

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

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

INDIAN HEALTH SERVICE

BEFORE THE

**INTERIOR APPROPRIATIONS SUBCOMMITTEE
OF THE
HOUSE APPROPRIATIONS COMMITTEE
UNITED STATES CONGRESS**

**HEARING
ON
THE PRESIDENT'S FY 2005 BUDGET REQUEST
FOR THE
INDIAN HEALTH SERVICE**

MARCH 10, 2004

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Subcommittee:

Good morning. I am Dr. Charles W. Grim, Director of the Indian Health Service. Today I am accompanied by Mr. Michel E. Lincoln, Deputy Director, Mr. Gary J. Hartz, Acting Director, Office of Public Health, and Mr. Robert G. McSwain, Director, Office of Management Support. We are pleased to have this opportunity to testify on the President's FY 2005 budget request for the Indian Health Service.

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

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

Through the government's longstanding support of Indian health care, the I/T/U Indian health programs have demonstrated the ability to effectively utilize available resources to improve the health status of AI/ANs. For example, there have been dramatic improvements in reducing mortality rates for certain causes from the three year periods of 1972-1974 to 1999-2001, such as maternal deaths decreased 58%, infant mortality decreased 64%, and unintentional injuries mortality decreased 56%. More recently, the funding for the Special Diabetes Program for Indians has significantly enhanced diabetes care and education in AI/AN communities, as well as building the necessary infrastructure for diabetes programs. Intermediate outcomes that have been achieved since implementation of the Special Diabetes Program for Indians include improvements in the control of blood glucose, blood pressure, total cholesterol, LDL cholesterol, and triglycerides. In addition, treatment of risk factors for cardiovascular disease has improved as well as screening for diabetic kidney disease and diabetic eye disease.

Although we are very pleased with the advancements that have been made in the health status of AI/ANs, we recognize there is still progress to be made. As the Centers for Disease Control and Prevention recently reported, the AI/AN rates for chronic diseases, infant mortality, sexually transmitted diseases, and injuries continue

to surpass those of the white population as well as those of other minority groups. The 2002 data show that the prevalence of diabetes is more than twice that for all adults in the US, and the mortality rate from chronic liver disease is more than twice as high. The sudden infant death syndrome (SIDS) rate is the highest of any population group and more than double that of the white population in 1999. Rates of chlamydia are 5.7 times higher than in whites, and the gonorrhea rate is 4 times higher than in whites. AI/AN death rates for unintentional injuries and motor vehicle crashes are 1.7 to 2.0 times higher than the rates for all racial/ethnic populations, while suicide rates for AI/AN youth are 3 times greater than rates for white youth of similar age. Maternal deaths among AI/ANs are nearly twice as high as those among white women.

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

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

The President's budget request for the IHS is an increase of \$45 million above the FY 2004 enacted level. The request will assist I/T/U Indian health programs to maintain access to health care by providing \$36 million to fund pay raises for Federal employees as well as funds to allow Tribal and Urban programs to provide comparable pay increases to their staff. Staffing for five newly constructed health care facilities is also included in the amount of \$23 million. When fully operational, these facilities will double the number of primary provider care visits that can be provided at these sites and also provide new services. The budget also helps maintain access to health care through increases of \$18 million for contract health care and \$2 million for the Community Health Aide/Practitioner program in Alaska. The increase for CHS, combined with the additional purchasing power provided in Section 506 of the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act, will allow the purchase of an estimated 35,000 additional outpatient visits or 3,000 additional days of inpatient care.

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

The budget request also supports the replacement of outdated health clinics and the construction of staff quarters for health facilities, which are essential components of supporting access to services and improving health status. In the long run, this assures there are functional facilities, medical equipment, and staff for the effective and efficient provision of health services. As you know, the average age of IHS facilities is 32 years. The FY 2005 budget includes \$42 million to complete construction of the health centers at Red Mesa, Arizona and Sisseton, South Dakota; and complete the design and construction of staff quarters at Zuni, New Mexico and Wagner, South Dakota. When completed, the health centers will provide an additional 36,000 primary care provider visits, replace the Sisseton hospital, which was built in 1936, and bring 24 hour emergency care to the Red Mesa area for the first time.

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

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

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

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director
Indian Health Service

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

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

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

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

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

In 1999, Dr. Grim was appointed as the Acting Director of the Oklahoma City Area Office, and in March 2000 he was selected as the Area Director. As Area Director, Dr. Grim managed a comprehensive program that provides health services to the largest IHS user population, more than 280,000 American Indians comprising 37 Tribes. The geographic area of responsibility covers the states of Oklahoma, Kansas, and portions of Texas. Health care is provided through direct care, contract care, or tribally operated facilities. He was also a member of the Indian Health Leadership Council, composed of IHS, tribal, and urban Indian health program representatives. The Council is a decision making body of the agency that examines health care policy issues.

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

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

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