SIHB found that there were no Indian "neighborhoods." Instead, it was found that Indian people are living in most county zip codes. Because the populations are culturally diverse and geographically scattered, establishing reliable ways to identify health problems and track health conditions over time is both difficult and expensive.

In this report, the health status of Indians living in King County is described using locally available health data such as birth and death records. Communicable disease reports and large state

Figure 1. King County population by racial and ethnic make up, 2000.



Note: 11.0% of King County residents reporting AI/AN heritage are also of Latino or Hispanic ethnicity. Of all King County residents, 5.5% report Latino or Hispanic ethnicity.

How Many American Indians and Alaska Natives Live in King County?

The main source of information concerning the number of American Indians and Alaska Natives living in King County comes from the U.S. Census. On the 2000 Census, 33,022 persons indicated AI/AN racial heritage. This total number probably reflects an increase in the number of AI/AN living in King County when compared to the 17,305 AI/AN counted in 1990. In 2000, however, 15,922 indicated AI/AN heritage alone, while the remaining 17,100 persons indicated a mixed heritage. Since persons in 1990 were not given the option of indicating a mixed heritage, it is difficult to compare the 1990 and 2000 figures. It would be inaccurate to use the 2000 figure of 15,922 alone, since we do not know how many of the 17,100 persons reporting mixed heritage would have recorded their heritage had they been given only one choice. It is likely, therefore, that the AI/AN population in King County has increased over the past decade, since this would require only one in 12 (8%) of those who reported being of mixed race in 2000 to chose the single AI/AN category.

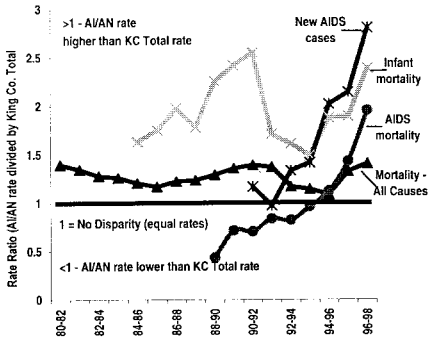
Other factors also influence estimates of AI/AN living in King County. For instance, some may not have participated in the census due to homelessness, frequent moving, or personal choice. Others remain skeptical of government attempts to count them due to historic abuses. Still other Indians, although they usually reside in King County, may have chosen to list themselves as living on a particular Indian reservation where they might have family or other strong connections.

wide surveys with large samples in King County are also used. In addition, findings from the 1999 Seattle Public Schools Teen Health Survey which included Indian students are reported. Because the number of actual cases of any particular indicator can be small, statistical confidence intervals may appear quite large. However, even with these statistical limitations, there is abundant evidence that Indians in King County suffer from poorer health when compared to the county as a whole. Key findings in this report are highlighted on page iv.

While some health indicators for Indians have improved since 1980, much of this progress has not kept pace with improvements seen for all county residents. For many indicators, health disparities have persisted or even increased significantly in the past decade **(Figure 2).**

Understanding the health of urban Indians and the conditions that affect them is an important step in designing programs and interventions to reduce the disparity in health status as demonstrated in this report.

Figure 2. Disparities in health indicators (comparison of health indicators between American Indians/Alaska Natives living in King County and all King County residents), three-year averages, 1980-1998.



Source: Washington State Department of Health. Center for Health Statistics and Public Health – Seattle & King County HIV/AIDS Epidemiology

II. Health Status and Access to Health Services

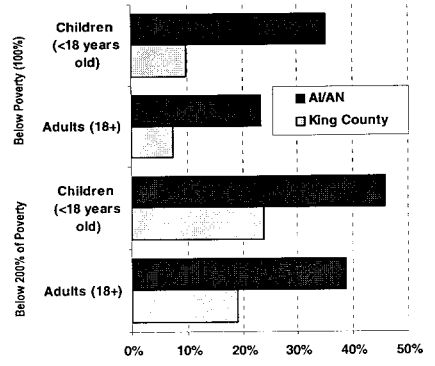
Social and Economic Well-Being

- According to 1990 Census data which include information on 1989 household income, 35% of Indian children less than age 18 and 26% of adults lived in poverty **(Figure 3 and Appendix 1).** These rates were significantly higher than countywide rates of 10% and 7%, respectively. Nearly half (46%) of AI/AN children and 39% of adults were living in households with incomes below 200%

- More recent data from the State Population Survey conducted by telephone in 1998 indicate little to no improvement in relation to the 1989 findings. In this survey 38% of adult AI/AN respondents reported household incomes below 200% of the federal poverty level, compared to 15% countywide.

- More recent local data for children were unavailable.

Figure 3. Percent of American Indians and Alaska Natives living in poverty in King County, 1989

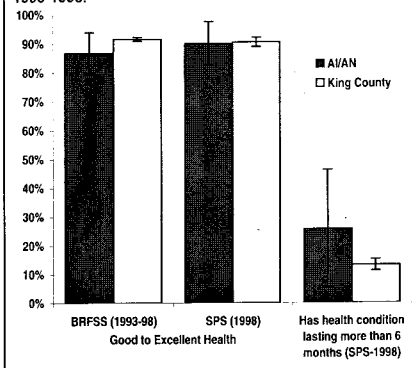


Source: 1990 U.S. Census.

General Health Status (Figure 4 and Appendix 2)

- Nearly all (approximately 90%) American Indian/Alaska Natives participating in two random telephone surveys between 1993 to 1998 reported "good" to "excellent" health. These rates were statistically the same as the rates for all King County residents.
- Although twice as many AI/AN respondents reported having a health condition lasting 6 months or longer, compared to all King County residents combined (25.8% and 13.3%, respectively), these differences also were not statistically different.
- Available 1990 Census data, however, report significantly higher rates of work limitations due to disability among AI/AN, compared to all King County residents combined. In particular, about 20% of AI/AN reported disability-related work limitations, compared to 11.3% countywide.

Figure 4. Self-reported health status and reports of having health conditions lasting more than 6 months, King County, 1993-1998.

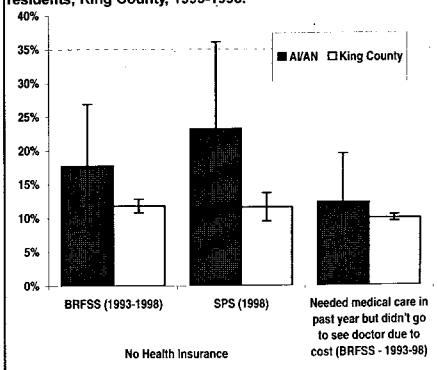


*BRFSS – Behavioral Risk Factor Surveillance System. Washington State Department of Health and U.S. Centers for Disease Control
SPS – State Population Survey. Washington State OFM.

Health Insurance Status and Unmet Medical Need (Figure 5 and Appendix 2)

- AI/AN respondents in King County had higher rates of being without health insurance in two studies, but these findings were not statistically significant. AI/AN rates in King County were 18% to 23%, compared to about 12% for all residents in both surveys.
- Reports of not receiving needed medical care among AI/AN were similar to countywide rates (12% and 10%, respectively).

Figure 5. No health insurance and unmet medical need due to cost among American Indians/Alaska Natives and all residents, King County, 1993-1998.



*BRFSS – Behavioral Risk Factor Surveillance System. Washington State Department of Health and U.S. Centers for Disease Control
SPS – State Population Survey. Washington State OFM.

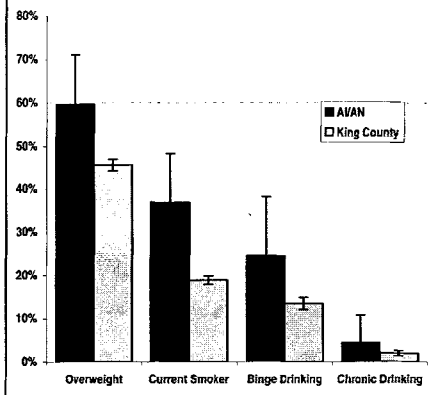
Risk Factors for Chronic Disease (Figure 6 and Appendix 3)

With respect to measures of risk factors for chronic disease, several indicators were significantly higher among AI/AN survey respondents, when compared to all King County residents.

These indicators included:

- Higher overweight status, 60% among AI/AN compared to 46% among all respondents.
- Higher rates of smoking, 37% among AI/AN compared to 19% countywide.
- Rates of binge drinking (consumption of 5 or more drinks on a single occasion in the past month) and chronic drinking, although consistently higher than countywide rates were not statistically different from the rates for all respondents countywide.

Figure 6. Risk factors for chronic disease, 1993-1998.

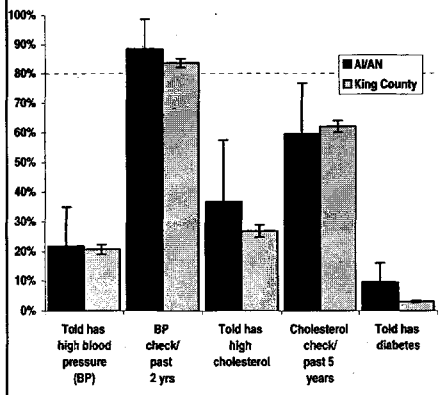


Source: Behavioral Risk Factor Surveillance System. Washington State Dept. of Health, Center for Health Statistics and U.S. Cntrs. for Disease Control and Prev.

Diagnosis of certain medical conditions and recent use of screening (Figure 7 and Appendix 3)

- Reports of having high blood pressure or high cholesterol among AI/AN in King County were not statistically different than countywide totals.
- Likewise, screening rates for high blood pressure or high cholesterol were also similar to countywide rates.
- However, nearly 10% of AI/AN respondents in King County reported having diabetes, compared to 3% of respondents countywide.

Figure 7. Diagnosis of certain medical conditions and recent use of screening, 1993-1998.



Source: Behavioral Risk Factor Surveillance System. Washington State Dept. of Health, Center for Health Statistics and U.S. Cntrs. for Disease Control and Prev.

III. Mortality

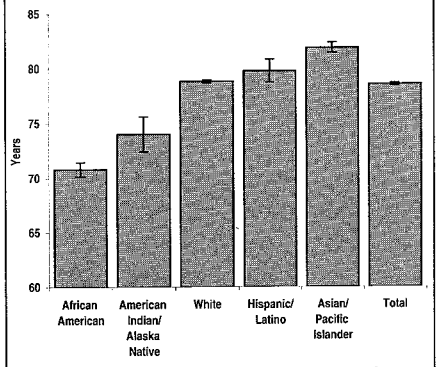
Life Expectancy and Mortality due to All Causes

- Based on data collected over the years 1996 to 1998, American Indians and Alaska Natives living in King County have life expectancies which are nearly 5 years less than the life expectancy of all residents countywide (74.0 years compared to 78.5 years, respectively) **(Figure 8 and Appendix 4a).**

- The shorter life expectancy is reflected in higher overall mortality rates among AI/AN compared to countywide rates. Since 1980 mortality rates among AI/AN in King County have dropped significantly **(Figure 9).** Some of this progress, however, has been erased due to a significant increase in mortality rates over the past five years (1994-1998).

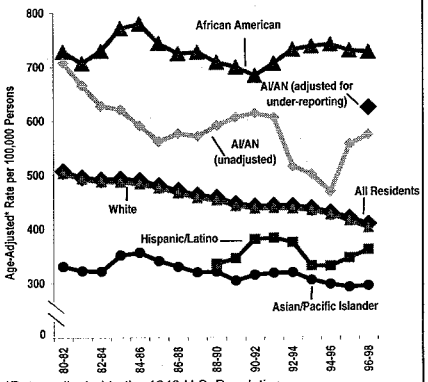
- Under-reporting of AI/AN race on death certificates has been documented in a number of death certificate review studies. Studies conducted by the U.S. Indian Health Service estimated that misclassification of AI/AN race on death certificates occurred on approximately 10% of death certificates in Washington State.[1] Findings of another study conducted by the Seattle Indian Health Board suggest that the rate of misclassification may be even higher.[2] In this study 29% of persons who had identified AI/AN as their race in their health records had their race incorrectly reported on their death certificate. All mortality statistics in this report, however, do not reflect this under-reporting, but this difference, as reported by the Indian Health Service, is illustrated in **Figure 9.**

Figure 8. Life expectancy at birth by race/ethnicity, King County, 1996-1998



Source: Washington State Department of Health, Center for Health Statistics.

Figure 9. Mortality due to all causes by race/ethnicity, King County, three-year averages, 1980-1998.



*Rates adjusted to the 1940 U.S. Population.
Source: Washington State Department of Health, Center for Health Statistics.

[1] U.S. Indian Health Service. Adjusting for miscoding of Indian race on state death certificates, November 1996.
[2] Sugarman, J.R., Hill, G., Forquera, R., Frost, F. Coding of race on death certificates of patients of an urban Indian health clinic, Washington, 1973-1988. *IHS Primary Care Provider.* 1992. 17 (7): 113-115.

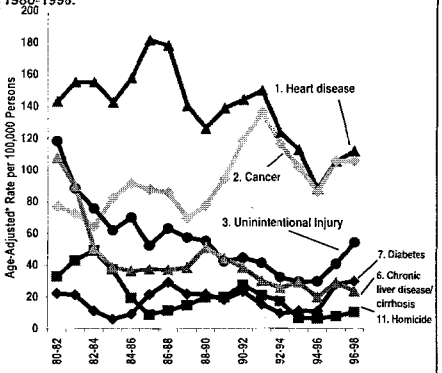
Age-Specific Mortality (Appendix 4b)

- Higher rates of death among American Indians/Alaska Natives in King County compared to countywide rates are observed primarily among persons less than age 45.
- 1980 through 1998 death rates decreased significantly among persons age 15 to 24 and 45 to 65. The decrease among the 25 to 44 year old group during this time period was only marginally significant.
- In the more recent years from 1994 through 1998, however, significant increases in mortality have been observed with respect to children (ages 1 to 14 years) and older adults (ages 65 to 84 years).

Leading causes of death (Figures 10 and 11, and Appendix 5)

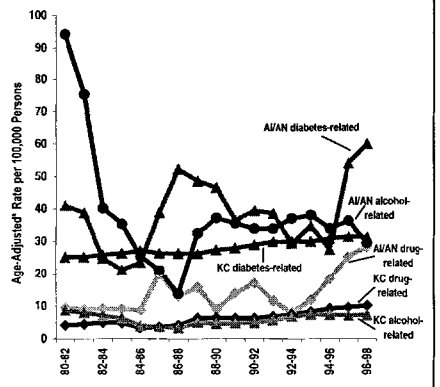
- Similar to other groups in King County, the leading causes of death among American Indians/Alaska Natives are heart disease and cancer. Heart disease mortality declined significantly over the period from 1986 to 1998. Althought the increase in mortality due to all types of cancer since 1980 is not statistically significant, a significant increase in lung cancer over this time period is evident.
- Unintentional injury is the third leading cause of mortality among AI/AN. Mortality rates due to unintentional injury are 122% higher than countywide rates, where unintentional injury ranks sixth in terms of leading causes of death. Similar to the trend for all mortality, the rate of unintentional injury deaths has dropped significantly since 1980, but since 1994 the rate has begun to rise again significantly.
- Cerebrovascular disease and pneumonia combined with influenza are equally ranked as the 4th leading cause of death.

Figure 10. Leading causes of death with significant increasing or decreasing trends among American Indians and Alaska Natives living in King County, three-year averages, 1980-1998.



*Rates adjusted to the 1940 U.S. Population.
Source: Washington State Department of Health, Center for Health Statistics.

Figure 11. Mortality related to diabetes and alcohol and drug use, 1980-1998.



*Rates adjusted to the 1940 U.S. Population.
Source: Washington State Department of Health, Center for Health Statistics.

- Chronic liver disease, including cirrhosis of the liver, among American Indians and Alaska Natives in King County is the 6th leading cause of death among AI/AN in King County. Although mortality due to this cause remains more than twice as high as countywide rates, there has been a significant decrease in deaths since 1980.

- Diabetes ranks as the 7th leading cause of death among AI/AN in King County. The mortality rate due to diabetes is more than twice as high as the countywide rate and has increased marginally over the the five year period from 1994-1998.

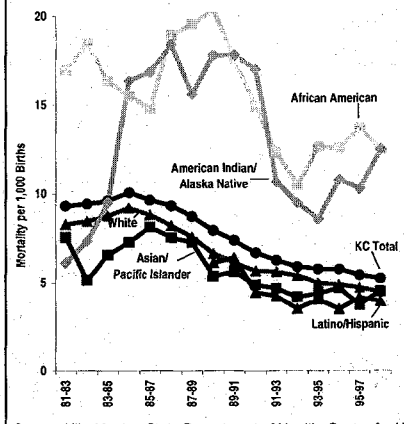
- The impact of diabetes as a major cause of death among American Indians/Alaska Natives in King County becomes even more pronounced when deaths listing diabetes as both a primary and contributing cause of death are considered. All mortality due to diabetes-related illness has increased significantly over the period 1994 to 1998. If it were listed among leading causes of death, it would rank 4th after unintentional injury.

- Homicide among AI/AN now ranks as the 11th leading cause of death. Homicide rates have declined significantly since 1980.

- Alcohol-related deaths have declined significantly over the period 1980 through 1998.

- However, drug-related deaths among American Indians/Alaska Natives in King County occur at a rate over 4 times higher than the countywide rate and have increased significantly since 1980.

Figure 12. Infant mortality by race and ethnicity, three-year averages, 1981-1998



Source: Washington State Department of Health, Center for Health Statistics.

IV. Maternal and Child Health

Mortality among infants born to mothers who are American Indian/Alaska Natives is more than twice as high as mortality for infants born to all mothers countywide **(Figure 12 and Appendix 6a).** Infant mortality peaked in 1990 with 8 deaths and declined significantly until 1993 when 2 deaths were recorded. Although rate in **Figure 12** appears to be increasing in recent years, no significant trend is evident at this time. More than half of the infant deaths are attributable to Sudden Infant Death Syndrome (SIDS), which occurs at a rate 10 times higher than the countywide rate.

- Rates of low birth weight and premature births among infants born to AI/AN mothers are marginally higher than countywide rates. In recent years (1994-1998), however, the rate of premature births has dropped significantly **(Appendix 6b)**.

- Several other factors associated with poor birth outcomes are significantly higher among mothers who are AI/AN compared to all mothers countywide **(Figure 13 and Appendix 6b)**. These factors include significantly higher percentages of teenage mothers (9% and 2%, respectively), unmarried mothers (60% and 23%, respectively), maternal smoking (22% and 10%, respectively) and maternal alcohol use (4% and 2%, respectively). Late (3rd trimester) or no prenatal care was also more common among AI/AN mothers than all mothers countywide (9% and 3%, respectively).

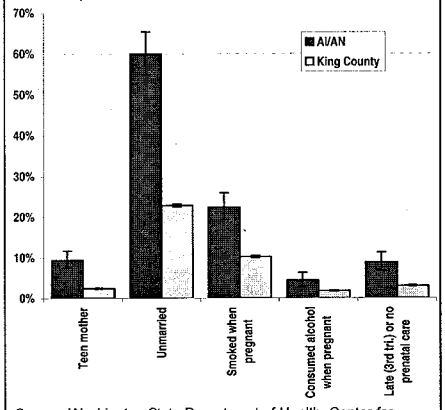
- Significant improvements over time since 1980 are evident with respect to late or no prenatal care **(Figure 14)**. More recently, from 1994 to 1998, smoking and alcohol use during pregnancy have decreased. Use of alcohol during pregnancy is strongly related to the occurrence of Fetal Alcohol Syndrome (FAS) and other disability. Due to limitations in screening for FAS, however, estimates of the number of persons affected by FAS are difficult to produce. More information concerning FAS is referenced in the resource section of this report.

- The percentage of single mothers giving birth has increased marginally to 60% in the period from 1980 to 1998.

Stress and Social Support During Pregnancy

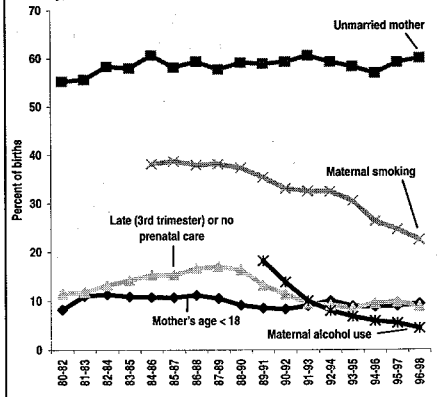
- Increasingly, researchers are better able to document the relationship between stress and its negative effect on birth outcomes (e.g., preterm delivery and other risk factors for infant mortality). As a surrogate measure of stress experienced by recent mothers, we present in **Appendix 7** details pertaining to stressful life events measured by the statewide Pregnancy Risk Assessment Monitoring System (PRAMS) survey conducted among women who gave birth in the preceding year.

Figure 13. Maternal risks associated with poor birth outcomes, 1996-98.



Source: Washington State Department of Health, Center for Health Statistics.

Figure 14. Maternal risks associated with poor birth outcomes among American Indians/Alaska Natives in King County, 1981-1998.



Source: Washington State Department of Health, Center for Health Statistics.

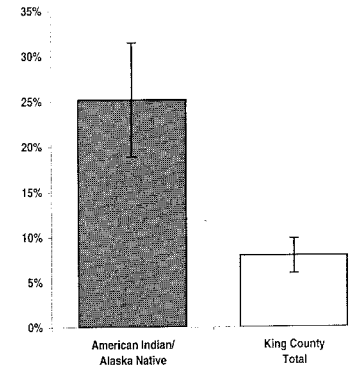
- With respect to eight of the 13 measures shown in **Appendix 7**, the rates for AI/AN mothers are significantly higher than for all mothers countywide. One in four (25.2%) AI/AN mothers reported 5 or more stressful life events in the year preceding the delivery of their child compared to less than one in 10 (8.0%) mothers countywide **(Figure 15).**

- Just as stress in a mother's life is believed to increase the risk of poor birth outcomes, some studies indicate that social support (particularly from the woman's partner or other close family members or friends) may help buffer the negative effects. However, with respect to four indicators measured in the PRAMS survey **(Figure 16)**, AI/AN mothers had consistently lower levels of social support when compared to all mothers countywide.

V. Middle and High School Youth

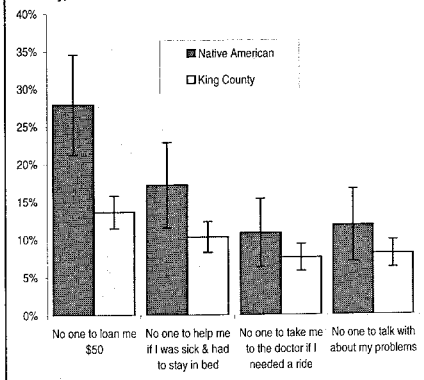
Data concerning the health of school-age youth of American Indian/Alaska Native heritage are extremely limited. In the year 2000, AI/AN children and youth living in King County under age 18 years old are estimated to number approximately 9,900. In addition to mortality data (Appendix 4b) and teen pregnancy data which has been reported earlier in this report, some health behavioral and risk factor data are available from statewide and local surveys of youth attending public middle and high schools. At the statewide level, only a sample of schools are surveyed, making the number of AI/AN youth surveyed within King County too small for analysis. Within Seattle Public Schools, however, larger samples of Indian students attending high schools and grades 7 and 8 have been included in periodic surveys. The most recent survey took place in the spring of 1999. The results of this survey, called the 1999 Teen Health Survey, are reported in detail in a final report published by the Seattle Public Schools Health Education Office.

Figure 15. Reporting Five or More Stressful Life Events in the Year Before Delivery, 1996-1998.



Source: Washington State Department of Health, Center for Health Statistics. Pregnancy Risk Assessment Monitoring System (PRAMS).

Figure 16. Lack of Social Support During Pregnancy, King County, 1996-1998.



Source: Washington State Department of Health, Center for Health Statistics. Pregnancy Risk Assessment Monitoring System (PRAMS).

This report includes a summary of the findings as they pertain to AI/AN youth in Seattle Public Schools who attend high school and 7th and 8th graders at selected middle schools. The 1999 Seattle Teen Health Survey included a sample of 31 7th and 8th graders and 117 high school students who self-identified as American Indian or Alaska Native. Overall, the total sample of students included 1,827 7th and 8th graders and 8,665 high school students.

These selected findings, however, should be interpreted with caution since the number of AI/AN students surveyed was only a small fraction of the AI/AN youth who would be of middle school and high school age. In addition, generalization of these results to AI/AN youth living in King County outside Seattle or who do not attend Seattle Public Schools should also be made with great hesitation.

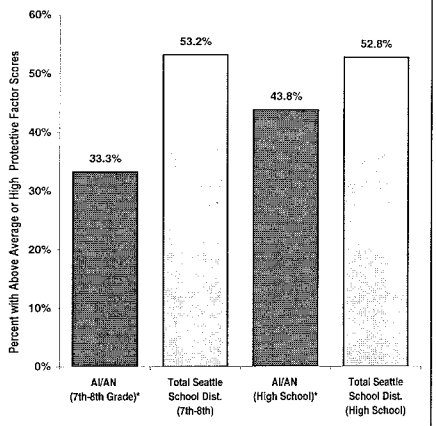
Family Environment and Protective Factors

This section summarizes the results for questions pertaining to family environment and protective factors (also called developmental assets). Emerging research shows that protective factors may help youth avoid engaging in harmful risk behaviors such as smoking or illegal drug use. The indicators used in the Seattle Teen Survey to describe some protective factors are presented in **Appendix 8**.

Family rule setting and parental encouragement among the AI/AN youth participating in the Teen Health Survey were similar for participants of all ethnicities. Reports of substance abuse among AI/AN family members, however, were reported more frequently by both middle school and high school youth compared to the rates for all students combined (41.9% and 26.3%, respectively, among 7th and 8th graders and 48.2% and 27.7% among high school students).

Above average or high protective factor scores developed from the 11 indicators listed in **Appendix 8** were significantly lower for AI/AN middle school students and marginally lower for AI/AN high school students (33.3% and 53.2% among 7th and 8th graders, respectively, and 43.8% and 52.8% among high school students) **(Figure 17)**.

Figure 17. Protective Factors (developmental assets) among Seattle Public School Middle (7th and 8th grade) and High School Students, 1999.



* Significantly different from total.
Source: 1999 Teen Health Survey. Seattle Public Schools, Health Education Office.

Physical and Mental Health

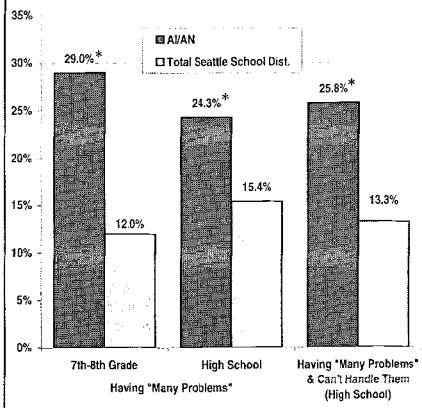
General physical and mental health indicators among Seattle Public Schools middle and high school students are presented in **Appendix 9**.

- Access to health and dental care and reports of asthma in the past year were similar among AI/AN respondents and all survey participants.
- Indicators for being overweight or at-risk for being overweight, however, were significantly higher among AI/AN high school respondents compared to all students (14.3% were overweight compared to 7.4% overall, and 21.4% compared to 12.8% overall were at-risk).

- With respect to transportation safety, AI/AN respondents reported always using a seatbelt at rates which were not statistically different from the rates for all students. Reports of never riding with a drunk or high driver, however, were significantly lower among AI/AN high school respondents compared to all respondents (57.3% and 69.5%, respectively).

- Reports of suicide attempts or depression among AI/AN respondents were also similar to overall rates. However, both middle and high school AI/AN respondents reported having "many problems" more frequently than all of the respondents combined (29.0% compared to 12.4% overall among 7th and 8th graders and 24.3%, compared to 15.4% overall among high school students) **(Figure 18)**. AI/AN high school students also reported "having many problems" and not being able to handle them more frequently that all respondents in general (10.4% and 4.4%, respectively). In addition, fewer AI/AN high school students felt their future would be good compared to students in general (57.4% and 70.5%).

Figure 18. Having "Many Problems" among Seattle Public School Middle (7th and 8th grade) and High School Students, 1999.



* Significantly different from total.
Source: 1999 Teen Health Survey. Seattle Public Schools, Health Education Office.

Risk Behaviors

Risk behaviors including violence and weapons, drug use, and sexual behaviors are reported in **Appendices 10 and 11**.

- There were few statistically significant differences between AI/AN 7th and 8th grade respondents compared to all 7th and 8th grade respondents. The pattern of responses among AI/AN 7th and 8th graders, however, is similar to AI/AN high school respondents, which may be cause for concern. Questions pertaining to sexual activity among middle school students were not asked.

- Among AI/AN high school respondents, many differences are evident when compared with all high school respondents combined. Carrying a gun in the past month and gang involvement were both reported more frequently among AI/AN high school respondents than among all respondents (14.8% compared to 5.6% overall carried guns in the past month, and 8.5% compared to 3.5% overall reported involvement in gangs).

- Lifetime use of any drug and use of any drug in the past month were also more frequently reported among the AI/AN high school respondents compared to all respondents (82.9% compared to 70.4% overall reported ever using any drug, and 60.7% compared to 48.1% overall reported using drugs or alcohol in the past month). Compared to all high school students, AI/AN students were more likely to report smoking, alcohol and other drug use in the past month **(Figure 19)**. Substance abuse among family members was also more likely to be reported by AI/AN students than all students.

- Reports of sexual activity and having six or more lifetime partners were reported at significantly higher rates among the AI/AN respondents than among all of the high school respondents combined. Over half (53.5%) of AI/AN high school respondents reported ever having sex compared to 39.5% overall. Nearly half (45.5%) of AI/AN respondents reported having sex in the past three months compared to 29.8% overall. Reports of having 6 or more lifetime partners were also reported more often among the AI/AN high school respondents compared to all respondents (21.6% and 7.9%, respectively).

- Reports of pregnancy (current or past) or causing a pregnancy were marginally higher among the AI/AN respondents than overall (11.6% and 7.9%, respectively).

VI. Communicable Disease

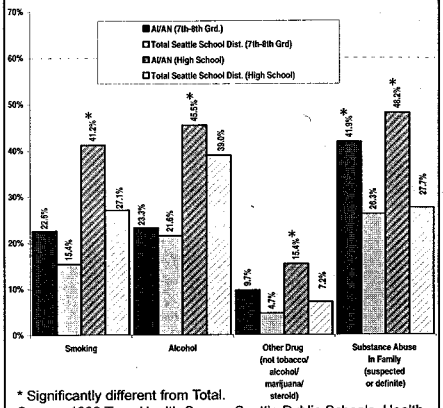
- The rates of sexually transmitted diseases, such as gonorrhea and chlamydia, among American Indians and Alaska Natives have decreased significantly over the 10 year period from 1989 to 1999 **(Figure 20 and Appendix 12).**

- Despite these improvements, however, the rate of chlamydia and gonorrhea for AI/AN remains significantly higher than countywide rates.

- Similarly, AIDS case reports are significantly higher among AI/AN than countywide.

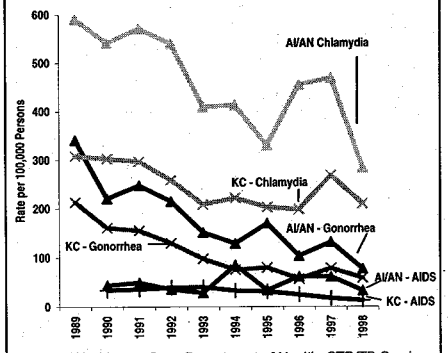
- Two other leading causes of reportable communicable disease are also higher among AI/AN than countywide **(Appendix 12)**. These include hepatitis A and pertussis (whooping cough). The rate of pertussis is more than double the countywide rate.

Figure 19. Substance Use in Past Month and Suspected or Definite Use by Family Members among Seattle Public School Middle (7th-8th Grade) and High School Students, 1999.



* Significantly different from Total.
Source: 1999 Teen Health Survey. Seattle Public Schools, Health Educ. Office.

Figure 20. STD and AIDS among American Indians living in King County and all King County residents, 1989-1998.



Source: Washington State Department of Health. STD/TB Services and Public Health – Seattle & King County. HIV/AIDS Epidemiology Unit.

VII. Other Factors Affecting Health Status

In addition to many of the factors and outcomes described in this report, there are many other factors which affect a person's health or access to health services. Some of these factors include:

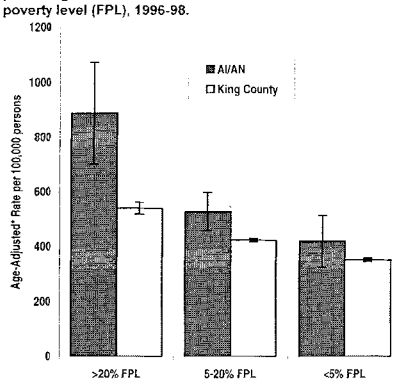
- *Economic opportunity and equity.* As previously mentioned, at least one quarter of American Indians/Alaska Natives in King County currently live in poverty. Poverty and economic inequity are major factors related to poor health. As an example, **Figure 21** shows that persons residing in neighborhoods with higher percentages of households living in poverty, experience higher rates of mortality than persons residing in neighborhoods with lower percentages of households living in poverty.

- *Stress due to social or environmental factors* such as being exposed to acts of racism or living in areas with high crime may impact a person's health directly or indirectly.

- *Mental health and social support* also play an important role in influencing health and well-being. Appropriate mental health services and a supportive environment of family, friends, and community are significant factors in maintaining good health.

- *Trust or confidence in the health care system.* Confidence in the health system may be eroded due to historical events. In particular, the indigenous peoples of this continent have been subjected to hundreds of years of severe mistreatment. These events may lead some to delay using existing health services or to distrust the providers of those services. In addition, the significant lack of American Indian/Alaska Native health care professionals and researchers may also reinforce feelings of distrust and lack of confidence in our current health system.

Figure 21. All-cause mortality among persons living in areas with high (>20%), medium (5-20%) and low (<5%) percentages of households with incomes below the Federal poverty level (FPL), 1996-98.



*Rates adjusted to the 1940 U.S. Population.
Source: Washington State Department of Health. Center for Health Statistics.

- *Language or other cultural factors* may also play an important part in a person's ability to navigate our complex medical system or to understand materials promoting better health. Among practitioners of Western medicine, traditional healing methods used among native peoples have often been discounted and not understood. In addition, few culturally appropriate social marketing methods are utilized to promote education for better personal health and understanding of the health care system.

All of these factors and many others influence an individual's health outlook and need to be considered when developing strategies to improve the health of American Indians and Alaska Natives.

VIII. Resources and Websites on Indian Health

- Seattle Indian Health Board (SIHB):
  Telephone: (206) 324-9360
  http://www.sihb.org/
  Urban Indian Health Institute (UIHI):
  http://www.uihi.org

- Affiliated Tribes of Northwest Indians:
  http://www.atni.org/
  Telephone: (503) 249-5770

- Fetal Alcohol Syndrome Education and Prevention
  Public Health – Seattle & King County:
  http://www.metrokc.gov/health/atodp/fas.htm

  Washington State Fetal Alcohol Diagnostic and Prevention Network:
  http://depts.washington.edu/fasdpn/
  Telephone: (206) 526-2522

- Muckleshoot Indian Tribe Health Clinic
  Telephone: (253) 931-6709/939-6648
  Tribal profile (NPAIHB):
  http://www.teleport.com/~npaihb/profiles/muckle.html

- Native American Diabetes Project:
  La Plaza Diabetes Wellness Connection
  Telephone: (505) 272-4462
  http://www.laplaza.org/health/dwc/

- Northwest Portland Area Indian Health Board (NPAIHB):
  Telephone: (503) 228-4185
  http://www.npaihb.org/index.html

- United Indians of All Tribes Foundation:
  Telephone: (206) 285-4425
  http://www.unitedindians.com/

- U.S. Department of the Interior. Bureau of Indian Affairs:
  Telephone: (202) 208-3711
  http://www.doi.gov/bureau-indian-affairs.html

- U.S. Indian Health Service (Portland Area):
  Telephone: (503) 326-4123
  http://www.ihs.gov/

IX. Sources and Limitations of Data

Data used in this report are derived from several sources. These include vital records (birth and death certificates, 1980 to 1998), U.S. Census data (1990 and 2000), communicable disease reports, and two telephone interview surveys and one survey of Seattle Public Schools high school and middle school students. All of these sources may produce figures and rates which may be below true rates largely due to under-reporting of American Indian/Alaska Native race. The results of the two telephone interview surveys are derived from the Behavioral Risk Factor Surveillance System surveys conducted in Washington State and King County from 1993 to 1998 and the 1998 State Population Survey. Both of these surveys may not be representative of the entire AI/AN population, since telephone surveys are likely to over-sample persons of higher socioeconomic status. Persons who are of lower socioeconomic status may not be contacted in these surveys due to not having a working telephone. Persons who are homeless will be excluded from these surveys. Census data from 1990, in particular, indicate that 8% of AI/AN living in King County did not have working telephones in their home or apartment, compared to 2% for all King County residents **(see Appendix 1).**

Appendix 1. Demographic information for American Indians and Alaska Natives (AI/ AN) living in King County compared to all King County residents, 1990-1998.

		King County								AI/AN in US	
		American Indian/Alaska Native			King County Total			Relative Difference		(BRFSS - 1997)	
	Source (Time Period)	n	Rate	95% Confidence Interval	n	Rate	95% Confidence Interval	(AI/AN compared to KC Total)		Median Result	Range across States
No telephone in house or apartment	PUMS (1990)	465	8. 4%	(5. 3- 11. 4)	46, 181	1.5%	(1. 3- 1. 7)	▲	+456%	-	
Household Income											
Below poverty (< 100% of poverty)											
Children (< 18 years old)	Census (1989)	4,788	35. 2%	(30.4- 40.1)	333,421	9. 8%	(9. 4- 10. 1)	▲	+260%	-	
	PUMS (1989)	197	25. 7%	(16.0- 35.5)	13, 518	9.6%	(8. 7- 10.4)	▲	+168%	-	
Age 18 and older	Census (1989)	12,492	25. 7%	(19. 4- 24.6)	1,143,641	7.4%	(7. 3- 7. 6)	▲	+247%	-	
	PUMS (1989)	479	23. 4%	(18.7- 28.2)	46, 365	7.4%	(7. 1- 7. 8)	▲	+215%	-	
	SPS (1998)	77	5.5%	(0. 0- 12.2)	2,552	4. 7%	(3. 2- 6. 2)		-	-	
Below 200% of poverty											
Children (< 18 years old)	PUMS (1989)	197	45. 8%	(35.0- 56.6)	13, 518	23. 9%	(22. 7- 25.1)	▲	+91%	-	
Age 18 and older	PUMS (1989)	479	38. 6%	(33.1- 44.1)	46, 365	19. 1%	(18. 6- 19.6)	▲	+102%	-	
	BRFSS (1993- 98)	98	41. 2%	(29. 8- 52.6)	8,706	19. 8%	(18.7- 20.9)	▲	+108%	-	
	SPS (1998)	77	37. 8%	(17. 6- 58.0)	2,552	14. 6%	(11.9- 17.2)	▲	+160%	-	
Food Security											
Skipped meal in last month due to lack of food/money	BRFSS (1993- 98)	42	12. 4%	(0. 7- 24. 2)	3, 043	3.6%	(2. 9- 4. 3)		-	-	
Did not eat for whole day due to lack of food/money	BRFSS (1993- 98)	42	2. 6%	(0. 0- 6. 2)	3. 043	0. 7%	(0. 4- 1. 0)		-	-	
Education											
Has high school diploma/GED (age 25+)	Census (1990)	10, 546	76. 1%	(73. 7- 78.4)	1,017,973	88. 2%	(88. 0- 88.4)	▼	-14%	-	
	BRFSS (1993- 98)	86	80. 9%	(71. 2- 90.6)	8,008	95. 2%	(94.6- 95.8)	▼	-15%	83. 0%	(68.0- 96.6)
	SPS (1998)	57	86. 2%	(73. 7- 98.8)	2,088	96. 3%	(95.3- 97.3)		-	-	
Has 4 year college degree (age 25+)	Census (1990)	10, 546	12. 4%	(10. 6- 14.2)	1,017,973	32. 8%	(32. 5- 33.1)	▼	-62%	-	
	BRFSS (1993- 98)	86	17. 3%	(8. 6- 25.9)	8, 008	44. 9%	(43. 5- 46.2)	▼	-62%	-	
	SPS (1998)	57	24. 5%	(4. 7- 44. 2)	2, 088	45. 4%	(42. 2- 48.7)	▽	-46%	-	
Marital Status (married)	PUMS (1990)	482	39. 8%	(34.9- 44.7)	47, 382	54. 2%	(53. 6- 54.8)	▼	-27%	-	
	BRFSS (1993- 98)	98	46. 8%	(35. 3- 58.3)	8,668	56. 3%	(55.0- 57.6)		-	-	
	SPS (1998)	75	33. 3%	(14. 6- 52.0)	2,509	55. 6%	(52.5- 58.8)	▼	-40%	-	
Employment Status (unemployed)	Census (1990)	8, 712	8.4%	(6. 8- 9. 9)	853, 717	4.2%	(4.0- 4.3)	▲	+102%	-	
	BRFSS (1993- 98)	86	4. 3%	(0. 0- 9. 1)	7, 768	4. 6%	(4.0- 5.2)		-	-	
	SPS (1998)	51	4.6%	(0. 0- 11.6)	1,747	4. 8%	(3.5- 6.1)		-	-	
Single Head of Household	Census (1990)	2,142	48. 5%	(42.8- 54.2)	178,990	22.3%	(21.8- 22.8)	▲	+118%	-	

Sources of data:

Census - U. S. Census conducted in 1990. Household income data were based on preceding year's income (i. e., 1989).

PUMS - Public Use Microdata Sample derived from a 5% sample of the 1990 Census.

BRFSS - Behavioral Risk Factor Surveillance System. King County: Washington State DOH. Ctr for Health Statistics. U. S: MMWR 2000; 49(No. SS- 3).

SPS - State Population Survey conduced in 1998 by Washington State Office of Financial Management.

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/ lower rate than rate for AI/ AN living in King County; ▽ / △ marginally (with 90% confidence) higher/ lower rate than rate.

Appendix 2. General health, disability status, and health service access among American Indians and Alaska Natives (AI/AN) living in King County, compared to all King County residents, 1990-1998.

		King County							AI/AN in US (BRFSS - 1997)	
		American Indian/Alaska Native			King County Total			Relative Difference (AI/AN compared to KC Total)		
	Source (Time Period)	n	Rate	95% Confidence Interval	n	Rate	95% Confidence Interval		Median Result	Range across States
General Health and Disability Status										
Good to excellent health	BRFSS (1993- 98)	98	86.8%	(79.6- 93. 9)	8, 687	91.6%	(90.9- 92. 3)	-	82.5% (64.6- 89. 9)	
	SPS (1998)	77	90.1%	(82.5- 97. 7)	2, 552	90.6%	(89.0- 92. 2)	-	-	
Days activity limited due to poor health	BRFSS (1993- 98)	96	3.1	(1.4- 4.8)	8,636	1.8	(1.7- 2.0)	-	-	
Poor mental health days	BRFSS (1993- 98)	97	4.0	(2.3- 5.7)	8,553	3.1	(2.9- 3.3)	-	-	
Poor physical health days	BRFSS (1993- 98)	95	4.9	(2.9- 6.9)	8,542	2.9	(2.7- 3.0)	△ +71%	-	
Disability or Health Condition Lasting > 6 Months										
Has health condition lasting more than 6 months	SPS (1998)	69	25.8%	(5.3- 46.2)	2,426	13.3%	(11.3- 15.3)	-	-	
Has health condition which limits work	SPS (1998)	69	21.3%	(1.1- 41.4)	2,426	10.0%	(8.2-11.8)	-	-	
Has health condition which prevents working	SPS (1998)	69	8.9%	(0.4- 17.4)	2,419	6.4%	(4.9- 7.9)	-	-	
Has permanent disability	SPS (1998)	62	21.7%	(4.2- 39.3)	2,322	14.8%	(12.0- 17.7)	-	-	
Disability limits work ability	PUMS (1990)	482	20.1%	(16.0-24.1)	47,382	11.3%	(11.0-11.6)	▲ +78%	-	
Disability prevents from working	PUMS (1990)	482	11.8%	(8.7- 15.0)	47,382	6.5%	(6.3- 6.8)	▲ +82%	-	
Disability limits personal care	PUMS (1990)	482	4.1%	(1.0- 7.1)	47,382	3.7%	(3.5- 3.9)	-	-	
Access to Health Services										
No health insurance	BRFSS (1993- 98)	88	17.7%	(8.5- 26.9)	7,062	11.8%	(10.9- 12.8)	-	24.5% (12.5- 50.5)	
	SPS (1998)	72	23.2%	(10.3- 36.2)	2, 196	11.6%	(9.5- 13.7)	-	-	
Has primary source of care	BRFSS (1993- 98)	98	81.6%	(72.0- 91.2)	8, 632	82.9%	(81.9- 83.9)	-	-	
Needed medical care in past year but didn't go to see doctor due to cost	BRFSS (1993- 98)	98	12.3%	(5. 1- 19. 5)	8,679	10.0%	(9. 1- 10. 8)	-	12.6% (9.2- 26.7)	

Sources of data:
Census - U. S. Census conducted in 1990. Household income data were based on preceding year's income (i. e., 1989).
PUMS - Public Use Microdata Sample derived from a 5% sample of the 1990 Census.
BRFSS - Behavioral Risk Factor Surveillance System. King County: Washington State DOH. Ctr for Health Statistics. U. S: MMWR 2000; 49(No. SS- 3).
SPS - State Population Survey conduced in 1998 by Washington State Office of Financial Management.
Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/ lower rate than rate for AI/ AN living in King County; ▽ / △ marginally (with 90% confidence) higher/ lower rate than rate.

Appendix 3. Risk for chronic disease and personal injury, diagnosis of chronic disease and utilization of screening measures among American Indians and Alaska Natives (AI/AN) living in King County, compared to all King County residents, 1993-1998.

	Source (Time Period)	King County						Relative Difference (AI/AN compared to KC Total)		AI/AN in US (BRFSS - 1997)	
		American Indian/Alaska Native			King County Total						
		n	Rate	95% Confidence Interval	n	Rate	95% Confidence Interval			Median Result	Range across States
Risk for Chronic Disease											
Overweight	BRFSS (1993-98)	93	59.7%	(48.2-71.1)	8,402	45.7%	(44.3-47.0)	▲	+31%	-	
Obese		93	17.6%	(9.3-25.9)	8,402	12.7%	(11.8-13.6)		-	30.1%	(8.1-34.7)
Sedentary lifestyle		58	25.1%	(10.7-39.4)	5,856	21.8%	(20.3-23.2)		-	-	
Eats 5 fruits/vegetables daily		58	33.4%	(18.4-48.4)	5,789	23.4%	(22.0-24.9)		-	-	
Current Smoker		97	36.9%	(25.6-48.3)	8,676	18.9%	(17.9-19.9)	▲	+96%	41.3%	(3.1-48.8)
Mean number of cigarettes smoked		23	24.2	(14.6-33.9)	1,292	17.8	(16.9-18.6)		-	-	
Current smoker (M)		46	44.2%	(27.6-60.8)	3,971	20.5%	(19.0-22.1)	▲	+115%	-	
Current smoker (F)		51	29.4%	(14.2-44.5)	4,705	17.3%	(15.9-18.6)		-	-	
Binge drinking		40	24.6%	(10.9-38.2)	2,822	13.5%	(12.1-14.9)		-	18.9%	(11.4-30.2)
Drove when had 'too much to drink'		40	0.0%	(0.0-8.8)	2,839	2.0%	(1.5-2.6)	▽	-100%	-	
Chronic drinking		38	4.4%	(0.0-10.8)	2,789	2.0%	(1.4-2.6)		-	-	
Risk for Personal Injury											
Always uses seatbelt		39	87.5%	(76.9-98.2)	2,833	80.1%	(78.4-81.7)		-	59.1%	(24.9-79.4)
Has unlocked loaded gun at home		33	1.4%	(0.0-4.0)	3,342	3.6%	(2.8-4.4)		-	-	
Chronic Disease Diagnosis and Use of Physical Exams and Regular Check Ups											
Told has high blood pressure	BRFSS (1993-98)	40	21.9%	(8.7-35.0)	2,832	20.8%	(19.1-22.4)		-	20.7%	(16.6-30.7)
BP check within past 2 years		38	88.5%	(78.3-98.6)	2,828	83.6%	(82.1-85.1)		-	-	
Told has high blood cholesterol		24	36.8%	(16.0-57.6)	2,126	26.9%	(24.8-29.0)		-	-	
Cholesterol check within past 2 years		36	59.6%	(42.5-76.8)	2,737	62.0%	(60.0-64.0)		-	54.7%	(49.9-75.4)
Told has diabetes		97	9.6%	(3.3-15.9)	8,698	3.2%	(2.8-3.6)	△	+201%	7.6%	(3.3-14.0)
Had Pap test in past 3 years (women, age 18+)		37	95.1%	(88.3-100.0)	3,680	87.8%	(86.6-89.1)	△	+8%	-	
Had mammogram in past 2 yrs (women, age 40+)		35	71.8%	(54.8-88.8)	2,881	73.4%	(71.4-75.4)		-	-	
CBE within last 2 years (women, age 40+)		35	80.2%	(65.5-94.9)	2,853	81.5%	(79.8-83.3)		-	-	
Medical check up in past year		96	58.9%	(47.4-70.4)	8,616	64.5%	(63.2-65.8)		-	-	
Medical check up in past 2 years		96	78.6%	(69.0-88.2)	8,616	80.8%	(79.8-81.9)		-	85.5	(70.0-91.2)

Source: BRFSS: Behavioral Risk Factor Surveillance System. King County: Washington State DOH Center for Health Statistics. U.S.: MMWR 2000; 49(No. SS-3)
Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 4a. Life expectancy for American Indians and Alaska Natives (AI/AN) living in King County compared with all King County residents, three-year averages, 1996-1998.

	AI/AN		Total King County		Relative Difference (AI/AN compared to KC Total)
	Years	95% Confidence Interval	Years	95% Confidence Interval	
Life Expectancy at Birth	74.0	(72.4-75.6)	78.5	(78.4-78.7)	▼ -6%

Source: Washington State Department of Health. Center for Health Statistics.

Appendix 4b. Mortality rates for American Indians and Alaska Natives (AI/AN) living in King County compared with all King County residents by age group and cause of death, three-year averages, 1996-1998.

	AI/AN					Total King County			Relative Difference (AI/AN compared to KC Total)		Trend for AI/AN in King County	
	Rank	Total Count Over 3 Years	Annual Count	Rate* per 100,000 persons	95% Confidence Interval	Annual Count	Rate* per 100,000 persons	95% Confidence Interval			80-98	94-98
<1 year		12	4	1,272.5	(658.6-2,215.2)	114	547.9	(491.5-609.2)	▲	+132%		
1-14 years		8	3	54.8	(23.7-107.2)	54	16.8	(14.3-19.6)	▲	+226%		▲
15-24 years		9	3	90.9	(41.6-171.5)	131	68.5	(61.9-75.6)		-	▼	
25-44 years		74	25	337.1	(264.8-423.0)	767	132.8	(127.4-138.3)	▲	+154%	▽	△
Unintentional injury	1	20	7	91.1	(55.7-140.6)	177	30.6	(28.1-33.4)	▲	+198%	▼	△
45-64 years		70	23	622.0	(485.2-785.5)	1759	489.7	(476.6-503.1)	△	+27%	▼	
Cancer	1	13	4	115.5	(61.6-197.0)	665	185.1	(177.0-193.4)		-		
65-84 years		107	36	3,847.5	(3,154.5-4,648.5)	5470	3,495.6	(3,442.3-3,549.5)		-	▲	
Heart Disease	1	27	9	970.9	(640.6-1,412.6)	1514	967.6	(939.7-996.1)		-		
Cancer	1	27	9	970.9	(640.6-1,412.6)	1602	1,023.8	(995.1-1,053.2)		-	▲	
..Respiratory cancer		11	4	395.5	(197.7-704.8)	488	312.1	(296.3-328.5)		-	▲	
85 and older		17	6	10,493.8	(6,122.7-16,778.6)	3217	14,785.7	(14,492.2-15,083.7)		-		
Heart Disease	1	9	3	5,555.6	(2,543.2-10,481.5)	1070	4,919.9	(4,751.2-5,093.1)		-		
All Causes		**297**	**99**	**572.9**	**(517.3-628.4)**	**11,511**	**407.2**	**(402.7-411.7)**	▲	**+41%**	▼	▲

Source: Washington State Department of Health. Center for Health Statistics.

*All rates are age-specific, except the rate for All Causes of death which is age-adjusted to the 1940 U.S. population.

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 5. Mortality rates for American Indians and Alaska Natives (AI/AN) living in King County compared with all King County residents by age group and cause of death, three-year averages, 1996-1998.

	King County												AI/AN in US (1998) Rate* per 100,000 persons
	AI/AN					Total King County			Relative Difference (AI/AN compared to KC Total)		Trend for AI/AN in King County		
	Rank	Total Count Over 3 Years	Annual Count	Rate* per 100,000 persons	95% Confidence Interval	Annual Count	Rate* per 100,000 persons	95% Confidence Interval			80-98	94-98	
All Causes		**297**	**99**	**572.9**	**(517.3-628.4)**	**11511**	**407.2**	**(402.7-411.7)**	▲	**+41%**	▼	▲	**458.1**
Heart disease	1	53	18	119.9	(84.5-139.2)	3029	93.9	(91.8-96.0)		-	▼		97.1
All cancer	2	51	17	105.7	(77.5-133.9)	2797	114.4	(111.9-117.0)		-			83.4
Respiratory cancer		18	6	38.2	(20.8-55.5)	754	32.4	(31.0-33.9)		-	▲		25.1
Colorectal cancer		6	2	11.5	(2.7-20.3)	280	10.7	(9.9-11.5)		-			8.2
Unintentional injury	3	35	12	54.3	(36.2-72.3)	486	24.5	(23.2-25.9)	▲	+122%	▼	▲	55.6
Cerebrovascular disease	4	16	5	35.3	(18.8-51.9)	934	25.0	(24.0-26.1)		-			19.6
Pneumonia and influenza	4	16	5	30.8	(15.4-46.1)	497	12.4	(11.7-13.1)	▲	+148%			14.1
Chronic liver disease and cirrhosis	6	14	5	23.6	(10.8-36.4)	130	6.4	(5.8-7.1)	▲	+269%	▼		22.0
Diabetes	7	13	4	29.7	(13.7-45.8)	311	12.3	(11.4-13.1)	▲	+141%		△	29.6
HIV infection	8	9	3	13.1	(4.5-21.6)	131	6.7	(6.0-7.4)		-			2.2
Suicide	8	9	3	15.0	(5.1-25.0)	191	10.5	(9.6-11.4)		-			13.4
COPD (Chronic Obstructive Pulmonary Disease)	10	8	3	17.6	(5.8-29.3)	527	17.9	(16.9-18.8)		-			15.7
Homicide	11	7	2	10.4	(2.6-18.3)	74	5.0	(4.3-5.7)		-	▼		9.9
Other Combined Causes of Death:													
Diabetes-related		26	9	59.7	(37.5-81.8)	848	31.1	(29.8-32.4)	▲	+92%		▲	-
Drug-related deaths		20	7	28.1	(15.6-40.5)	192	10.0	(9.2-10.9)	▲	+181%	▲	△	-
Alcohol-related deaths		19	6	29.3	(15.8-42.8)	137	7.1	(6.4-7.8)	▲	+313%	▼		-
Firearm deaths		6	2	10.1	(2.0-18.2)	137	8.3	7.5-9.2		-			
All Mortality by Poverty Areas													
> 20% FPL		67	22	888.6	(703.5-1073.7)	864	540.6	(518.8-562.4)	▲	+64%	▼	▼	-
5 - 20% FPL		160	53	528.6	(459.6-597.7)	6,601	424.9	(418.4-431.3)	▲	+24%	▼		-
< 5% FPL		53	18	421.6	(326.8-516.3)	3,856	754.5	(348.4-361.0)		-	▼		-

*All rates are age-adjusted to the 1940 U.S. population.

Sources of data: Washington State Department of Health, Center for Health statistics, U.S. Centers for Disease Control and Prevention. CDC Wonder (http://wonder.cdc.gov/) and National Center for Health statistics, *Health, United states, 2000 With Adolescent Health Chartbook.* Hyattsville, MD: 2000.

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 6a. Infant mortality rates for American Indians and Alaska Natives (AI/AN) living in King County compared with all King County residents, three-year averages, 1996-1998.

	King County										US (1997)
	AI/AN				Total King County			Relative Difference (AI/AN compared to KC Total)	Trend for AI/AN in King County		
	Total Count Over 3 Years	Annual Count	Rate* per 1,000 births	95% Confidence Interval	Annual Count	Rate* per 1,000 births	95% Confidence Interval		80-98	94-98	Rate per 1,000 births
Total infant mortality	11	4	12.5	(6.3-22.3)	114	5.2	(4.7-5.8)	▲ +140%	-	-	8.7
Primary cause of infant death: SIDS	7	2	8.0	(3.2-16.2)	18	0.8	(0.6-1.1)	▲ +900%	-	-	1.6

Sources of data: Washington State Department of Health, Center for Health statistics, U.S. Centers for Disease Control and Prevention. CDC Wonder (http://wonder.cdc.gov/) and National Center for Health statistics, *Health, United states, 2000 With Adolescent Health Chartbook*. Hyattsville, MD: 2000.

Symbols: ▲ / ▼ Significant y (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 6b. Factors associated with poor birth outcomes among American Indians and Alaska Natives (AI/AN) compared with all King County residents, three-year averages, 1996-1998.

	King County							Relative Difference (AI/AN compared to KC Total)	Trend for AI/AN in King County		AI/AN in U.S. (1997)
	AI/AN				Total						
	Total Over 3 years† or Surveyed*	Annual Count	Percent of births	95% Confidence Interval	Annual Count	Percent of births	95% Confidence Interval		80-98	94-98	Percent of Births
Infant-Related Factors at Birth†											
Low birth weight (< 2500 g)	68	23	7.8	(6.0-9.8)	1,280	5.9	(5.7-6.1)	△ +32%			6.8
Very low birth weight (<1500 g)	10	3	1.1	(0.6-2.1)	224	1.0	(1.0-1.1)	ns			1.2
Born premature	77	26	12.2	(9.6-15.2)	1,574	9.5	(9.2-9.8)	△ +28%		▼	7.8
Maternal Circumstances†											
Teenage mother (age < 18)	83	28	9.4	(7.5-11.7)	515	2.4	(2.3-2.5)	▲ +292%			8.6
Unmarried	525	175	60.0	(55.0-65.4)	4,961	22.8	(22.5-23.2)	▲ +163%		△	58.7
Smoked during pregnancy	191	64	22.4	(19.4-25.9)	2,111	10.2	(10.0-10.5)	▲ +120%	na	▼	20.8
Consumed alcohol during pregnancy	29	10	4.4	(2.9-6.3)	290	1.8	(1.6-1.9)	▲ +144%	na	▽	-
Prenatal Care†											
Late (3rd trimester) or none	65	22	8.9	(6.9-11.3)	549	3.0	(2.9-3.2)	▲ +197%		▼	8.6
Pregnancy Intention (1993-97)*^											
Intended	141		46.8	(40.6-52.9)	1,814	65.8	(62.8-68.9)	▼ -29%	na	na	-
Unintended	152		53.2	(47.1-59.4)	1,285	34.2	(31.1-37.2)	▲ +56%	na	na	-
Unwanted	28		10.6	(6.3-14.8)	323	7.8	(6.2-9.5)	ns	na	na	-
Mistimed	124		42.7	(36.6-48.8)	962	26.3	(23.5-29.1)	▲ +62%	na	na	-

Sources of data: Washington State Department of Health, Center for Health statistics, U.S. Centers for Disease Control and Prevention. CDC Wonder (http://wonder.cdc.gov/) and National Center for Health statistics *Health, United states, 2000 With Adolescent Health Chartbook*. Hyattsville, MD: 2000.

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 7. Stressful Life Events For Mothers During Year Before Delivery, King County, 1996-1998.

	Native American/ Alaska Native		King County Total		Relative Difference (AI/AN compared to KC Total)	
	Percent	95% Confidence Interval	Percent	95% Confidence Interval		
Stress Events						
Changed residence	**47.1%**	(39.9-54.3)	**40.0%**	(36.3-43.7)		
Argued with husband/partner more than usual	**43.3%**	(36.1-50.5)	**24.2%**	(21.0-27.4)	▲	+79.2%
Had bills and couldn't pay	**40.6%**	(33.4-47.7)	**22.8%**	(19.6-25.9)	▲	+78.2%
Someone close had drinking/drug problem	**38.9%**	(31.9-46.0)	**11.5%**	(9.1-14.0)	▲	+237.4%
Close family member hospitalized	**26.9%**	(20.7-33.2)	**20.0%**	(16.9-23.0)		
Someone close died	**26.4%**	(20.0-32.9)	**15.2%**	(12.5-17.9)	▲	+74.0%
Separated or divorced from husband/partner	**17.1%**	(11.5-22.6)	**6.7%**	(5.1-8.4)	▲	+153.0%
Mom or husband/partner went to jail	**17.0%**	(11.5-22.5)	**3.6%**	(2.3-4.9)	▲	+369.4%
Husband/partner lost job	**16.9%**	(11.4-22.3)	**9.3%**	(7.1-11.4)	▲	+82.4%
Involved in a physical fight	**12.8%**	(7.9-17.6)	**3.3%**	(2.1-4.5)	▲	+286.0%
Mom lost job	**12.7%**	(8.0-17.4)	**7.3%**	(5.5-9.2)		
Husband/partner didn't want pregnancy	**9.2%**	(5.0-13.4)	**8.9%**	(6.9-11.0)		
Homeless	**8.4%**	(4.4-12.5)	**4.6%**	(3.0-6.1)		
Reported 5 or more of the listed stress events	**25.2%**	(18.9-31.5)	**8.0%**	(6.1-10.0)	▲	+213.1%

Source: Washington State Department of Health, Center for Health statistics. Pregnancy Risk Assessment Monitoring System (PRAMS)
Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 8. Family Environment and Protective Factors among American Indians and Alaska Natives (AI/AN) attending Seattle Public Schools compared to all Seattle Public Schools attendees, 1999.

	Middle School (7th-8th Grade)					High School				
	AI/AN		Total		Relative Difference (AI/AN compared to Total)	AI/AN		Total		Relative Difference (AI/AN compared to Total)
	Pct	(N)	Pct	(N)		Pct	(N)	Pct	(N)	
A. Protective Factors (above average or high)	33.3%	(30)	53.2%	(1777)	▼ -37.3%	43.8%	(89)	52.8%	(6679)	▽ -17%
a. Family rules (always enforced)	44.4%	(27)	54.4%	(1756)	-	52.3%	(88)	53.6%	(6600)	-
b. Parents encourage student to do best (always/most of time)	90.0%	(30)	85.3%	(1765)	-	85.2%	(88)	90.3%	(6633)	-
c. Teachers encourage student to do best (3 or more)	43.3%	(30)	46.7%	(1753)	-	42.0%	(88)	43.0%	(6616)	-
d. Knows one/more adult at school to talk to about problems	48.4%	(31)	59.3%	(1793)	-	51.3%	(115)	60.1%	(8421)	▽ -14.6%
e. Knows an adult at school if they see something illegal or harmful	51.6%	(31)	73.5%	(1815)	▼ -29.8%	63.8%	(116)	67.2%	(8561)	-
f. Does not go along with friends if they ask him/her to do something harmful	26.7%	(30)	20.2%	(1771)	-	19.3%	(114)	17.8%	(8419)	-
g. Gets as much help as needed with homework	58.6%	(29)	59.4%	(1737)	-	55.0%	(109)	50.9%	(8104)	-
h. Participates in organized after school activities (2 or more days/week)	39.3%	(28)	52.9%	(1760)	-	37.1%	(89)	49.6%	(6621)	▼ -25.2%
i. Volunteer work (1-4 hours or more per month)	42.9%	(28)	54.6%	(1750)	-	36.4%	(88)	46.3%	(6620)	▽ -21.4%
j. Physical exercise (3 or more days/week)	80.0%	(30)	74.6%	(1796)	-	76.4%	(110)	64.4%	(8216)	▲ +18.5%
k. Perception that future will be good	74.2%	(31)	70.2%	(1810)	-	57.4%	(94)	70.5%	(6977)	▼ -18.6%
B. Family Environment										
a. Family rules (always enforced)	44.4%	(27)	54.4%	(1756)	-	52.3%	(88)	53.6%	(6600)	-
b. Parental encouragement most or all of the time	90.0%	(30)	85.3%	(1765)	-	85.2%	(88)	90.3%	(6633)	-
c. Substance abuse in the family (definite or suspected)	41.9%	(31)	26.3%	(1805)	▲ +59.7%	48.2%	(114)	27.7%	(8400)	▲ +74%

Source: 1999 Teen Health Survey, Seattle Public Schools, Health Education Office.

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 9. General Physical and Mental Health among American Indians and Alaska Natives (AI/AN) attending Seattle Public Schools compared to all Seattle Public Schools attendees, 1999.

	Middle School (7th-8th Grade)						High School					
	AI/AN		Total		Relative Difference (AI/AN compared to Total)		AI/AN		Total		Relative Difference (AI/AN compared to Total)	
	Pct	(N)	Pct	(N)			Pct	(N)	Pct	(N)		
I. General Physical and Mental Health												
A. Physical health and lifestyle												
1. Access to health care												
a. General medical care (physical exam in past year)	80.6%	(31)	64.1%	(1807)	△	+25.8%	66.7%	(90)	66.2%	(6729)		-
b. Dental exam in past year	70.0%	(30)	75.1%	(1799)		-	67.9%	(112)	70.2%	(8285)		
2. Weight Status (based on body mass index)												
a. At-risk							21.4%	(84)	12.8%	(6970)	▲	+66.9%
b. Overweight							14.3%	(84)	7.4%	(6970)	▲	+93.7%
3. Asthma (past year)	11.1%	(27)	10.6%	(1737)		-	14.7%	(109)	12.0%	(8007)		-
4. Transportation safety												
a. Seat belt use (always)	48.4%	(31)	44.5%	(1823)		-	38.8%	(116)	43.8%	(8647)		-
b. Riding with drunk or high driver (never)	80.6%	(31)	81.7%	(1816)		-	57.3%	(117)	69.5%	(8640)	▼	-17.6%
B. Mental health												
1. Life satisfaction and handling problems												
a. Personal Problems												
1. Having "many problems"												
2. Having "many problems" and can't handle them	29.0%	(31)	12.4%	(1821)	▲	+133.9%	24.3%	(115)	15.4%	(8535)	▲	+57.9%
							10.4%	(115)	4.4%	(8535)	▲	+136.9%
3. Doesn't know what to do about problems												
4. No adult at school to help with problems	12.9%	(31)	8.2%	(1819)		-						
b. Outlook for future (feel it will be good)	51.6%	(31)	40.7%	(1793)		-	33.0%	(115)	39.9%	(8421)		-
2. Depression and suicide	74.2%	(31)	70.2%	(1810)		-	57.4%	(94)	70.5%	(6977)	▼	-18.6%
a. Depression (2 weeks or more/past year)							33.6%	(116)	28.9%	(8543)		-
b. Seriously considered suicide in past year	19.4%	(31)	23.0%	(1803)		-	24.3%	(115)	19.7%	(8538)		-

Source: 1999 Teen Health Survey, Seattle Public Schools, Health Education Office.

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 10. Risk Behaviors among American Indians and Alaska Natives (AI/AN) attending Seattle Public Schools compared to all Seattle Public Schools attendees, 1999.

	Middle School (7th-8th Grade)					High School				
	AI/AN		Total		Relative Difference (AI/AN compared to Total)	AI/AN		Total		Relative Difference (AI/AN compared to Total)
	Pct	(N)	Pct	(N)		Pct	(N)	Pct	(N)	
II. Risk Behaviors										
A. Violence and weapons										
1. Violence in the community										
a. Guns and weapons										
1. Carried a gun past month, anywhere	9.7%	(31)	6.6%	(1804)	-	14.8%	(115)	5.6%	(8579)	▲ +164.8%
2. Self, friends, or family shot at by a gun	35.5%	(31)	28.0%	(1815)	-	46.2%	(117)	30.4%	(8627)	▲ +51.7%
b. Gang involvement (currently in gang)	6.5%	(31)	4.1%	(1811)	-	8.5%	(117)	3.5%	(8606)	▲ +147.7%
c. Dating violence (boy/girlfriend hurt you/past year)	9.7%	(31)	7.5%	(1805)	-	12.8%	(117)	8.8%	(8617)	-
d. Forced intercourse						7.3%	(109)	8.0%	(8241)	-
2. Violence and safety at school										
a. Weapons at school										
1. Carried a weapon (past month)	12.9%	(31)	8.8%	(1821)	-	19.7%	(117)	9.4%	(8621)	▲ +108.7%
2. Carried a gun (past month)	6.5%	(31)	2.4%	(1798)	-	4.5%	(112)	2.2%	(8520)	-
b. Fights and injuries at School										
1. Target of weapon (past year)	9.7%	(31)	11.0%	(1824)	-	15.4%	(117)	9.8%	(8634)	▲ +57.4%
2. In fight at school (past year)	35.5%	(31)	27.0%	(1917)	-	25.0%	(116)	16.9%	(8605)	▲ +48.2%
c. Property damage/theft at school (past year)	32.3%	(31)	42.9%	(1816)	-	40.2%	(117)	32.0%	(8621)	△ +25.7%
d. Harassment at school										
1. Racial harrassment at/to/from school	38.7%	(31)	41.0%	(1809)	-	27.4%	(117)	32.2%	(8593)	-
2. Sexual harrassment at/to/from school	38.7%	(31)	29.8%	(1810)	-	40.5%	(116)	34.4%	(8598)	-
e. Perceived safety at school (most/all of the time)	12.9%	(31)	6.4%	(1809)	-	3.4%	(117)	5.3%	(8639)	-

Source: 1999 Teen Health Survey, Seattle Public Schools, Health Education Office
Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 11. Risk Behaviors among American Indians and Alaska Natives (AI/AN) attending Seattle Public Schools compared to all Seattle Public Schools attendees, 1999.

	Middle School (7th-8th Grade)						High School					
	AI/AN		Total		Relative Difference (AI/AN compared to Total)		AI/AN		Total		Relative Difference (AI/AN compared to Total)	
	Pct	(N)	Pct	(N)			Pct	(N)	Pct	(N)		
II. Risk Behaviors (continued)												
B. Drug use												
1. Lifetime drug use												
a. Ever tried any drug	58.1%	(31)	51.0%	(1827)		-	82.9%	(117)	70.4%	(8665)	▲	+17.7%
b. Ever tried drug other than tobacco/ alcohol/marijuana/steroids	22.6%	(31)	17.0%	(1827)		-	37.6%	(117)	24.5%	(8665)	▲	+53.8%
2. Past month drug use												
a. Used drugs/alcohol	29.0%	(31)	27.3%	(1827)		-	60.7%	(117)	48.1%	(8665)	▲	+26.1%
b. Drug other than tob/alc/marijuana/steroids	9.7%	(31)	4.7%	(1827)		-	15.4%	(117)	7.2%	(8665)	▲	+113%
3. Summary of use by substance												
a. Cigarettes												
1. Smoked in past month	22.6%	(31)	15.4%	(1791)		-	41.2%	(114)	27.1%	(8520)	▲	+52.1%
2. Smoking by other household members	54.8%	(31)	41.4%	(1784)		-						
b. Alcohol												
1. Used in past month	23.3%	(30)	21.6%	(1777)		-	45.5%	(110)	39.0%	(8330)		-
2. Binge drinking in past month	16.7%	(30)	9.5%	(1764)		-	27.3%	(110)	22.5%	(8322)		-
c. Marijuana (used in past month)	25.8%	(31)	14.8%	(1803)	△	+74.9%	46.5%	(114)	28.4%	(8416)	▲	+64.0%
C. Sexual behavior												
1. Sexual activity												
b. Sexual intercourse, ever and current												
1. ever							53.5%	(114)	39.5%	(8464)	▲	+35.5%
2. Past three months							45.5%	(101)	29.8%	(7787)	▲	+53.0%
c. Age of first intercourse (14 or younger)							38.1%	(113)	21.3%	(8409)	▲	+78.5%
d. Number of partners (6 or more life-time partners)							21.6%	(111)	7.9%	(8376)	▲	172.7%
2. Contraception												
a. No method of pregnancy prevention (last time had sex)							13.8%	(58)	12.9%	(3169)		-
b. Condom used (last time had sex)							63.0%	(54)	58.8%	(3140)		-
3. Pregnancy (pregnant or has caused pregnancy)							11.6%	(112)	6.9%	(8308)	△	+68%
4. History of sexually transmitted disease							6.1%	(115)	3.4%	(8421)		-

Source: 1999 Teen Health Survey, Seattle Public Schools, Health Education Office
Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Appendix 12. Communicable disease among American Indians and Alaska Natives (AI/AN) living in King County compared to all King County residents, three-year averages, 1996-1998.

	King County								
	AI/AN				Total			Relative Difference (AI/AN compared to KC Total)	Trend for AI/AN in King County 1994 - 98
	Total Count Over 3 Years	Annual Count	Rate per 100,000 persons	95% Confidence Interval	Annual Count	Rate per 100,000 persons	95% Confidence Interval		
Water or Foodborn Disease									
Hepatitis A	22	7	40.5	(25.4-61.4)	414	25.2	(23.8-26.6)	△ +61%	
Bloodborn or Sexually Transmitted Disease									
Hepatitis B	2	1	3.7	(0.4-12.7)	51	3.1	(2.6-3.6)	ns	
Chlamydia	226	75	366.9	(320.7-418.0)	3,296	200.1	(196.2-204.1)	▲ +83%	▽
Gonorrhea	53	18	86.1	(64.5-112.5)	939	57.0	(54.9-59.2)	▲ +51%	▼
Syphilis	4	1	6.5	(1.8-16.3)	64	3.9	(3.4-4.5)	ns	
AIDS cases	28	9	45.5	(30.3-65.8)	303	18.4	(17.2-19.6)	▲ +147%	
Other Communicable Disease									
Pertussis (Whooping cough)	15	5	27.6	(15.5-45.5)	205	12.5	(11.5-13.5)	▲ +121%	

Source: Washington State Department of Health, STD/TB Services/Communicable Disease Epidemiology, and Public Health - Seattle & King County, HIV/AIDS Epidemiology Unit.
Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate than rate for AI/AN living in King County; △ / ▽ marginally (with 90% confidence) higher/lower rate.

Errata

Footnote on Appendices 1-7 and 12 pertaining to table symbols should read:

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/ lower rate for AI/ AN living in King County than King County total rate; ▽ / △ marginally (with 90% confidence) higher/ lower rate than rate.

Footnote on Appendices 8-11 pertaining to table symbols should read:

Symbols: ▲ / ▼ Significantly (with 95% confidence) higher/lower rate for AI/AN in Seattle Public Schools than total rate; △/ ▽ marginally (with 90% confidence) higher/lower rate.

Native Directions, Inc.
13505 Union Road, Manteca, CA 95336 • (209) 858-2421 • Fax (209) 858-4692

July 26, 2001

Senate Committee on Indian Affairs
Senate Hart Building, Room 838
Washington, DC 20515
Attn. Marilyn Bruce

RE: Written Testimony July 31st Urban Indian Health Issues.

The purpose of this letter is to introduce the work performed by Three Rivers Indian Lodge under the auspices of Native Directions, Inc. (NDI) and to request your support for the continuation and expansion of this successful program. Native Directions, Inc./Three Rivers Indian Lodge founded in 1974 has successfully operated a 15-bed, 90-day drug and alcohol rehabilitation program for Native American men from San Joaquin and surrounding counties. The program combines a conventional 12-step approach to overcoming addictions with a cultural component that emphasizes traditional Native American values and practices. It is the philosophy of the Native Directions Inc that through the renewal of traditional Native values and customs it is possible for American Indians to secure a sober life style and promote a positive self-image within their community. We do so by:

- Promoting and encouraging the renewal of traditional Native values, customs, and lifestyles through community gatherings.
- Operating a 90-day drug and alcohol rehabilitation program for Native American men to help break the generational cycle of addiction.
- Providing clients with educational preparation for GED testing.
- Coordinating with EDD for employment assistance, and providing assistance in locating housing upon completion of the rehab program.
- Conducting educational presentations on Native American cultures for community schools and organizations.
- Organizing and conducting an annual Pow Wow and Summer Ceremonies to reinforce the local Native community and to educate the general public concerning diversity among Native cultures.
- Providing emergency food services to individuals and families in need.
- Conduction educational seminars on Domestic Violence and referring victims to additional area services.
- Developing services and activities for Native American youth to encourage continued education, and to prevent substance abuse and participation in group violence.

Alcoholism is considered by many professionals to be the number one health program for American Indians. The availability of programs like Three Rivers is essential to effectively address this multigenerational problem. The California Endowment and California HealthCare Foundation published a report in April 1997 (The Health Status of American Indians in California) based on a study by Felicia Schanche Hodge, Dr.P.H.,

form the Center for American Indian Research and Education, University of California, Berkeley. The study reports that alcohol mortality among Native Americans is 10 times the rate for all other races combined. and Fetal alcohol syndrome is 33 times higher among Indians that for non-Indians (p.13). In addition, the report states that alcoholism can be indirectly related to problems of family dysfunction, suicide, mental illness, violent death, and accidents (p.17).

Historically, funding for Three Rivers Indian Lodge program has been provided solely by the U.S. Department of Health and Human Services, Indian Health Service (IHS). Funding from IHS has not grown in proportion to the needs of the program and regular inflation. The 2000 census report of the United States Department of Commerce reports that California has the largest population of American Indians in the United States. There are 300,000 American Indians residing in California today, with well over 80 % increase in the number of American Indians living in San Joaquin County alone. Native Directions Inc. recognized the need for structured culturally based social services for the growing Indian population in San Joaquin and surrounding counties. Specifically, They desired services such as employment assistance, housing, alcoholism counseling, court intervention, and educational tutorial programs.

Three Rivers' approach to alcohol and drug rehabilitation has proven to be very successful; a 78% completion rate for the 90-day program was recorded from October 1, 1995 to the present. As cited above, growth in the American Indian population and the prevalence of alcoholism within the culture has resulted in an increased need for the services provided by Three Rivers Indian Lodge. Currently our facility is fully occupied and a total of 30 potential clients are on the waiting list. In order to meet increased demands for services and establish enhancements of the program components, the following goals and objectives have been established:

- Move to a larger facility to accommodate increased service demands and proposed program expansions.
- Increase the residential capacity of the men's program from 15 to 50 clients and provide appropriate staffing.
- Develop a women's residential program to serve a minimum of 15clients and provide appropriate staffing.
- Improve program completion rate from 78% to 85%.
- Identify continued sobriety rates by consistent follow-up contact with graduates
- Develop a long-range funding plan to diversify the sources of financial support.
- Update the computer skills of current employees to provide more efficient means of work production and record keeping.
- Enhance program components with anger management and individual nutritional classes and provide physical fitness guidance through the use part-time consultants.

The most obvious measurable outcome will be the increase in the number of clients served. Our current facility has the capacity to service 60 clients per year, however funding has allowed us to treat at just 2/3 capacity (40)/ With the proposed increase in the men's treatment facility and establishment of a women's program we anticipate treatment of 160 clients per year- a 300% increase.

The proposed enhancements of the Three Rivers' program relate directly to the Communities First Objectives to "improve access to affordable, quality health care for

underserved individuals and communities: and "to develop the field of multicultural health." The previously cited report by Felicia Schanche Hodge states that even though California has the largest concentration of American Indians in the U.S., it receives the least in allocations of federal funds for Indian health care. This has severely limited the availability of rehabilitative services for American Indians, especially the 80 percent residing in California's urban areas. Expansion of Three Rivers Indian Lodge program by the planned 300% will obviously improve access for this underserved community. However, even with that increase we expect to have a waiting list because of the prevalence of substance abuse within the Native American community. Native Americans are reluctant to utilize county or private rehab programs because of cultural differences and feelings of being misunderstood and/or isolated.

There are other health needs that accompany alcoholism and drug addiction. We get clients who have diabetes, heart disease, hepatitis, HIV/AIDS, mental illness, cirrhosis, depression, medical illness, and dental. The Native people in San Joaquin County have not the political or local legislative support to assist us with these issues, nor the funding. Especially, when indigent and for medical care at the local hospital you are asked for insurance to pay for any care. This leads to feelings of hopelessness and helplessness for our people. I know to receive adequate funding we need a data gathering system that is dependable. Presently we have a CADMIS system that has not properly recorded our data since we began utilizing the system. In essence, Committee Members, we are servicing our people, but we have a long way to go in perfecting a proper data gathering tool. Maybe, with your assistance we can finally acquire the proper tools for a system that works. The enclosed attachments consist of the last five years of client data as evidence to our services.

As stated previously, the local Indian community identified the need for this program in the early 1970's. It has remained a successful grass roots organization for the past 25 years. A large number of volunteers (45+) assist an eight-member staff in accomplishing the many facets of the program. Three Rivers Indian Lodge is recognized in both the Indian community and the Substance Abuse community as an effective and successfully program.

We hope this Senate Committee will seriously take in to consideration the current important health needs of our Urban Indian Communities throughout the country. We appreciate any assistance that may be extended on behalf of the Urban Indian Community.

Sincerely,

Ramona Valadez
Executive Director
Native Direction, Inc/Three Rivers Lodge

	CADMIS SYSTEM OCT., 1995 THRU SEPT., 1996			
CADMIS#	NAME	ENTRY	EXIT	TERM
000001	DANIEL CLOUD	09/20/95	12/20/95	COMP
000002	DEWEY LUCAS	10/16/95	01/16/96	COMP
000003	GAREN SCOTT	11/29/95	02/28/96	COMP
000004	BLAKE STIFFARM	12/16/95	03/18/96	COMP
000005	VERNON WILSON	12/21/95	03/23/96	COMP
000006	GREGORY RUSSELL	12/25/95	02/28/96	QUIT
000007	ROBERT GOODLUCK	01/10/96	04/11/96	COMP
000008	FRANK BROWN	01/09/96	04/12/96	COMP
000009	TED AVILA	02/26/96	05/13/96	COMP
000010	JOHN MONROE	01/28/96	04/30/96	COMP
000011	VIRGIL BUSSELL	03/22/96	06/23/96	COMP
000012	KAI WILLIAM	03/22/96	06/23/96	COMP
000013	STAN WILSON	04/17/96	07/18/96	COMP
000014	HARVEY PRATT	12/15/95	03/17/96	COMP
000015	DAN FRANKLIN	12/18/95	03/20/96	COMP
000016	DONOVAN YAZZIE	10/11/95	01/10/96	COMP
000017	PAUL HANSEN	10/09/95	01/08/96	COMP
000018	CULVIN MAY	09/13/95	12/13/95	COMP
000019	COLMA YOUPIE	08/01/95	11/02/95	COMP
000020	JIMMY BOWIE	07/18/95	10/19/95	COMP
000021	BRAIN MATHEISEN	02/16/96	05/18/96	COMP
000022	CECIL DUANE DICK	03/18/96	06/19/96	COMP
000023	PHILLIP BOX	03/19/96	05/10/96	TERMIN
000024	KENNETH WILLIAM	03/22/96	06/23/96	COMP
000025	ALFREDO VEDOLLA	03/28/96	06/30/96	COMP
000026	ROGER SMITH	01/26/96	03/15/96	TERMIN
000027	STEVE CRUZ	07/21/95	10/22/95	COMP
000028	DAVID MALLORY	01/26/96	04/28/96	COMP
000029	ISADORE ESTRADA	09/03/95	12/04/95	COMP
000030	IRA GEMILL	07/10/95	10/11/95	COMP
000031	DAVID THOME	05/01/95	08/02/95	COMP
000032	MARVIN JERKY	04/26/95	07/25/95	COMP
000033	PAUL LARA	05/06/96	08/06/96	COMP
000034	LOUIS MOLINA	05/07/96	08/08/96	COMP
000035	DARRYLL MIX	06/05/96	09/06/96	COMP
000036	ANGELO ROSE	06/10/96	09/11/96	COMP
000037	SILAS PARKER	06/03/96	09/03/96	COMP
000038	LAWRENCE LAWTON	06/04/96	09/04/96	COMP

CADMIS#	NAME	ENTRY	EXIT	TERM
000039	ARRON HART	06/05/96	09/05/96	COMP
000040	LEONARD PINOLA	06/10/96	09/11/96	COMP
000041	KEENYN REED	06/11/96	09/12/96	COMP
000042	DAVID LOUIS	06/24/96	09/24/96	COMP
000043	RAUL VALENCIA	07/19/96	10/18/96	COMP
000044	JOHN COLEY	07/21/96	10/20/96	COMP
000045	ROBERT HAMMOND	07/25/96	10/24/96	COMP
000046	DANIEL CALDER	07/29/96	10/28/96	COMP
000047	STAR ROMERO	09/07/96	12/08/96	COMP
000048	DAVID FREASE	09/09/96	12/08/96	COMP
000049	HARLAN SAMPLE	09/13/96	12/12/96	COMP
000050	CLETUS MCNOISE	09/13/96	10/30/97	QUIT
000051	TONY WILLIAMS	09/16/96	12/15/96	COMP
000052	VINCENT HEADMAN	09/18/96	12/17/96	COMP

CADMIS SYSTEM OCT.,1996 THRU SEPT., 1997

CADMS#	NAME	ENTRY	EXIT	TERM -
000053	DOUG DOLAN	10/04/96	11/16/96	QUIT
000054	RANDY KLOSS	10/11/96	11/1296	TERM.
000055	JODY YORK	10/18/96	02/28/97	COMP.
000056	FLOYD McLAUGHLIN	10/20/96	02/28/97	COMP.
000057	EDWIN APPLING	11/12/96	02/09/97	COMP.
000058	WILLIAM GONE	11/13/96	02/10/97	COMP.
000059	RAYMOND DOUGLAS	11/18/96	03/16/97	COMP.
000060	STEVE STEEL	12/20/96	03/19/97	COMP.
000061	LYNDON JOHNSON	12/20/96	03/19/97	COMP.
000062	BRANDON PHILLIPS	12/26/96	04/01/97	COMP
000063	VIRGIL BROWN	01/02/97	04/01/97	COMP
000064	MARCUS HUNTER	01/06/97	04/01/97	COMP
000065	ROSS ANDERSON	02/14/97	05/16/97	COMP
000066	FRANK BLACKOWL	02/20/97	05/30/97	COMP
000067	SALVADOR DIAZ	02/26/97	05/27/97	COMP
000068	MIKE BOMBERRY	03/03/97	06/01/97	COMP
000069	CHARLES COPP	03/04/97	06/01/97	COMP
000070	JOEL RODRIQUEZ	03/21/97	06/24/97	COMP
000071	RON EDWARDS	04/14/97	07/21/97	COMP
000073	JAMES BROWN	04/14/97	07/12/97	COMP
000074	RAYMOND BEGAY	04/01/97	06/05/97	QUIT
000075	DEWEY LUCAS	05/02/97	10/01/97	COMP
000076	DANA YAZZIE	06/03/97	08/23/97	TERM.
000072	MATHEW AVILA	04/17/97	08/11/97	COMP
000077	TERRANCE DUDLEY	06/06/97	07/07/97	TERM
000078	JOE BALLARD	06/18/97	07/22/97	TERM
000079	ALFRED JONES	06/18/97	09/15/97	COMP
000080	MATHEW DALSON	06/24/97	09/21/97	COMP
000081	GARY ROBINSON	06/26/97	09/02/97	QUIT
000082	GERALD MEYERS	07/02897	10/12/97	COMP
000083	JAMES SMITH	07/10/97	08/23/97	QUIT
000084	DAN BARLOW	07/15/97	10/12/97	COMP
000085	BILLY GATES	07/28/97	08/23/97	TERM
000086	MICHAELCARTER	07/28/97	08/01/97	QUIY
000087	BOB LILY	08/18/97	11/10/97	QUIT
000088	JAMES SOMERSALL	08/28/97	11/26/97	COMP
000089	JOHN DELGADO	09/08/97	12/06/97	COMP
000090	JASON PINTO	09/11/97	12/09/97	COMP
000091	MARK WHITEHORN	09/12/97	12/10/97	COMP
000092	ANTHONY ARMSTRONG	09/16/97	11/20/97	QUIT
000093	HARLAN SAMPLE	09/19/97	12/17/97	COMP
000094	LEONARD AZBILL	09/24/97	12/22/97	COMP

CADMS SYSTEM 10/01/97 THRU 09/30/98

CADMS#	NAME	ENTRY	EXIT	TERM
000095	Edward Hayes	10/16/97	01/13/98	Completed
000096	Lance W. Dondero	10/20/97	11/03/97	quit
000097	Kenneth Engesser	11/10/97	02/12/98	Complete
000098	Bryan Johnson	11/20/97	11/29/97	quit
000099	Allen cohoe	12/02/97	01/26/98	Quit
000100	Raul Valencia	12/14/97	03/03/98	Completed
000101	Adam Walker	12/11/9 7	03/10/98	Completed
000102	Harlan Arnett	12/17/97	03/16/98	Completed
000103	James Benner	12/19/97	03/02/98	Completed
000104	Dan Foreman	12/29/97	03/29/98	Comp/AC
000105	Jason Estrada	12/29/97	03/27/98	Completed
000106	Layayete Jerry	01/05/98	04/04/98	Completed
000107	Yakima Dixie	01/14/98	04/1398	Comp/AC
000108	John Walls	01/16/98	02/26/98	Quit
000109	Ezra Willey	02/02/98	05/02/98	Completed
000110	Niklas Lucich	02/11/98	03/16/98	Quit
000111	Steven Taylor	03/04/98	06/01/98	Completed
000112	Lucius Catha	03/09/98	05/02/98	Quit
000113	Thomas Martinez	03/12/98	03/20/98	Quit
000114	Colby DeGarmo	03/18/98	06/15/98	Completed
000115	Billy Eisenhour	03/27/98	06/24/98	Comp/AC
000116	Dominick Goodwin	03/27/98	06/19/98	Terminated
000117	Frank Gams	04/01/98	05/10/98	Quit
000118	Terry Lamb	04/15/98	07/13/98	Completed
000119	melvin Dale	04/03/98	04/30/98	Incomplete
000120	Darrel Mix	04/16/98	07/14/98	Comp/AC
000121	Clayton Britton	04/20/98	07/18/98	Completed
000122	Louis Molina	04/24/98	07/27/98	Comp/AC
000123	Lloyd Maples	05/04/98	08/03/98	Comp/AC
000124	Anthony Anderson	05/18/98	08/16/98	Comp/AC
000125	Matt Williams	06/17/98	08/10/98	Terminated
000126	Alan Gibson	06/17/98	09/25/98	Comp/AC
000150	Ray Hunter	06/29/98	09/26/98	Completed
000151	Cody Thompson	07/27/98	10/24/98	Completed
000152	Dennis Moffett	07/30/98	10/27/98	Completed
000153	Clarence Lavell	07/31/98	10/28/98	Completee
000154	Silas Parker	08/04/98	08/12/98	Quit
000155	Harrison Polk	08/06/98	11/03/98	Completed
000156	Dan Barlow	08/26/98	11/23/98	Completed
000157	Alfredo Vedolla	09/03/98	12/02/98	Completed
000158	Todd Lewis	09/15/98	12/03/98	Terminated
000159	David Davalle	09/21/98	12/19/98	Completed
000160	David San Diego	06/25/98	10/25/98	Comp/AC
000161	Tim Beltaga	09/29/98	12/29/98	Comp/AC

Three Rivers Indian Lodge
CADMS SYSTEM 10/01/98 THRU 09/30/99

CADMS#	NAME	ENTRY	EXIT	TERM	COSEL.
000162	STEVEN REED	10/19/98	01/15/99	COMPLETED	RAY
000163	JOHN KIRBY	10/26/98	12/29/98	QUIT	RAY
000164	BRANDON LEE MAIN	11/03/98	01/31/99	COMPLETED	MARV
000165	LILBURN HOGLEN	11/03/98	01/31/99	COMP/AFTER CARE	RAY
000166	WILL ANDREAS	11/09/98	02.06/99	COMPLETED	MARV
000167	NOAH PARKER	11/10/98	12/07/98	TRANSFER	RAY
000168	BOWE DAVID	11/15/98	02/12/99	COMPLETED	MARV
000169	RUBEN PIONLA	11/20/98	02/17/99	COMPLETED	RAY
000170	JERALD DALE	12/02/98	12/16/98	QUIT	BEN
000171	SAM OWLE	12/03/98	03/02/99	GRAD/AFTER CARE	RAY
000172	GEORGE NINE	12/18/98	03/17/99	COMPLETED	BEN
000173	RAYMOND BEGAY	01/04/99	04/03/99	COMP/AFTER CARE	MAR
000174	BREW ERICSON	01/06/99	04/05/99	COMPLETED	RAY
000175	LESLIE EBEN	01/11/99	02/23/99	TERM.	MARV
000177	BARRY BRENARD	02/01/99	04/30/99	COMP/AFTER CARE	RAY
000178	DENNIS HOAGLEN	02/12/99	04/06/99	TERM.	MARV
000179	HARLAN DEWEY	02/12/99	05/12/99	COMP	MARV
000180	CYRUS BURROUGH	02/24/99	05/24/99	COMP	RAY
000181	DUSTIN COOK	03/01/99	05/29/99	comp	RAY
000182	RONALD CLARK	03/02/99	05/30/99	COMP	MARV
000183	JOHN CLARK	03/04/99	06/01/99	COMP	RAY
000184	MARVIN JACK JONES	03/08/99	06/05/99	COMP	MARV
000185	ROGER SMITH	03/16/99	05/11/99	Term	BEN
000186	ALAN L. HATCHER	03/18/99	06/15/99	comp	RAY
000187	JAMESON TRUEX	04/07/99	07/09/99	COMP	MARV
000188	RUSSELL M. MILLS	04/12/99	04/17/99	(medical reason)	MARV
000189	DELBERT JACKSON	04/15/99	07/13/99	COMP.	RAY
000190	RAYMOND STANDING BEAR	04/23/99	07/22/99	COMP/AF	MARV
000191	KELLY WILLIAMS	04/27/99	07/04/99	LEFT ON HIS OWN	MARV
000192	EMIL McCLOUD	05/03/99	05/10/99	QUIT	RAY
000193	LEONARD STARKEY	05/12/99	05/26/99	(trans. To charter hosp)	MARV
000194	ARYLIS PETERS	05/14/99	08/10/99	Comp/AF	RAY
000195	ANTHONY RIVERA	05/17/99	08/16/99	COMP.	RAY
000196	ALBERT GOLDSMITH	05/17/99	07/20/99	term.	Mar
000197	charles pratt	06/08/99	09/05/99	COMP.	RAY
000198	Daniel Rockey sr.	06/09/99	09/06/99	COMP/AF CARE	Janet
000199	Carl Brown	06/09/99	09/06/99	COMP	Ray
000200	Henry Rose	06/09/99	09/06/99	COMP	Marv
000201	Charles Copp	06/15/99	09/13/99	COMP	Ray
000202	Bernardo Oandasan	06/16/99	09/13/99	COMP.	MARV

CADMS SYSTEM 10/01/98 THRU 09/30/99

CADMS #	NAME	ENTRY	EXIT	STATUS	COUNSELOR
000203	Charles Brown	06/24/99	09/21/99	COMP.	Ray
000204	James Warden	07/13/99	10/1099	COMP	MARVN
000205	Randy Lee Mike	07/14/99	09/13/99	QUIT	Ray
000206	CHRISTOPHER SEARS	07/27/99	10/25/99	COMP	MARVIN
000207	LEVI MULLEN	07/30/99	10/27/99	comp	MARVIN
000208	SANCHEZ SANTANA	08/17/99	10/13/99	term.	RAY
000209	ANDREW ORTEGA	09/13/99	12/12/99	COMP	RAMONA
000210	RONALD JACK	09/17/99	11/01/99	JAIL TIME	RAY
000211	ROBERT JAMES DRESSLER	09/17/99	12/15/99	COMP.	MARVIN
000212	THOMAS WALKER	09/21/99	12/20/99	COMP	RAY
000213	MICHAEL A. CARRIZOSA	09/27/99	12/25/99	COMP	MARVIN
000214	TILFORD PAUL DENVER	09/30/99	12/28/99	COMP	RAY

CADMS SYSTEM 10/01/99 THRU 09/30/00

CADMS #	NAME	ENTRY	EXIT	TERM	COUN.
1. 000215	[redacted]	10/04/99	01/01/00	COMP.	MARVIN
2. 000216	VERNON SMITH	10/08/99	01/05/00	COMP.	RAY
3. 000217	WILLIAM SCOTT	10/11/99	12/25/99	QUIT	MARVIN
4. 000218	LEONARD ESPINOSA	10/27/99	01/24/00	AFC	MARVIN
5. 000219	LANCE DONDERO	10/29/99	01/26/00	COMP.	MARVIN
6. 000220	LARRY DEAN NOVA	10/29/99	01/26/00	COMP.	RAY
7. 000221	JOHN STEVEN LAWSON	12/01/99	01/31/00	QUIT	RAY
8. 000222	LUCAS BACON	12/20/99	03/01/00	TERM.	MARVIN
9. 000223	JOSEPH VAN ETTEN	01/03/00	04/01/00	COMP	RAY
10 000224	[redacted]	01/03/00	04/01/00	COMP	MARVIN
11 000225	ANDREW RORIE	01/04/00	02/29/00	TERM.	MARVIN
12 000226	BOB BRIAN PLUMMER	01/06/00	03/30/00	EMERG	RAY
13 000227	FRANK SPENCER	01/10/00	04/08/00	COMP.	RAMONA
14 000228	JAMES SMITH	01/13/00	04/11/00	(af 10/27/00) COMP/AF	RAY
15 000229	RONALD JACK	01/21/00	04/26/00	COMP.	RAY
16 000230	JONATHAN BANEGAS	01/31/00	03/13/00	TERM.	MARVIN
17 000231	ALLEN STANSHAW	02/01/00	04/04/00	COMP	RAY
18 000232	MATTHEW SYLVIA	02/11/00	05/30/00	COMP	MARVIN
19 000233	CHRISTOPHER BROWN	02/24/00	05/24/0	COMP	MAARVIN
20 000234	ROBERT FIESTER	03/15/00	06/12/00	COMP	MARVIN
21 000235	FREDDIE WATKINS	03/16/00	0501/00	QUIT	RAY
22 000236	DONALD LEE SNELLS	03/17/00	06/14/00	COMP	MARVIN
23 000237	[redacted]	04/07/00	05/11/00	TERM..	RAY

CADMS SYSTEM 10/01/99 TO 09/30/00

CADMS#	NAME	ENTRY EXIT	TERM	COUN.
24 000238	LAWRENCE WHIPPLE	04/11/00	07/09/00 COMP.	RAY
25 000239	LEN BLACKOWL	04/11/00	05/10/00 QUIT	RAY
26 000240	SIDNEY CERVANTES	04/21/00	07/18/00 COMP	RAY
27 000241	HONOVAA LEWIS	04/24/00	07/22/00 Comp	MARV
28 000242	RON WILSON	04/27/00	07/25/00 COMP	RAMONA
29 000243	MICHAEL HILLEGEIST	05/05/00	08/02/00 Comp.	RAY
30 000244	ERNEST MIKE SMITHER	05/10/00	05/30/00 Qut	RAY
31 000245	FLOYD DOLLAR	0511/00	08/08/00 Comp.	MARV
32 000246	CHARLES WILLIAMS	05/11/00	08/08/00 Comp.	RAY
33 000247	TONY WILLIAMS	05/24/00	06/20/00 PROBA.	RAY
34 000248	ELDON MILLER	05/31/00	08/28/00 comp	MARV
35 000249	RANDY T. MATTZ	06/05/00	09/02/00 AF 09/26/00	RAY
36 000250	DAVID RICHARDS	07/07/00	10/04/00 Comp.	RAY
37 000251	ROBERT ZALEWSKI	07/11/00	10/11/00 Comp/AF	MARV
38 000252	ROBERT L. STRA	07/11/00	09/11/00 quit	RAY
39 000253	PEDRO D. JIM	07/14/00	10/11/00 Comp.	MARV
40 000254	JAMES WEEMS	07/20/00	10/17/00 Comp/ AF	RAY
41 000255	GLENN QUINN	07/21/00	10/18/00 Comp.	MARV
42 000256	BARRY BRENARD	08/03/00	10/31/00 AC	RAMONA
43 000257	PETE NORRIS	08/05/00	11/02/00 Comp.	RAY
44 000258	PERRY VIZZANE ANDO	08/09/00	08/28/00 Quit	MARV
45 000259	JOHN DANIEL WALKER	08/10/00	08/18/00 Quit	MARV
46 000260	MICHAEL BETTZ	08/21/00	11/18/00 comp	RAY
47 000261	MARK YAZZIE	08/22/00	11/19/00 comp	RAY
48 000262	RONALD REED	09/05/00	12/03/00 COMP	MARV
49 000263	OLANDO FREESE	09/13/00	12/11/00 Comp	RAY
50 000264	MARK DOMINGO	09/14/00	12/13/00 Comp	MARV

NATIVE DIRECTIONS INC./ THREE RIVERS INDIAN LODGE
CADMS SYSTEM 10/01/00 TO 09/30/01

CADMS	Name	Entry	Tribe/age	Exit	Status	Counselor
000265	01 Britton Leonard Azbill	10/10/00		01/07/01	Completed	Ray
000266	02 Paul White Rock	10/11/00	Pomo Santa Rosa	01/08/01	Completed	Marvin
000267	03 Stanley Nalton	10/11/00		01/08/01	Comp. Went to After care	Ray
000268	04 Timothy D. Bettega	10/17/00	Wintu Walaki Ukiah	01/14/01 01/24/01	Comp. After Care	Marvin
000269	05 Jose R. Pacheco	10/20/00		01/17/01	Completed	Ray
000270	06 James Stewart	11/03/00		01/30/01 04/04/01	Completed After Care	Ray
000271	07 Kevin L. Haberman	11/08/00	Yurok Eureka	02/05/01	Completed	Marvin
000272	08 Donald L. Howerton	11/20/00		02/17/01	Completed	Ray
000273	09 Gibb J. Oliverez	11/21/00	Pomo Miwok Petaluma	02/18/01	Completed	Marvin
000274	10 Nemechay Bates	12/06/00	Yurok Klamath	03/05/01	Completed	Marvin
000275	11 Harrison Polk	12/11/00	Apache Santa Cruz	03/11/01	Completed After care 6/13/01	Marvin
000276	12 Larry G. Bunch	12/11/00		03/10/01	Completed	Ray
000277	13 Vernon Smith	01/08/01		04/07/01	Completed	Ray
000278	14 Steven Wilson	01/08/01	Sioux Lakota Stkn	04/08/01	Completed	Marvin
000279	15 Larry Davis	01/09/01		04/09/01	Completed	Ray
000280	16 David L. Thome	01/16/01		04/16/01	Completed 04/17/01 AF	Ramona
000281	17 Anthony Gomez	01/17/01		04/20/01	Completed	Ray
000282	18 Keith W. Fuller	02/07/01	Pauite BigPine	05/07/01	Completed	Marvin
000283	19 David Karlich	02/09/01		05/09/01	Completed	Ray
000284	20 Theodore Dick	02/20/01	Pauite Prymaid	05/2001	Completed	Marvin
000285	21 Lee Roy Grubbs	02/27/01		05/27/01 after care	Completed	Ray
000286	22 Michael Mitchell	03/09/01		06/08/01	Completed	Ray

CADMS	NAME	ENTRY	TRIBE	EXIT	STATUS	COUNSELOR
000287	24 Erick Duane Nelson	03/13/01	Karuk Euerka	06/09/01	Completed	Marvin
000288	25. Dustin Cook	04/02/01				Ray
000289	26. Dewey McGarva	04/09/01	Pit River Altura	07/07/01	Completed	Marvin
000290	27 Harold Bever Jr.	04/11/01	Paiute Bishop	07/09/01	Completed After Care	Marvin
000291	28 Leonard Mota	04/16/01	Pit Riv Burney	07/14/01	Completed	Ray
000292	29 Anthony Pettipas	05/10/01	Sioux Reno	06/16/01	Emergency discharge	Ray
000293	30 Brian J. Weeks	05/11/01	Maidu Oraville			Marvin
000294	31 Sparrow Cox	05/15/01				Marvin
000295	32 Reynaldo Santiago	05/18/01	Pomo Santa Rosa			Ray
000296	33 Ronald Evert Barr	05/23/01				Marvin
000297	34 Henry Smiley	05/29/01	Navajo N.M.			Ray
000298	35 Shannon Jones	06/12/01	Yurok Euerka			Howard
000299	36 William D. Burley	06/13/01	Miwok Tuola.			Howard
000300	37 Timothy Cowden	07/03/01	Yurok			Ray
000301	38 Negie Fallis	07/09/01	Wylaki			Marvin
000302	39 Michael Garcia	07/11/01	Sioux			Howard
~~000303~~ 000055	Jody Ice York	7/24/01		10/24/01		Ray

South Dakota Legislative Research Council

Sen. Arnold M. Brown, Chair
Rep. Michael Derby, Vice Chair

James Fry, Director
Doug Decker, Code Counsel

SOUTH DAKOTA LEGISLATIVE RESEARCH COUNCIL

MEMORANDUM

TO: **Senate Committee on Indian Affairs**

FROM: **Tom Magedanz, Staff**
South Dakota State-Tribal Relations Committee

DATE: **July 20, 2001**

SUBJECT: Written Testimony on Senate Bill 212

On behalf of the State-Tribal Relations Study Committee, an interim study committee of the South Dakota Legislature, please submit the two enclosed items as written testimony on Senate Bill 212, the reauthorization of the Indian Health Care Improvement Act, scheduled for hearing on July 31 and August 2, 2001. The letter to former President Clinton is one of a series of letters sent by the 2000 State-Tribal Relations Committee to various officials and agencies dealing with the subject of long-term care and elderly care for Native Americans. The resolution was introduced by the State-Tribal Relations Committee and adopted by the 2001 South Dakota Legislature.

Thank you for your assistance.

Enclosures

State Capitol, 500 East Capitol, Pierre, SD 57501-5070
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http://legis.state.sd.us

South Dakota **Legislative Research Council**

October 2, 2000

President Bill Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Clinton:

On behalf of the members of the State-Tribal Relations Committee, a statutory interim committee of the South Dakota Legislature, I am writing to formally request that your administration make the issue of elderly care and long-term care for Native Americans one of its priorities.

The provision of adequate care for Native American elders is becoming more critical as life expectancy increases and more Native Americans are in need of long-term care. The need is exacerbated by the high incidence of illness, particularly diabetes, among Native Americans and by the difficult economic conditions that many on the reservation face. However, it is distressing to note that the federal government, in spite of long-standing legal and moral obligations to provide for the well-being of Native Americans on reservations around the nation, does not offer even the most basic long-term nursing home care for tribal members, even though the federal government routinely provides other health and education services on the reservation.

This situation has arisen because the Congress and the executive branch have refused to consider care for the elderly as an issue of health and well being and refuse to authorize funding for the appropriate federal agencies, particularly the Indian Health Service, to provide long-term care. Given the sovereign status of Indian tribes, the relationship of tribes with the federal government, and the lack of state jurisdiction on reservations, conventional mechanisms for the funding of long-term care are simply not appropriate for tribal members on Indian reservations, just as they are not appropriate in the areas of education and basic health care.

In South Dakota, Native Americans are forced to use nursing homes off the reservation, which usually means long distances from home, separation from family and friends, and financial hardship for family members who wish to visit. It also means social and cultural isolation at a time in elders' lives when understanding and cultural support are most important. The United States government must live up to

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its responsibilities by helping to maintain and establish facilities that will allow our Native American elders to spend their final years with dignity in their own community and cultural surroundings.

We ask for your understanding and support on this issue and thank you for your consideration.

Sincerely,

Senator Robert Benson, Chair
State-Tribal Relations Committee of the South Dakota Legislature

cc: Governor Willliam J. Janklow
Mr. Webster Two Hawk, South Dakota Commissioner of Tribal Government Relations
South Dakota Tribal Presidents and Tribal Chairs

State of South Dakota

SEVENTY-SIXTH SESSION
LEGISLATIVE ASSEMBLY, 2001

660E0082

SENATE ENGROSSED NO. SCR 2 - 02/20/2001

Introduced by: Senators Albers, Brown (Arnold), Hagen, Hutmacher, and Putnam and Representatives Nachtigal, Napoli, and Valandra at the request of Interim State-Tribal Relations Committee

A CONCURRENT RESOLUTION, Urging the federal government to authorize and fund long-term health care on Indian reservations.

WHEREAS, among all the states in the Northern Plains region, South Dakota has the highest percentage of its Native American population, sixty-seven percent, living on Indian reservations. In addition, South Dakota is experiencing a growing elderly population on its Indian reservations; and

WHEREAS, Native Americans are living significantly longer today than they did in the early 1900s. The life expectancy of Native Americans in South Dakota is currently sixty-five. This increased life expectancy, combined with rising birth rates, ensures continuing population increases at all age levels, presents new challenges in caring for the elderly, and creates the need for elderly care facilities to provide services that were once provided solely by the family; and

WHEREAS, the rate of debilitating diseases, particularly diabetes, on South Dakota Indian reservations has been increasing over the years. The age-adjusted diabetes mellitus death rate among Native Americans in South Dakota is 62.6 per 100,000 population, which is five times

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Insertions into existing statutes are indicated by underscores. Deletions from existing statutes are indicated by ~~overstrikes~~.

higher than the combined rate for all races in the United States; and

WHEREAS, Native American culture strongly embraces the extended family in which elders are considered the source of wisdom, history, and tradition; and

WHEREAS, a loss of important cultural traditions for families and tribal members occurs when elderly Native Americans must seek nursing facility placement off the reservations. This separation means social and cultural isolation at a time in elders' lives when understanding and cultural support are most important; and

WHEREAS, due to the high percentage of Native American families below poverty level living on Indian reservations, lack of transportation to visit family members in nonreservation nursing homes creates a hardship for the elderly and their families; and

WHEREAS, the federal government has a long-standing legal and moral obligation to provide for the health care needs of Native Americans on reservations. This obligation is based on treaty and federal law; and

WHEREAS, the Indian Health Service currently provides primary and acute health care services, such as physician and hospital care, through federal facilities located on each of the reservations; and

WHEREAS, the Indian Health Service currently does not provide long-term care services, such as assisted living and nursing home care, on any of South Dakota's Indian reservations; and

WHEREAS, the federal government has failed to take responsibility for providing long-term care services to elderly Native Americans residing on reservations in South Dakota. The federal government has refused to recognize long-term care for Native Americans as a federal responsibility and has failed to provide authorization and funding that would enable the Indian Health Service to provide those needed services; and

WHEREAS, the lack of long-term care services has created an undue hardship for

reservation residents and their families creating a growing need for the Indian Health Service to appropriately address the long-term care needs of South Dakota's Native American population:

NOW, THEREFORE, BE IT RESOLVED, by the Senate of the Seventy-sixth Legislature of the State of South Dakota, the House of Representatives concurring therein, that the federal government is requested to formally take responsibility for long-term care for Native Americans residing on Indian reservations by providing the necessary authorization and funding to enable the Indian Health Service to offer long-term care for Native American elders on Indian reservations. The United States government must live up to its responsibilities by helping to establish facilities that will allow our Native American elders to spend their final years with dignity in their own communities and cultural surroundings; and

BE IT FURTHER RESOLVED, that copies of this Resolution are to be forwarded to Senator Tom Daschle, Senator Tim Johnson, and Representative John Thune and that Senator Daschle, Senator Johnson, and Representative Thune are requested to brief the 2002 South Dakota Legislature on any progress or developments that have occurred at the national level on this issue.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

July 27, 2001

The Honorable Daniel Inouye, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office
Washington, DC 20510-6450

Re: Indian Health Care Improvement Act (IHCIA)
Reauthorization Hearing July 31, 2001

Dear Senator Inouye:

Thank you for the opportunity to submit this letter for the written record of the subject hearing.

Alaska is very concerned about the erosion, and consequent shift to the states, of the federal government's trust responsibility and obligation for the health status of American Indian and Alaska Native peoples. Alaska urges Congress to amend the Social Security Act to clearly bring the availability of 100% federal Medicaid cost sharing (FMAP) into line with the original intent of the Indian Health Care Improvement Act (IHCIA).

The IHCIA was landmark legislation in that it defined the federal government's obligations with respect to health care services to American Indians and Alaska Natives:

> *It is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.*

Section 1905(b) of the Social Security Act was enacted in 1976 as part of Title IV of IHCIA, and provides that:

> *The federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian Tribe or Tribal Organization.*

The IHCIA sought to improve access to free health care for American Indians and Alaska Natives by entitling IHS facilities to reimbursement from Medicare and Medicaid for eligible

beneficiaries. The Congressional record is also very clear that the 100% FMAP was being provided for these services because:

> *The Committee wishes to assure that a State's election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to States a financial burden previously borne by the Federal Government.* (Legislative History P.L. 94-437.)

In the 25 years since the adoption of IHCIA, the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) has never adopted regulations regarding the 100% FMAP. Over the years, policy guidance issued by CMS has been erratic and contradictory, with differing advice provided to states.

State Medicaid agencies have acted in good faith in relation to the availability of the 100% FMAP, as they have had the responsibility of assuring coverage of American Indian and Alaska Native peoples, and enrollment and reimbursement of Indian Health Service and tribal health providers. States have also assumed considerable financial costs in this endeavor, providing funds for both administration and state match for services which the CMS has treated as not eligible for 100% FMAP. Such partially reimbursed services include Medicaid State Plan services and services provided by the Indian Health Service or the tribes.

The climate regarding Indian policy has changed in CMS in recent years. Increased, but inconsistent, attention has been devoted to the actions of states in relation to Indian health policy. For example, states have received letters from CMS regional offices containing guidance in conflict with information provided to other states, and subjective financial audits are being performed on states' claiming practices. Millions of dollars are being deferred and disallowed related to claiming of the 100% FMAP, resulting in confusion and financial hardship for states.

Alaska respectfully requests that Congress clarify the language in 1905(b) of the Social Security Act to bring the availability of the 100% FMAP in line with the original intent of the IHCIA, and to reverse the shifting of federal responsibility for American Indian and Alaska Native health care to the states. Further, to avoid the CMS interpreting the amendment as "new" policy and recouping even more funds from states for past actions, Alaska urges Congress to adopt clarifying language *as though enacted in 1976 in P.L. 94-437* and containing the following elements:

- Coverage of any Medicaid State Plan or Waiver service
- Provided by the Indian Health Service, a Tribe, or Tribal Organization
- Is eligible for 100% FMAP
- Regardless of the location of the service delivery
- Whether the service is provided directly, by referral, under contract, or other arrangement

At the time the IHCIA was enacted, definition of the federal responsibility for the health status of American Indians and Alaska Natives was long overdue. But since that time, the federal Executive Branch's failure to implement regulations has jeopardized Congress' policy intent and purpose. The federal Executive Branch is de facto creating and implementing policy that shifts the responsibility to the states. Mr. Chairman, please take this opportunity to make clear to all the federal government's trust responsibility for the health status of American Indians and Alaska Natives, and bring the federal government's actions into line with Congress' intent.

Thank you for this opportunity to provide this written testimony.

Sincerely,

Karen Perdue
Commissioner

cc: John Katz, Governor's DC Office
Senator Ted Stevens
Senator Frank Murkowski
Congressman Don Young

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