

**HEALING IN INDIAN COUNTRY:  
ENSURING ACCESS TO QUALITY HEALTH CARE**

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**HEARING**  
BEFORE THE  
**COMMITTEE ON FINANCE**  
**UNITED STATES SENATE**  
ONE HUNDRED TWELFTH CONGRESS  
SECOND SESSION

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(CROW AGENCY, MT)

—————  
AUGUST 8, 2012  
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## HEALING IN INDIAN COUNTRY: ENSURING ACCESS TO QUALITY HEALTH CARE

WEDNESDAY, AUGUST 8, 2012

U.S. SENATE,  
COMMITTEE ON FINANCE,  
*Crow Agency, MT.*

The hearing was convened, pursuant to notice, at 11 a.m., in the Crow-Northern Cheyenne Hospital, Crow Agency, MT, Hon. Max Baucus (chairman of the committee) presiding.

Present: Democratic Staff: Kelly Whitener, Professional Staff; and Richard Litsey, Counsel and Senior Advisor for Indian Affairs.

The CHAIRMAN. The Senate Finance Committee field hearing at Crow Agency, MT will come to order.

This is a standard Finance Committee hearing. We have field hearings like this one on occasion, just trying to help, especially during some of the recess periods, to get around the country, hold hearings, and learn a lot more about what we should be doing and maybe not doing in Washington, DC. This is one of those hearings, so thank you very, very much for letting me attend.

I know that the surrounding wild fires are working pretty heavily in the hearts and minds of many of the folks here today. Some of you are probably victims, some of you are related to those who are victims and their families, and you are all in our thoughts and prayers.

I want to thank you before we begin, though, and just say that we have something more important before we begin, and that is the flag ceremony. So let me just stop here and hold the ceremony. Thank you.

[Whereupon, the flag ceremony commenced.]

Mr. JEFFERSON. Senator Baucus, staff, and all the guests, welcome to Crow Agency. Once again, if you will bear with me, I will say a prayer.

[Whereupon, Mr. Jefferson performed the invocation.]

### **OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. Thank you all very much for the flag ceremony and prayer; it was very appropriate. Thank you.

There is a Crow proverb that teaches us, "People's eyes can say words that the tongue cannot pronounce."

A hospital should be a place of healing and relief, but here at the Crow-Northern Cheyenne Hospital, far too many eyes tell a story of pain, frustration, and disappointment. Stories like the one I heard from a man who was denied his medication without any ex-

planation or alternative treatment—medication he needed to treat rheumatoid arthritis, a condition that, when left untreated, can lead to increased risk of heart attacks and even death.

After months of inquiries at the Indian Health Service, his family learned that the problem stemmed from a failure to communicate among the doctors, the hospital, and the pharmacist. The patient had done everything right and still could not get the medication the doctor prescribed. I know that this patient is not alone.

The American Indians and Alaskan Natives have a life expectancy that is about 5 years shorter than that of the general population. Access to quality health care can help the folks live longer, but it is increasingly difficult to provide this kind of care with shortages as high as 20 percent for IHS doctors and 15 percent for nurses and dentists.

And health is not just physical. Native Americans and Alaska Natives are more likely to die from alcohol-related diseases or commit suicide than any other racial group, and yet here, at this hospital, there are only three mental health providers.

The flooding last year led to evacuations, damaged more than 50 homes, and left people without clean water for months. The physical damage is apparent, but the psychological effects often go unrecognized.

Imagine being uprooted from your home, unsure when you will be able to return. When you turn to the hospital for help, you are told you are going to have to wait months to see a clinician, if at all. Imagine losing a child to suicide and being unable to get any professional help. Many of you do not have to use your imaginations at all. You have lived through it.

Many also know all too well that one in three American Indian women have been raped in their lifetimes, twice the national average. Each one of those numbers is a mother, a daughter, a sister, or a friend. That is why I fought hard to include language in the Violence Against Women Act, which passed the Senate but has not yet passed the House, to give tribes more power to prosecute sexual predators. I am hopeful that the House will act soon.

So, I was shocked to hear stories of staff at this very hospital refusing to conduct full sexual assault examinations or provide rape kits to victims. It is appalling enough to deny much-needed care to the victims who have already suffered severe trauma. And these refusals also make it harder to build evidence to prosecute those who perpetrated these crimes and prevent them from hurting more women in the future.

The problems are serious, they demand serious solutions, and that is why we are here today.

We made important progress when we passed the health reform law, known as The Affordable Care Act. That law also made the Indian Health Care Improvement Act permanent, which is a big win for tribal health care. The law gives the IHS the authority to expand tribal mental and behavioral health services. It provides financial incentives to help the tribes recruit and retain clinicians. American Indians will also have access to many other benefits in the law if they choose to purchase private insurance plans in the insurance exchanges. I would like to hear from any of you today as we continue to implement these programs.

Of course, none of what we have done, or hope to do, can be accomplished without sufficient resources. The administration requested about \$4 billion for the Indian Health Service in this last budget. That would be an increase of about \$116 million.

Third-party reimbursements and mandatory appropriations for the special Indian diabetes program bring the total to about \$5.5 billion. A significant chunk of that money will go toward Contract Health Services, otherwise known as referrals, that purchase care from outside providers when the IHS is unable to meet the patients' needs. In 2010, the funding shortfalls and insufficient resources led to nearly 220,000 denials for Contract Health Services. Every one of those denials means a patient goes without care, so this funding is needed.

Still, referrals do not help us provide higher quality care at reservation hospitals like this one. The Crow people and the Northern Cheyenne people deserve to be able to use this hospital that was built for them. Many want services here; they do not want to have to go someplace else to get them.

In 2010, the Centers for Medicare and Medicaid Services conducted a survey of this hospital and issued a 900-page plan. Many solutions lie in that plan, so we need to understand what is being done to implement the plan, and what more is needed.

This is not going to be easy. It is not going to happen overnight. But just as the eyes in this room tell a story of pain and disappointment, they also tell a story of determination and hope.

Each one of you is here because you care. You want to see a change, and you are part of the solution. There will be a sheet here distributed later where you can submit testimony on your way out, and I urge you to use it. The more people who participate, the better. Give us your ideas; they all are going to be read. You may agree with some things that somebody said, and you may disagree with something somebody said. I just urge you to take advantage of the situation and just say what you think.

Our goal is to begin a new era of providing not only affordable health care, but quality health care. Health care that can change the vicious cycles American Indians suffer from. So let us begin our journey today together, learn from what we hear, and think creatively. Like I said earlier, do not be afraid to throw out ideas; we are here to make things happen. It is not going to be easy, but we are here to make things happen. We have no alternative but to keep thinking positively, constructively, and moving forward, and that is what we are going to do.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Okay, let me begin. I am very honored to have Chairman Cedric Black Eagle, the Chairman of the Crow Nation, here today. Chairman Black Eagle and I have worked on many matters, water rights, et cetera, and others.

I just want to thank you, Chairman, for all you have done, and I would love to hear from you on this subject.

**STATEMENT OF HON. CEDRIC BLACK EAGLE,  
CHAIRMAN, CROW NATION, CROW AGENCY, MT**

Mr. BLACK EAGLE. Thank you. Thank you, Senator Baucus, in your position today as chairman. I will call you Chairman Baucus, and, members of the staff of the Senate Finance Committee, welcome to the Crow Reservation, as well the home of the Apsaalooke Nation, also known as the Crow Tribe of Indians. And we want to thank you for this opportunity to share the views and concerns of the Crow Nation on the Indian Health Service and the current state of health care on the Crow Indian Reservation.

We are here in the Crow-Northern Cheyenne Hospital. It is an impressive facility, and many good people work very hard here. We absolutely must acknowledge the staff who keep this hospital running and deal with many challenges due to insufficient funding and challenges of location in the rural reservation community.

The Crow people are entitled to receive medical care here and in other Indian Health Service facilities. It is our right as a treaty tribe to be healed within these walls. However, the healing should take place, as well as preventative care that has been compromised and elusive for many people of the tribes. The reality is that many tribal members are unable to obtain health care here because of inadequate staffing and programs and services that are no longer offered. There are many problems that require concern and consistent attention and work.

A CMS survey was recently conducted in September of 2010. The CMS conducted a survey on the Crow-Northern Cheyenne Hospital, and confirmed and documented what the Crow Tribe conveyed to Dr. Roubideaux in our initial meetings with her on August 25, 2010, both physical plant issues as well as internal management policies and accountability failures. Through the survey, CMS found and documented a number of significant shortcomings in the facility.

And, because you are chairman of the Finance Committee, we have budget issues that we are very concerned about. There are several items needed for the Crow Service Unit, which funding is currently not available within our budget, including an upgrade for the outdated phone system for the hospital and clinics—\$35,000 would be required to replace it. The hospital and clinics need approximately \$2 million in upgrades for medical equipment. We currently receive \$130,000 for medical equipment and replacement equipment, which barely makes a dent in the need. Replacing the existing dental operator records to digital, which would cost \$500,000, would enable the dental clinic to use EHR.

We currently have \$2.7 million in deficiencies for the hospital and clinics, which include various building deficiencies that need to be addressed.

The Indian Health Care Improvement Act, as permanently reauthorized through the Affordable Care Act, authorized the Indian Health Service to operate dialysis services; however, there is no funding provided for these programs. We currently transport our tribal members who receive dialysis 3 times a week to either Billings or Sheridan, distances averaging from 30 to 70 miles or more each way, over roads that are often nearly impassable during the harsh Montana winters. As you know, funding for dialysis on-site

at Crow Agency would improve the quality of life and long-term prognosis of these patients.

Emergency room services are basically unfunded. This puts an additional demand of approximately \$5 million on the Crow Service Unit budget. Because Crow is a Critical Access Hospital, meaning that the ER cannot turn anyone away for ER services, this is an additional burden on the budget that is already insufficient to meet the health needs of the Crow Tribe.

The Catastrophic Health Emergency Fund is another area where additional funds are needed. This fund provides for accidents and serious medical emergencies where the costs are unforeseeable. However, there are shortfalls each year which are then deducted from the Service Unit's budget. According to figures provided by the Billings area office, in fiscal year 2010, unfunded CHEF costs were \$135,000; in fiscal year 2011, the unfunded CHEF costs were \$1,033,462; and in fiscal year 2012, the unfunded costs to date have been \$319,000.

Population increases place higher demand on services and providers that are available. The facility needs repair and upgrades as it ages. The Service Unit has consistently operated on a shortfall of around \$2 million each year, which is then made up from the following year's 3rd-party collections.

Community concerns. The community members bring a wide variety of issues, and some you have already mentioned, but one of the most consistent issues is the perception that the providers do not listen, and do not treat them with respect. A communication barrier may exist because of cultural differences. This can be alleviated with appropriate training, which the Crow Tribe can and has begun to assist with. However, there may be deeper-seated issues than simple lack of cultural sensitivity. When multiple patients consistently are not given routine tests and screenings, are repeatedly sent home with aspirin or ibuprofen, and finally go to off-reservation facilities to be admitted immediately and treated for life-threatening conditions within hours after being sent home from the Crow Hospital, something is wrong. There is more than a simple breakdown in communication.

There is also concern about the continued closure of the OB delivery services. We have a hospital. Crow people should be able to give birth on their own reservation. The limitation of inpatient services is also an ongoing concern. We should have the hospital up and running and fully staffed so tribal members can receive treatment here rather than being sent off reservation, which is time-consuming and financially difficult for many families.

In conclusion, in short, there is much work to be done, but there are good foundations that can be built on to bring quality patient care back to the Crow people.

And I also want to say that, you know we generally want to hear good things, and there are a lot of good things to report back in terms of how the hospital has been improving from, let us say, a year ago. And so the consistency of health care and the improvements that we have been seeing, there is still a ways to go, but I can say that improvements are beginning, and we would like to assist from the tribal side, as much as we can, to do all we can to

help this hospital continue to bring back the programs that were here before. Thank you.

[The prepared statement of Mr. Black Eagle appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Chairman, very much. And now we will hear from Henry Pretty On Top, Cabinet Head for Crow Agency Health and Human Services. Henry, go ahead.

**STATEMENT OF HENRY PRETTY ON TOP, CABINET HEAD,  
CROW AGENCY HEALTH AND HUMAN SERVICES, CROW  
AGENCY, MT**

Mr. PRETTY ON TOP. Good morning. It is still morning here in Montana.

The CHAIRMAN. Yes it is.

Mr. PRETTY ON TOP. I want to extend my personal welcome to you, Senator Baucus, and members of your staff and entourage, and welcome back to Montana. But more specifically, welcome to Crow country, which we believe is the best place on earth.

The CHAIRMAN. Nobody is going to dispute that.

Mr. PRETTY ON TOP. Okay, I am glad you agree.

The CHAIRMAN. Well, there may be others in other parts of Montana who might not agree, but it is all great.

Mr. PRETTY ON TOP. But we are from Montana.

The CHAIRMAN. Right.

Mr. PRETTY ON TOP. So that is all that matters right now.

The CHAIRMAN. Right.

Mr. PRETTY ON TOP. You have my written testimony on record, and in my comments I will make reference to notes and to consultations that I have had with the Chairman and also with the legal department. I believe I can be much more effective if I speak from experience and being in the trenches with people.

I want to first off say that I and we, the Crow people, appreciate the fact that we have this facility, in view of the ongoing difficulties in health care nationwide, and even worldwide. And I want to go on record as saying that we are extremely fortunate to have a facility such as this.

I am a former employee of IHS. We moved in here in 1995; construction began on this building in the early '90s. And you had to have seen the old hospital, which is the tribal building right now. Compared to this facility, it is just a world of difference, day and night.

As with any organism or any life being, we go through an evolutionary process, experience a lot of difficulties, changes. So it is with this organization also.

I was a social worker, I still am; I consider myself a social worker. I worked for this hospital, and I worked over at Lame Deer, and then I retired 3 years ago. And the Honorable Chairman offered me a position with the Tribal Health Department, and I said, well, hell, I will do it. And I did it, not out of a sense of idealism, but a sense of reality. I felt that I could be a strong advocate, a strong voice for my people, the Crow people.

I began that process of advocating for Crow people, and I do it daily. And even if I were not in this capacity that I am now in as the tribal representative, I would still do it, and I still intend to

do it. Somebody has to speak for the people, and I will do that. Even if they have to drag me off, I guess. But it is that important to me, health care.

In the 3 years that I have been with the Health Department as Health and Human Services Cabinet Head—I know that is an awesome-sounding title, and I am a little bit self-conscious about that title, but it is just my social roots; I speak for the people.

Our work and our performance has been predicated on Dr. Yvette Roubideaux's stated philosophies, and I would like to reiterate them right now. She came on board pretty much about the same time that I did, maybe a little bit earlier than myself. But our department has taken to heart and to soul and into mind what Dr. Roubideaux said. We take those words to mean that she means what she said.

Her goals, her statements were, number one, to renew and strengthen our partnership with tribes; to reform the Indian Health Service; to improve the quality of and access to care; and, finally, to make all other work accountable, transparent, fair, and inclusive. Those are, in my mind, in my estimation, powerful, actionable, attainable statements and goals.

So consequently we, the Tribal Health Department, have operated on those premises. And to this point, I personally deeply appreciate your personal attention to the Crow Reservation, the Crow people, to conduct this hearing in this facility on Crow land.

Reference has already been made to some of the issues: CMS, funding. If I were to elaborate on some of those points, it would be repetitious and time-consuming. But plain and simple, we need money, we need funds. And, as you listen to us and as you devise strategy getting back to Washington, we want to be an integral part of that process. We want to be partners, as Dr. Roubideaux intends, and we want to help reform IHS. It is a system, unfortunately, in disrepair. And I do not say that with any animosity; I say that with all reality. As we help repair the organization, we hope and we intend to improve the quality of health care and access, our access to health care. You know, being an old-timer like yourself, age just wears away the strength. I am in that position right now. I require not constant care, but, you know, I am not young anymore.

The CHAIRMAN. You look very young.

Mr. PRETTY ON TOP. Thank you. And that is one of the reasons I say that I appreciate the fact that we have this facility, and we do have dedicated, committed health care providers.

But, as with any organization, as I mentioned, there are problems and difficulties. And we have to pay attention to that. Give us more money.

To give you a specific example, we need an ambulance service that is based out of this facility. It used to be that we had that ambulance service here. Now, directly connected to the current situation, you mentioned Contract Health Services funding earlier. The current ambulance service that we have is based out of Hardin, and that situation has ramifications of all that we are saying today.

The bulk, the huge majority of money for that ambulance service comes out of Contract Health Services money that was budgeted

for this facility. Unfortunately, when that contract was negotiated, the tribe had absolutely no input into that contract. This is another instance of somebody deciding for me what I need, somebody deciding or determining that they know more about what I need than I know myself.

In any case, one of our plans eventually is to bring the ambulance service back, and it is doable. We will do it. But right now that chunk of money that was intended for patient care is taken out of here, and it is operating out of Hardin. Not only that, but the current ambulance service serves all people, non-Indians as well. Again, I do want to repeat for the record that my understanding, my knowledge, is that that money was budgeted for Contract Health Services for this service unit.

Other issues have been mentioned quickly, and I do not want to take up a lot of time, but—

The CHAIRMAN. Go ahead, say what you think.

Mr. PRETTY ON TOP. All right.

The CHAIRMAN. That is why we are here.

Mr. PRETTY ON TOP. I am concerned that you might be on a schedule to get back to DC.

The CHAIRMAN. Do not worry about it; no, no, I am home.

Mr. PRETTY ON TOP. Good, stay home.

The CHAIRMAN. You bet.

Mr. PRETTY ON TOP. For a while.

The CHAIRMAN. You got that right.

Mr. PRETTY ON TOP. How long have you been in DC?

The CHAIRMAN. You mean how long have I had this job?

Mr. PRETTY ON TOP. Yes.

The CHAIRMAN. A good number of years.

Mr. PRETTY ON TOP. Get back here while you can still do a lot of things physically, enjoy the mountains, enjoy the country.

The CHAIRMAN. I will. The day before yesterday I hiked, not here, I hiked Glacier Park. And 2 days before that I hiked up in—what mountain range is it that I tried? Well, I tried to climb a mountain called Mount Wilson, but I am getting a little older and did not quite make it. It is outside of Big Sky.

Mr. PRETTY ON TOP. Well, if you can still do some of those things, do it. Get back here more often than—sometimes I question what goes on in DC, you know?

The CHAIRMAN. I get home around every other weekend.

Mr. PRETTY ON TOP. That is good.

Anyway, going on. A mention was made of the behavioral health services, and that is a topic near and dear to my heart, because that is my profession. And I do not do it anymore, none of the clinical stuff anymore, but people still come approach me and ask me if they can see me. And I say, well, you know, it is not like it used to be, because I do not do that stuff anymore; I should not say “stuff.”

But it was not work to me, it was something that I needed to give back. And that is not idealistic. A lot of us who grew up and lived on the reservation, we went through a lot of difficult times. And what I did not know and what I did not experience—I try to help young people with opportunities.

When I was in that field, Mr. Jefferson and myself, our Vice Chairman, also a licensed professional, we used to work in the same department, so he knows of what I speak.

But we do need money; we do need additional funding. There was a time when the department here had six full-time mental health professionals, three clinical social workers, and three psychologists. Now it is down to three. Those three people are expected to serve the entire geographic area of the Crow Reservation, about 8,000, 9,000 people. And we have two outlying clinics, and I do not know what the coverage is right now for the behavioral health, the problems of domestic violence, drug and alcohol abuse behavior, school behavior, young people, the current prevalence of obesity.

All of these problems, some I probably have not mentioned, all afflict the Crow Tribe. So we do need money, funding, for additional mental health professionals.

That brings to mind—I do want to share this with you—getting to the accounting practice methods of IHS. Several years ago when I was still working in this department, we were at full staff. One of our psychologists left for a different job. And it was fully budgeted for six people plus the medical clerk. I said, good, we can hire somebody else; we can hire another worker. So we got the process started, and about a month later we were notified by the area office, you guys are in the hole, in the red in terms of personnel. And I said, how can that be? We are budgeted for those full time. No, you are—I think at the time he said, you are \$45,000 in the red for that particular personnel. And I asked, and to this day I have never gotten a reasonable response, why we can be fully budgeted, somebody leaves, and we can be in the red. But I guess that is not for me to question. I guess it is, it really is.

But a couple of the major afflictions, health conditions, diabetes—the special diabetes program for Indians is coming up for renewal. We need your help in pushing that, renewing it, because diabetes is running rampant in Indian country. It used to be much more so down in the southwest, but now it is afflicting us too. So that particular initiative, we ask, we request that you promote, push, finagle, whatever, to keep that alive, to re-fund it, and to keep it going.

OB, you know, that is costing a lot of money. We want that facility, that department opened up again. We have been meeting—I do not want to paint a negative picture; I will dwell on the positive components that are going on right now. As Mr. Chairman Black Eagle alluded to, there has been some significant progress made. Namely in hiring Mr. Old Elk—Clayton Old Elk is currently the chief executive officer of the hospital here. And he brings to us, and he brought to us, long experience in IHS and administration. So that has been an accomplishment that we have fought for, advocated for, and now we have one of our own who is administrator of this hospital. And the administrative officer position right now is being handled by the Chairman's son who is detailed with us. That is an accomplishment. But it is a beginning. It is only a beginning.

I would like to also share with you one situation. You know, in our pharmacy department, there is a qualified pro individual for the pharmacy supervisor position, and for whatever reason, this

and that, I do not know the ins and outs of it, the details, but that person has been passed over twice, I believe, Heather, is it?

Ms. WHITE MAN RUNS HIM. Yes.

Mr. PRETTY ON TOP. Yes, that needs to be looked at, you know. This is one of our own who has the credentials, who has the experience, and, for whatever reason, she is not hired. But this is a movement that eventually in the future I would like to see, God willing, if I live long enough, to see Crow M.D.s on staff here. This is one of the initiatives that I am pushing, establishing educational curriculum for college.

The CHAIRMAN. There is none now?

Mr. PRETTY ON TOP. None here, but that is something that we would like to put in place and have the young people pick up.

The CHAIRMAN. Okay, I appreciate that.

Mr. PRETTY ON TOP. Okay.

The CHAIRMAN. Thank you.

Mr. PRETTY ON TOP. All right. I have taken up a lot of time, but again I—

The CHAIRMAN. It is very important; I learned a lot. Thank you.

Mr. PRETTY ON TOP. Yes. What else? Staff shortages; that seems to be a chronic difficulty here. We need to devise an approach to deal with that. Mr. Chairman alluded to that earlier too.

Cultural sensitivity. We are human beings, the Crow people. We experience the same emotions, the same likes and dislikes, we are afflicted by absolutely everything medical and social and emotional and spiritual just as everybody else. We are no different. And I know that, a lot of times, non-Indians come here probably with preconceived notions. I am not being judgmental—that is a fact, that is real. You know, we need to put into place a mechanism that attracts professionals and that will retain professionals here.

We as Crow people are very hospitable. Our doors are open. But we are—we do welcome non-Crows, you know, but they need to take the time, and I guess we need to do something to let them know that, hey, come get to know me. But we have to devise something that will retain M.D.s, nurses, those who want to be here and who will stay here.

You know, in my long experience here and over in Lame Deer, it was really interesting, working with Crow people, and over in Northern Cheyenne when I worked there. I lived there for 5 years, lived in the community. And, after about a couple years, I was working with a man, and he came into my office, and he said, “Hey, I want to ask you something before we even get started.” “Sure, if I can answer it, I will.” He says, “How long are you going to stay?” He said, “First of all, why are you, Crow, coming over here and helping Cheyennes?” I said, “Well, you know, number one, I have to be someplace, and number two, this is what I want to do.” And I said, “I will go anywhere that people will take me.”

And his second question was, “How long are you going to stay?” I said, “I do not know; I do not have a time limit. I have not set a time limit.” And I asked him, “Why do you ask me that?” And he said, “You know, one of our problems here,” he said, “people like yourself and non-Indians have come here, we trust and respect and accept certain people, non-Indians, you know, because we like them, and then they pick up and leave.” And he said that really

makes a difference. And I said, "I cannot tell you when I will leave." But that has stuck with me. The same thing occurs here too.

The CHAIRMAN. I know.

Mr. PRETTY ON TOP. So that is an area that, with additional funding, with money, we can create, again, a mechanism to retain individuals committed to people; you know, make it attractive here, add to their enthusiasm, add to their desire to be here.

But I know that Mr. McSwain is chomping at the bit here.

The CHAIRMAN. I am waiting to hear from him too, but thanks. I do appreciate it.

Mr. PRETTY ON TOP. But I will conclude and say, I do appreciate you being here, and your staff being here. And we are meeting with Mr. Old Elk regularly, which I say again, is a positive. We are also meeting with Area Director Conway on a monthly basis to talk about issues, topics, initiatives, and whatnot; we are doing that consistently and regularly.

But there is still a lot to be done. And, as you push for a lot of money for us, we will do a lot more. Sad to say, but, you know, money talks, and that is the reality of the world.

The CHAIRMAN. Yes it is.

Mr. PRETTY ON TOP. Thank you very much.

The CHAIRMAN. Okay, thanks very much.

Mr. PRETTY ON TOP. Thank you.

[The prepared statement of Mr. Pretty On Top appears in the appendix.]

The CHAIRMAN. Now we will hear from Bob McSwain, Deputy Director for Management Operations for the Indian Health Service. And, Mr. McSwain, thanks so much for being here.

**STATEMENT OF ROBERT G. McSWAIN, M.P.A., DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS, INDIAN HEALTH SERVICE, ROCKVILLE, MD**

Mr. McSWAIN. You are welcome.

Thank you, Mr. Chairman and members of the committee, certainly tribal leaders Chairman Black Eagle and Cabinet Head Pretty On Top.

First of all, I am pleased and honored to be here, quite frankly, and to have the opportunity to testify before the Senate Finance Committee on operations of the Crow-Northern Cheyenne IHS Hospital.

I had the fortunate opportunity to actually walk through the facility and spend an hour or so with Mr. Old Elk and Mr. Conway and Diane Wetsit. What I found is everything that my predecessors here have said, and that is that the staff are really committed. They are doing multiple jobs. They are working hard, they are committed to the community, they are committed to the patients, and some of the numbers that they are sharing with me is something that I will certainly talk with Mr. Conway and Mr. Old Elk about.

I am going to summarize my statement; I am not going to go into my talking points on it, because I think the most important thing to talk about is the fact that Mr. Old Elk, since he has arrived, what, 4½ months ago, has really begun to turn around the very essence of what we are talking about, which is staffing. And the

way you turn that around is with leadership; you turn that around with leadership at the very key levels.

I will state for the record that, for example, he has hired certainly a clinical director, he has hired a director of nursing, and a business office manager. The business office manager is so crucial because, as we know, collections and reimbursements are the lifeblood for Indian Health Service systems across the country. In fact that, in many cases, really keeps the program afloat. And I want to say that that was a great set of priorities that the new CEO has engaged in.

He is also considering positions for an administrative officer, a very critical position, and the chief financial officer position. The jobs are closed—I mean the idea is that we are filling in a complete team that he will lead. And the selection that I was struck by was the pharmacy office, and the fact that a selection has been made—the person is going to report the 1st of October, and you will begin to, again, have leadership in those particular components that can be available to provide the recruitment and actually work on filling the vacancies.

There are a number of vacancies, and there are certainly challenges to that effect. And I will say that the Northern Plains Human Resources—and for purposes of everyone's information, we have broken the country up into five regions across Indian Health Service, and the northern plains region is comprised of Billings, Aberdeen, and Bemidji. And it just so happens that the Director of the northern plains regional center is actually in Billings and working very closely with Mr. Conway, and of course Mr. Old Elk and all of the other folks in the Billings area, to reduce the numbers.

I will say that our target that the Director has been watching has reduced the hiring time to 80 days per the OPM guidelines. Actually, Billings has reduced it to 60 days. Now what that means is, obviously, we are getting people hired faster, but now we have to make sure that the quality of people we bring on is equally to the point. And as was mentioned earlier, he has established monthly meetings with the two tribes and the respective tribal health officials, a weekly governing body meeting. So there is a lot of communication, there is a lot of accountability that is being built in, as we move forward. And the action plan that has been put in place actually begins to lay a template for further improvements.

And clearly, you know, we certainly have an Area Director, and I just want to say publically that Mr. Conway was due to retire in March, I think it was March or February, but the idea was, he decided that, when Mr. Old Elk came on board, he would stay here until Mr. Old Elk was actually in place and able to be supported and beginning to get those other positions filled. And I envy Mr. Conway retiring, because I probably could have retired a few years ago myself. But the fact is that he is committed to doing this to make sure that the response to the Crow-Northern Cheyenne Hospital is made.

And of course the whole notion of the governing body is crucial to any health system, and that is where we are at. Effective collaboration between IHS and the two tribes, as Mr. Pretty On Top talked about, is Dr. Roubideaux's number-one priority, to increase

the effectiveness of the tribal IHS partnership. And it is crucial to ensuring that the shared goals are met. We are grateful for the commitment the Crow Nation and the Northern Cheyenne Tribe have made to focus on the challenges facing the Billings area. And we look forward to solutions, and I see them actually coming very quickly. And we will continue to make improvements, with a core being staffing.

And this is not unusual to the Crow. We have this across Indian Health Service; we are struggling. Where we operate is in rural areas and where people are turned out of medical schools, and professionals schools tend to want to work in urban centers. We want them out here, and so we are using as many of those incentives to get people moving along. And I believe that, even with the progress we have made thus far, there is no question that we have a long way to go. We have some additional challenges, but I feel very confident that Mr. Old Elk, in his position, and the staff and team he is putting together, will enable that to parlay into filling those vacancies in the native areas.

I cannot leave my opening remarks until I say that the numbers were just really striking for me, the numbers of ER visits. Because of the situation of the Crow-Northern Cheyenne Hospital, the fact is that last year they saw 240 patients in ER. The average for any other hospital in the region is 5 per month. So they are operating at about 20 a month. And so you can see its value to the people it serves, but also, because they are people who—maybe it is an accident out on the highway, so the first place they come for care is here. And so I offer that as another striking example of how critical this particular facility is for this part of the region.

With that, Mr. Chairman, thank you for your long-standing commitment on behalf of Dr. Roubideaux, your commitment to improve Indian health in the Billings area and throughout the Indian Health Service, and finally for the opportunity to testify. Thank you.

The CHAIRMAN. Thank you, Mr. McSwain.

[The prepared statement of Mr. McSwain appears in the appendix.]

The CHAIRMAN. I have to ask the three of you some questions. And I would urge the audience to, as I said earlier, thinking about it, submit some ideas later on.

I am also going to be asking those in the audience who want to stand up and speak to do so. Say anything that is on your mind. You may agree with something that is said, you may disagree with something that is said, but I am going to try to be as effective as I can, but it may be a bit unorthodox in how we do all this; I will just do my best.

Okay. To me it comes down to, it just seems anyway, that there are certain basic services that can be performed here that perhaps cannot be performed elsewhere. Let us just take some specialty services like some very special neurosurgery that is not expected to be here, I am guessing, and probably a place like Billings or someplace else. But there is a lot that can and should be here, a lot that can and should be done. So I would like you, and others who want to, to speak up.

Mr. Old Elk, right, you are the CEO? You are the top guy here. If anybody wants to, chime in here. So I am going to ask—the first question is going to be, what kinds of services should be provided here at this hospital that perhaps cannot be provided, or should be provided but you do not have the resources, what specialty services? What are the basics that should be provided here? What good health care should be provided here? Let us just go down the list. Anybody.

Mr. MCSWAIN. First of all, it is a hospital, so you have to be able to provide care for inpatient.

The CHAIRMAN. What kind of care?

Mr. MCSWAIN. Basic hospital inpatient care. And surgery, obviously, is critical.

The CHAIRMAN. There is no surgery here now?

Mr. MCSWAIN. I do not believe so, there is some light surgery, but it is—

AUDIENCE SPEAKER. Outpatient.

Mr. MCSWAIN. There is outpatient surgery, but if you have to have the patient recover—

The CHAIRMAN. I know, but why is there no inpatient surgery here?

Mr. MCSWAIN. You do outpatient surgery.

The CHAIRMAN. I know, but I am talking about inpatient. Why no inpatient surgery?

AUDIENCE SPEAKER. Because of the cost.

The CHAIRMAN. Cost?

Mr. MCSWAIN. Yes, cost.

The CHAIRMAN. Because you just cannot afford it, is that the reason? Stand up if you want.

AUDIENCE SPEAKER. Yes.

The CHAIRMAN. Okay. Any other services?

Mr. BLACK EAGLE. I guess we talked about it earlier, and because of the dramatic increase in our population, there are 13,000—over 13,000 Crows, and approximately 8,000 of those Crows live on the Crow Reservation. And the influx that this hospital receives is quite a bit.

And of that population, there is a high rate of diabetes that occurs. And so aside from, you know, the in-service/out-service surgeries that should be required, the dialysis program should be provided here. Even a mobile dialysis would be beneficial—

The CHAIRMAN. Right.

Mr. BLACK EAGLE [continuing]. Because a lot of our elder people are still at home, and they have to drive miles to get here—

The CHAIRMAN. Right, we talked about that earlier.

Mr. BLACK EAGLE [continuing]. Or even to get to Sheridan.

The CHAIRMAN. Right, right.

Mr. BLACK EAGLE. So that is one.

The CHAIRMAN. Can appendectomies be performed here? If someone has appendicitis and has to have their appendix taken out?

Mr. BLACK EAGLE. No.

The CHAIRMAN. No appendectomy? No gallbladder removal? No general surgery?

Mr. PRETTY ON TOP. Senator, I really wanted to—at one point I forgot to mention dialysis; Chairman Black Eagle had brought that up. We used to have that service here.

The CHAIRMAN. Dialysis?

Mr. PRETTY ON TOP. Yes.

The CHAIRMAN. Right.

Mr. PRETTY ON TOP. And with the increasing number of patients, I just wanted to say, the request that we have been hearing over and over from the community is, please bring that program back and operate it out of here. And I do not know the particulars and details about the Health Care Improvement Act, but I understand that dialysis is addressed in that, and that perhaps now IHS can contribute in some way monetarily or resource-wise or whatever; but we do need to bring that service back.

The CHAIRMAN. Yes.

Mr. PRETTY ON TOP. That is something we want back here.

The CHAIRMAN. That is a good act, and it goes back to earlier points you mentioned. It is money, it is dollars. If that is basically an authorization for lots of great services, it should be available, but it just comes back to dollars.

What about OB–GYN care and delivery of babies here? I am sure you would like to get that back, too.

Mr. MCSWAIN. Well, that is huge. I think the staffing is—you have two docs now. You need four.

Mr. OLD ELK. Two.

Mr. MCSWAIN. So it becomes a staffing issue as to how much you actually take on. But OB is clearly needed, because otherwise they are having to travel great distances for the care.

The CHAIRMAN. How long ago was there OB care here?

Ms. WHITE MAN RUNS HIM. Before the flood.

The CHAIRMAN. Sorry?

Ms. WHITE MAN RUNS HIM. Before the flood.

The CHAIRMAN. Before?

Ms. WHITE MAN RUNS HIM. Before the flood.

Mr. OLD ELK. May of 2011 when we had the flood and had to close it down, but now we are talking about October 1st to open it up again.

The CHAIRMAN. So you are looking to reopen it October 1st. That is good.

Mr. OLD ELK. Yes.

The CHAIRMAN. And you have the doctors to open it up?

Mr. OLD ELK. Yes.

The CHAIRMAN. That CMS study—some of you just addressed what parts of that you think are accurate and some of their complaints and what is not accurate. And help me start to address the parts that are accurate versus the ones that might not be accurate.

Who wants to take a crack at that?

Mr. PRETTY ON TOP. Can I quickly just lead into that?

The CHAIRMAN. Yes.

Mr. PRETTY ON TOP. And I will just leave it up to people with more knowledge about that.

The CMS survey, there was a big scare back when it came out. Word spread that the hospital was going to close down; people were very concerned about that. And then the tribe, our knowledge, our

information was that IHS came up with a corrective action plan which was accepted by CMS in DC. And, what, that is going on 2 years now, and we still do not know what the office in Washington, DC is going to do. So that is where we are as a tribe. Correct, Heather?

Ms. WHITE MAN RUNS HIM. Yes.

The CHAIRMAN. Yes, that is a good question. Where is that action at?

Mr. MCSWAIN. I would expect that Mr. Old Elk could answer that.

The CHAIRMAN. But I understand it is something IHS is addressing.

Mr. MCSWAIN. Right.

The CHAIRMAN. The CMS survey.

Mr. MCSWAIN. We have a plan that was actually an action plan that was submitted to CMS. And, if you know CMS, if it is not acceptable, they will take actions. They will take actions such as removing your conditions of participation, which means you cannot bill Medicare. That has not occurred.

So they have accepted the plan. And moving forward—

The CHAIRMAN. Who has accepted the plan?

Mr. MCSWAIN. The CMS, the Centers for Medicare and Medicaid Services.

The CHAIRMAN. The IHS plan?

Mr. MCSWAIN. Yes. They have come out, done the survey, and then we have submitted an action plan, just as we are always asked to do.

And it is when they accept the action plan that, if we complete those actions, then we have addressed their findings.

The CHAIRMAN. At what stage are you in on that?

Mr. JEFFERSON. We are in the second year.

Mr. MCSWAIN. The second year, but I mean, how far down the list are we?

Mr. JEFFERSON. The plan of correction addressing the deficiencies—

The CHAIRMAN. Okay. Let us go through the main deficiencies. What are they that are being addressed?

Do you want to come up too and get a microphone up here? You seem to be the guy who has some of the answers. Thank you.

Mr. OLD ELK. The CMS identified a number of deficiencies for the “conditions of participation” is what it is called; some of those things that are outlined. And there are many, many things that are provided in there, such as the quality of services that are provided here, and the equipment that we use at the facility—how all of these pieces of equipment are used, how they are maintained, if they are sanitary. Basically things like that: housekeeping and sanitation and infection control. There are many, many things that they have listed on there.

I have only been here 4 months. I am not really familiar with the report itself, but I know the area has made significant progress in addressing these deficiencies that are outlined and identified. And we have a plan of correction for each of these deficiencies that we are addressing. It is an ongoing thing. We have our area sup-

porting us 100 percent, and they have monthly conference calls with CMS.

The CHAIRMAN. Right. Number one, one of them is equipment, sanitary requirements for equipment that need to be addressed. Am I correct in understanding that that is one of the deficiencies that was suggested?

I am trying to get a sense of what two or three or four of the basic deficiencies are so we can then start working on them. So the first one was sanitary equipment? Was that it?

Mr. OLD ELK. Well, I am just outlining the type of things that they look for.

The CHAIRMAN. Yes.

Mr. OLD ELK. And I mentioned equipment, because we make do with what we have.

The CHAIRMAN. Right.

Mr. OLD ELK. And sometimes we do not have the equipment, so we do without.

The CHAIRMAN. Right.

Mr. OLD ELK. And the equipment that we have needs to be up to standards; state-of-the-art, if you will.

The CHAIRMAN. But one is inadequate equipment. Is that one of the deficiencies?

Mr. OLD ELK. What?

The CHAIRMAN. Inadequate equipment or insufficient or improper equipment?

Mr. OLD ELK. I would say it is outdated.

The CHAIRMAN. Outdated equipment. Okay, that is one. What else? What other deficiencies?

Mr. OLD ELK. They have 90 pages of deficiencies that are listed—

The CHAIRMAN. Right.

Mr. OLD ELK. I think 97.

The CHAIRMAN. Yes.

Mr. MCSWAIN. Fundamentally, Mr. Chairman, it is by staffing, and it is by staffing by department. And so, if you are not meeting the staffing levels to do the necessary quality of care, quality care checks, and the protocols that you are necessarily going through, a lot of it has to do with governing boards, and governing boards follow up on activities. So it is the oversight, it is the documentation. If they see documentation lacking, there may be in-service training requirements for providers.

These are consistent findings that we found across all the CMS folks, and they use this rubric called “conditions of participation” that sets criteria as to how you are staffed, how you are providing care, how you are documenting the care, and what are the outcomes; not just medical errors, but prescription errors. So there are a lot of these criteria that they are looking at.

I do not have the actual report, but I know that it did occur, and it did occur not just in Crow, but several facilities across the northern plains.

The CHAIRMAN. Right.

Mr. MCSWAIN. And every one of them addressed the deficiencies.

The CHAIRMAN. Right. But the CMS report was for all Indian country, or is it—

Mr. MCSWAIN. No, they just do it by facility.

The CHAIRMAN. By facility.

Mr. MCSWAIN. Yes.

The CHAIRMAN. Okay. Well obviously, the thing that makes sense, to me anyway, is to try to figure out what the major issues are and just identify them and then figure out how to address them. And, in figuring out how to address them, there have to be some standards or some benchmarks, some follow-up, some way of knowing the degree to which we are actually addressing them. Like one very minor issue is turnover. As I understand, there have been ten CEOs in 10 years. Well, if it turns out there is one CEO in 10 years, that is progress. The same thing in staffing; if there is less turnover in staffing, that is progress. We need to put numbers next to it. Let us say, this number of docs here, and see how many more docs are here in a year or two. Let us find out in a year or two from now, are there more docs or not? Is there a dialysis center here? Let us find out in a year or two. Is there an OB-GYN? Can you deliver babies here or not? I mean, it just seems to me there are a lot of categories that are not so little that you can look at to measure the progress. You said, follow up a year from now and see where we are.

Everybody is trying to help everybody out here, believe me. It is a mutual effort to try to get better health care for Crow people and Northern Cheyenne people. That is what this is really all about. And I know a lot of it is resources, believe me, I know that, and we struggle back there to get more resources. And I do not want to get too far down this road, but there are some people back there who just do not want to spend many dollars on Indian health care. I do not want to name them, but they are there. And it kind of depends who gets elected back there as to whether resources are going to be provided or not. I mentioned the President suggested \$116 million in addition, but that has to get enacted by Congress. And with some of the people back there in Washington these days, it is kind of hard to get some of that.

So we just have to deal with that and try to persuade them to appropriate, try to get the right people elected in the first place, and try to deal with what we have, given the dollars that we do have. There are lots of ways to skin a cat. There are ways to get dollars from here, dollars from there, and maybe a doc here, I am just—I really need to know what the major problems are. I guess the deficiencies are in the CMS report. And the second thing is, what your thoughts are on how we start to address those problems, and I will do my best to try to help out.

So equipment, that is one; turnover, that is another. Is that correct?

Mr. OLD ELK. Yes.

The CHAIRMAN. And I will ask you the same question Henry Pretty On Top was asked: tell us how long you plan to stay.

Mr. OLD ELK. Well, I am from here, so I am here to stay forever, for good.

The CHAIRMAN. So you plan to stay a while?

Mr. OLD ELK. That is right.

The CHAIRMAN. That is good to hear.

Mr. MCSWAIN. Mr. Chairman, while you are thinking about that question, what occurs to me, what I discovered is that the staffing is so critical because it does two things: one, if you can increase staffing, you can increase billing, and billing then produces another form of revenue stream, not just appropriations, but billing and collecting.

The other thing that is happening is—certainly on the CMS survey—what happens with us is that, in this particular facility, when we try to operate an ER, we will steal people from the hospital itself to staff the ER. And then along comes CMS and says, are those folks adequately trained to do 24/7 ER? And the answer is “no.”

So it is a matter of getting staff on board so you can have actually specialized trained trauma docs as opposed to taking a family practice doc out who might have delivered a baby that afternoon to pull duty at night in the ER. That is the challenge; if you can get staffing up with qualified staffing by department, you can actually begin to see a different revenue stream. But that is happening right now, and it is how Mr. Old Elk is building his business plan as he goes forward.

The CHAIRMAN. Sure.

Mr. PRETTY ON TOP. Mr. Chairman, really quickly.

The CHAIRMAN. Yes.

Mr. PRETTY ON TOP. I apologize for butting in, but I take this opportunity seriously.

The CMS issue is an area where we can put into practice what Dr. Roubideaux says about partnership.

We want to be a part of the solution. We want to help. Tell us about the CMS survey, where we are, what they are saying. The tribe can help. We want to help. We do not want to be at each other's throats with IHS. Staffing, hiring, we want to be a part of that process here in the hospital. You know, we are the people IHS is serving. I am a customer of you guys.

The CHAIRMAN. Yes, if you want to sit down, let us get together and work this out.

Mr. PRETTY ON TOP. Yes. But you talk about the partnership, let us sit down and do it instead of just talking about it.

The CHAIRMAN. Okay. Where would you like to see more partnership?

Mr. PRETTY ON TOP. Everything.

The CHAIRMAN. Give us one example, one or two.

Mr. PRETTY ON TOP. Staffing, hiring. We want to be a part of the process, and we want our voices to be heard.

I will give you an example of what happened a while back. The AO position several years ago, Mr. Vice Chairman and myself were part of the interview process. I think the CEO for the tribe, Mr. Half, was part of the interview process.

We interviewed along with IHS representatives, and we kept everybody informed. We interviewed, what, about four or five people, didn't we, Calvin?

Mr. JEFFERSON. Yes.

Mr. PRETTY ON TOP. And it boiled down to three who showed up personally. And we, the group, the committee, came up with one recommendation, and we thought it was the unanimous decision,

the unanimous choice for one individual, one Crow man, and that was the tribe's recommendation.

The CHAIRMAN. Right.

Mr. PRETTY ON TOP. And the next day we found out that they hired somebody else.

The CHAIRMAN. IHS did?

Mr. PRETTY ON TOP. Right.

The CHAIRMAN. And did they tell you why?

Mr. PRETTY ON TOP. I would still like to know why.

Mr. MCSWAIN. I did not sign the cert; no, I defer to—

The CHAIRMAN. Well, but this is an important question.

Mr. MCSWAIN. This is an important point.

If you are going to involve tribal leaders in the selection process, you should give them feedback—

The CHAIRMAN. Yes.

Mr. MCSWAIN [continuing]. As to why you make the decisions.

The CHAIRMAN. Sure. And did you ask him why?

Mr. PRETTY ON TOP. We did, but unless somebody got a sufficient answer, I never got it. Calvin, did you?

Mr. JEFFERSON. Never.

Mr. PRETTY ON TOP. Oliver, did you get an answer?

Mr. HALF. No.

Mr. PRETTY ON TOP. Heather, did you get an answer?

Ms. WHITE MAN RUNS HIM. No. What we were told is, it was just a formality to include the tribe in the processes, and we were pretty upset when we—

The CHAIRMAN. They basically were telling you it was not real?

Ms. WHITE MAN RUNS HIM. We did not have any decision-making power, that is right.

The CHAIRMAN. Well, what about other positions or other similar instances? Are there other instances where you, the tribe, have made the determination or would like to make the decision, but were overruled by IHS or dictated—I can maybe get a better word—or told by IHS what the decision is going to be after you really were consulted? Are there other areas?

Mr. PRETTY ON TOP. I think this really was the first and only time that we actually participated in that process. And we do not pretend to say that we want to hire—that is officially an IHS function. But just the fact of participation and having our opinion and our voice heard after reviewing applicants, interviewing them, and what we consider as the best fit for any position, then we would like to believe that our voice has credibility.

The CHAIRMAN. Yes. At what level of IHS were you working with?

Mr. PRETTY ON TOP. Service Unit and Area.

The CHAIRMAN. So "Area" is Billings.

Mr. PRETTY ON TOP. Was Area involved in that?

Mr. OLD ELK. I thought so.

Mr. PRETTY ON TOP. Yes.

Mr. HALF. Yes, they were.

The CHAIRMAN. So who was, sorry? I have to learn here.

Mr. PRETTY ON TOP. These gentlemen here can elaborate more on the situation.

Mr. HALF. Some of the HR personnel were available who—

The CHAIRMAN. Where is that? In Billings?

Mr. HALF. We had meetings here, and we had some meetings at Billings, and we made our request, and a majority of the meetings were in that green room, in that one room.

The CHAIRMAN. Right.

Mr. HALF. And we had HR out of Billings that we met with, and we voiced our concern, and we even wrote letters and everything for that particular AO position that time. So we never got a response on the outcome.

The CHAIRMAN. Are there other instances coming up in the future where you would like, as a tribe, to make the determination, but where there might be conflict with IHS, and IHS might be making decisions irrespective of what you might be thinking? Are there other decisions coming up down the road over the next months or a year or two, positions to be filled or services to be provided or something?

Obviously, what I am trying to get at is to try to figure out some way so both sides are talking a lot better than they have been.

Mr. PRETTY ON TOP. Well, currently, right now, Mr. Old Elk is in the process of considering hiring a CFO and an AO, and we would certainly like to be a part of that process.

Mr. HALF. Excuse me.

The CHAIRMAN. Yes.

Mr. HALF. I guess the bottom line is that we want our very own people who are qualified and have the credentials. You know, just like everybody said, we want them to occupy those positions that are available so that we know they will be here. This guy, Mr. Old Elk, he is old now, and he is not going anywhere. That is what I hear.

The CHAIRMAN. You are going to make sure of that. Right?

So what about this, Mr. McSwain? It kind of sounds like, in some sense, a lot of folks are just getting stuffed, just not being listened to.

Mr. MCSWAIN. I would not speak for Mr. Old Elk, but I believe that it is certainly a reasonable request.

And the other part of it—and I think Mr. Pretty On Top did not talk about the fourth thing, which is transparency, in that there has to be that feedback.

The CHAIRMAN. Right.

Mr. MCSWAIN. Recognizing that the authority, and, again, it was very correct, it is an inherent authority to appoint a Federal employee, and that does not happen at Crow, it happens at the regional personnel office. That is where the authority rests, and so that is probably where the disconnect may have occurred. But the feedback should have come from the selecting official, because the selecting official is the actual appointing authority who will look at a cert. If there is a check mark next to a name, that is a green light for the appointing authority to go ahead, offer the job, and make the appointment.

Now, there is a lot that can happen before then, and that is the selection process. And whether or not those particular entities, such as the AO or any of the other positions that the tribe feels really interested in—I mean obviously they may not want to get involved in hiring housekeeping or maintenance or floor nurses; I do

not know. But at least the key positions that really affect the overall operation of a hospital would be fair areas for consultation, bearing in mind that that process has to be an exchange, so that, when the selection is ultimately made, that is all communicated back. Bear in mind, too, the selection process in a Federal personnel system is a selection. It is not really final until the appointing authority does say, okay, this person can be appointed to this position. There may be some other things that occur, but that needs to be fed back if that particular person is not appointed.

For example, if per chance, all of a sudden, somebody pops up on the OIG exclusion list, you are not supposed to hire those people. And we do not see that until the selecting official's decision is made. But those are the processes. But I think the most focus should be on the selection, and when, in the case of Mr. Old Elk, when he actually is going to sign the cert.

The CHAIRMAN. Yes.

Mr. MCSWAIN. He selects somebody. How he does that is where the discussion should occur.

The CHAIRMAN. What about if some people feel that there is insufficient examination in the ER of women who are sexually assaulted? It is not sufficient. It has not been done as much as it should. At least I have heard that charge. Does anybody want to address that?

Mr. MCSWAIN. My first response is, trained personnel. You need to have SANE and SART folks trained, Sexual Assault Nurse Examiners, Sexual Assault Response Teams, for example. I would defer to Mr. Old Elk if he—I know you are relatively new; I do not know if you have had any cases. But how that particular activity occurs—I know where you are going with the Tribal Order Act and the whole requirement that we actually assist. And I know that—I do not know if the kits are here, but maybe you can respond to that.

Ms. JOHNSON. Can I make a comment?

The CHAIRMAN. Yes, sure, I would like that. I like comments.

Ms. JOHNSON. Okay. When we talk about funding, the budget that started this whole facility, the one budget that was left out was ER. There was no funding allowed for ER.

The CHAIRMAN. That is when the facility was built?

Ms. JOHNSON. When the facility was built in '94, '95. And so the entire budget for the hospital has had to carry that added burden.

The CHAIRMAN. Why was ER not included? That seems pretty obvious to me.

Ms. JOHNSON. That was before I was born. That was before my time, so I do not know why in the world they left that out, but that came to our attention. And so the burden is being carried. And so, therefore, we do not have sufficient staffing and people who would be adequately trained to—and the first place people go when they have that kind of an incident is the ER, and so that is why we do not have adequate personnel in that area.

And then I just have two things I wanted to add. When it comes to finances—

The CHAIRMAN. I am sorry, could you give your name, please?

Ms. JOHNSON. Leanne Johnson.

The CHAIRMAN. Okay.

Ms. JOHNSON. And I am currently the Tribal Health Director. I am the Commission Corps Officer assigned to the tribe, and I have been there for 2 years so far.

The CHAIRMAN. Thank you.

Ms. JOHNSON. And the two things I just wanted you to think about as you go back and think about finances is that, first, we are inadequately funded at 50-some percent. And nothing says that IHS is the only one to provide us health services. There are other government entities such as NIH, CDC, other government entities, that could provide those health services, that could possibly meet that 100 percent if they were allowed to and brought in to meet that insufficient need. That would be really helpful, or just an idea I am throwing out there.

The other one is also funding, possibly, for insurance for every tribal member. If there was any funding at all in a very good insurance that tribal members could have access to, to then get their health care—

The CHAIRMAN. Now, are you talking about health care other than and in addition to IHS care?

Ms. JOHNSON. Yes. They are not getting it here.

The CHAIRMAN. Because IHS covers services that are provided here.

Ms. JOHNSON. They cover services, but, as you well know, it is not 100 percent. There are no specialty services. And to also meet that 100 percent, if insurance was provided for every tribal member, they could go out and get the health care.

The CHAIRMAN. Yes. Well, this raises a very, very difficult question. When Congress passed the health care bill, one big question was, what do we do about Indian health care? And most people felt at the time, well, IHS is just separate, we will just—we will not include the Native Americans within the health care bill, except to the degree that when Montana and/or the Feds set up exchanges, then anybody, including persons on or off reservation, can apply for health insurance under these exchanges, which are to go into effect in 2014. And there are credits, tax credits for those who are unable to afford to buy health insurance.

But other than that, it is just—there is a big problem there. And I asked my staff frankly many, many times, what are we doing about the Native Americans in this health care bill? I could not get much traction because the other members of the Senate and the House just did not really—the president either—did not want to deal with Indian health, that whole part of the health care reform, in part because the Native Americans did not want to be included, because the tribes want to have their own health service, and IHS wanted to have its own health service. And there is just a conflict there with the two together.

But I grant you are right, just as the Affordable Care Act does provide much more coverage, much more insurance for many, many more people, it should also include Native Americans to the same degree it includes everybody else, and I think it basically does. But still, as you say, it has to be insurance for specialized services that are not otherwise provided for here. I am no expert on that part.

So are there any specialized services that Native Americans have covered, even though they are not covered by the actual hospital

here? What if somebody here requires a service that is not provided here, like the appendectomy, as I mentioned earlier, so that person goes to Billings, and the appendectomy is performed there. To what degree does IHS pay that bill?

Ms. WHITE CRANE. Can I say something?

The CHAIRMAN. I am just asking the question. I do not know.

Ms. WHITE CRANE. Can I say something?

The CHAIRMAN. Yes.

Ms. WHITE CRANE. I had my gallbladder removed, and I came here to Crow Hospital to try to get it removed. And I could not get it done here at Crow, even though they did have the facility to do it. I ended up having to do it in Billings at Billings Clinic. Now I am stuck with a \$10,000 bill when it could have been done here.

The CHAIRMAN. So that is the answer to the question.

Ms. WHITE CRANE. Yes.

The CHAIRMAN. IHS does not cover the gallbladder.

Ms. WHITE CRANE. Yes, they did not do it. And we come from Billings, we ride the bus. Okay, we stand in line here. And the first ten people here are supposed to be seen. Well, they are not being seen, so everybody ends up going to the emergency room, and there is only one doctor back there; like right now it is full back there. So everybody needs to come together to help us as patients here.

And as far as everybody wants money for this and wants money for that, it is about us people getting health care. And you guys are fighting, maybe you need to work together, because people like us, we are getting stuck with bills in Billings when it could be done here.

The CHAIRMAN. If you had—I am just trying to get information here. If there were a surgeon here who could provide just basic general surgery—removal of a gallbladder is not that difficult.

Ms. WHITE CRANE. No, it is not.

The CHAIRMAN. And so, if there were a surgeon here who—why isn't there? Is it all money? But let me ask it this way: If there were a surgeon here who did gallbladder removal, then it is my understanding that that bill would be paid. You would not be charged if that service were provided here; is that correct?

Ms. WHITE CRANE. It seems like it should be.

The CHAIRMAN. I see heads nodding in the back indicating it is probably correct. Thank you.

Well, that is all the more reason we need services here.

Mr. McSWAIN. Well, you have hit on a fundamental question, and that is what you can provide here that you do not have to refer out.

But I think it is important to point out that patients who wind up needing a gallbladder removed, unless they are referred, because, as you know, we have had CHS—our Contract Health Services hearings—about why it is we have to manage the way we do, and that is that we want to make sure there is a continuity of care—we are not an insurance company. So, if a patient is referred out and there is an authorization, we pay the bill. But if they simply just walk into a facility and they are not authorized—I have seen enough of the appeals that come in asking for payment, and, if it was not authorized, or if it was not priority—there is a set of regulations that govern the Contract Health Services program. And

that is, you know, obviously, if you can provide the care here, you do not have to go and buy it.

The biggest problem I know that Mr. Old Elk will face is, if he wants to put in surgery, he has to have some additional backup if anything goes wrong. And then, if you have to rush a patient out of here who has had a bad surgery that they discovered when they went in, then you have to transport them—

The CHAIRMAN. Well, that would be authorized.

Mr. MCSWAIN. Yes, that would be authorized. But then, when you talk about, can we provide some of those services, it is just how much backup support really do you have in the facility to be able to support those services. Surgery is one, certainly, OB is another. Any time you get into the secondary services, you are going to have to have enough support to respond to a situation.

The CHAIRMAN. Let me ask this lady here, though, what she did.

AUDIENCE SPEAKER. She stepped out.

The CHAIRMAN. Oh, she is gone. I was wondering where she tried to get her gallbladder removed. She could not get it done here if she wanted to—

Mr. MCSWAIN. No.

The CHAIRMAN [continuing]. Because you do not provide it here. She had to get her gallbladder removed, and she is a member of the tribe presumably. So why was that not authorized?

Mr. MCSWAIN. I guess the other question, I would imagine, is, is she in the Contract Health Services delivery area?

Mr. OLD ELK. Yes, she is.

Mr. MCSWAIN. And if she is—

Mr. OLD ELK. There is an appeals process.

Mr. MCSWAIN [continuing]. There is a process.

The CHAIRMAN. That would seem pretty automatic to me. If she is in the area and the service is not provided here, it seems to me that is an automatic authorization.

Mr. OLD ELK. Yes.

Mr. MCSWAIN. Well, if it is an emergency, yes, because—

The CHAIRMAN. Sorry?

Mr. MCSWAIN. Because, really, as you heard us testify, the fact is that we are hovering at the life and limb level of care because of the CHS budget level. But with the increases, the 40-percent increases from CHS, now we are talking about doing some prevention, paying for colonoscopies and the like. So the situation, this particular case, I would have to see it and look it at it.

The CHAIRMAN. Sorry. Are we at life and limb position here now?

Mr. MCSWAIN. No. We were.

The CHAIRMAN. Until when?

Mr. MCSWAIN. Until probably 2010. And then there was the big increase in 2010, and then we have had a series of increases since then. Because of the tribal priority on Contract Health Services, the Indian Health Service asked for increases in the Contract Health Services budget because we buy more care.

The CHAIRMAN. Okay. Are any doctors in the audience here? Any M.D.s? Anybody? Are there any PAs, any other providers in the audience? Nurses, are there any nurses in the audience? Okay, we have one nurse.

Ms. WETSIT. I did have a couple more back there; I do not know if they left.

The CHAIRMAN. Okay. Your thoughts about all this. Let us talk about how some people provide services to patients. What are your thoughts about all this?

Ms. WETSIT. My name is Diane Wetsit. I am the lady who took Mr. McSwain around and gave him the interview and the tour of the building.

The CHAIRMAN. Yes.

Ms. WETSIT. I have been listening to the comments. I have served here for the last 12 years. And I have watched in those 12 years a number of leaders, like what the tribe just talked about, the various CEOs come and go.

When Mr. Old Elk came on board, we were functioning over in Administration with myself and others as acting this and acting that, and acting over various times in the interim of our leadership. And it is very hard to maintain any kind of continuity of services when you have such a fluctuation in your leadership and your management teams.

And so, with Mr. Old Elk coming on board, and us knowing that he is a permanent resident, and the chance of him going anywhere probably pretty minimal, that has raised the morale of this facility probably 10-fold, knowing that we have someone and we are going to have some stable leadership here.

And what Mr. McSwain has talked about, as far as in the short period of time, the types of things that have been happening, one of them that is the key to this whole process to me is, you cannot provide health care if you do not have medical providers.

The CHAIRMAN. Yes.

Ms. WETSIT. And when we started moving toward various chains of leadership, and then we got hit with the flood, that really brought our health care system to its knees. And we, in that process, like what they have talked about, we stopped inpatient services, we stopped surgery, we stopped OB services, and we were down to having one provider to provide outpatient services, but usually we—10 years ago, we used to average 180 patients in our outpatient area. We are lucky if we even hit 80 to 90 patients in a day, because we do not have the health care providers.

The other part is nurses. We have an extremely high vacancy rate in our nursing positions. If we start our OB services like what we are projecting to do, we are scrambling to try to figure out—we have two OB permanent providers here, and we need a minimum of four OB providers to provide accurate OB services. We have four OB nurses. We need eight. So where are we going to get these additional services? It is more than likely we are going to have to use money we do not have to contract those services.

So that is just one portion. And when we do the OB services, we need to have surgery services. That is a given with the CMS accreditation standards. And so, you start looking at—it just goes from one to another, to this and to that with additional resources that we do not currently have.

We have made the commitment to the tribe that we are going to have OB services. And our clinical director, Dr. Bates, who is not here, is working very hard toward recruiting additional providers.

And he does have some—we are starting to work on that process, but definitely not moving fast enough. For the lady who stood here and said she needed to have gallbladder surgery, she is just one of so many others whom we are turning away because we do not have a surgeon.

We had a surgeon here. He was a commissioned officer, and he retired on us. And that was last year, April. And he retired just when we went into the flood situation. So, for us to have surgery, definitely it would be great if we had a surgeon whom we could recruit.

So we have identified a number of different issues and are slowly working with the governing body. And people such as myself are coming forward with our ideas, corrective actions, things that worked previously. But we took a very hard hit when we went through that flood, and then we lost a number of providers—not only medical providers, but we lost nurses as well, because we were not able to provide services. We did not have running water; I mean, there are a whole bunch of things that happened during that process.

And so we have lost a number of, not only just services, but positions, providers, whatever. And we have—we are slowly working toward action plans to help address those issues. But again, as I am saying, it is not fast enough for everybody.

The CHAIRMAN. All right. Thank you very much.

Mr. PRETTY ON TOP. Really quickly.

The CHAIRMAN. Yes?

Mr. PRETTY ON TOP. Really quickly. You know, everything is connected here. The flood was a benchmark, devastating, catastrophic event, but the problems were there before the flood. That has to be on record also.

The CHAIRMAN. All right. I have some ideas, but before I talk about that, other thoughts? Who wants to contribute here?

Yes, sir.

Mr. HALF. Oliver Half, CEO of the Crow Tribe.

I gave Richard my business card there, and I wrote on there we have a lot of veterans who are returning, starting from Desert Storm, Iraq, Iran, all the way down to Korea and so forth. We have an MOU in place for the VA to come over, and that would help facilitate some of the medical issues that occurred in combat. And at one point I had been in contact with someone at the VA, Buck Richardson, you probably know Buck Richardson. Anyway, during our contacts and meetings, we had set some standards for PTSD counseling, some for bipolar issues due to combat.

The CHAIRMAN. Right.

Mr. HALF. And we had made contact with the Sheridan VA, with Miles City, with Helena, and we were trying to bring some of the medical doctors over here to help the Crow hospital at one point. And then it fizzled out for some reason. But that is still there. So, I would like to—

The CHAIRMAN. What docs is it? Is it VA doctors or what?

Mr. HALF. VA doctors, VA specialists; they were willing to come over here to help. They were even willing to bring a CAT scan, a portable CAT scan, within their rounds between Helena and Wyoming, and I thought that would have helped out over here if we

could have utilized that for some of the patients here. But that did not work out, I do not know why. Maybe it was because we did not make our assertion for that service, I do not know.

So I was wondering if we can maybe look into that.

The CHAIRMAN. This is—

Mr. HALF. We do have a lot of insurance. And I was kind of hoping that Senator Tester was here, because I have had talks with him probably about 3 times.

The CHAIRMAN. Yes. He has a representative here, so at some point she wants to read a statement. He is here in spirit.

I would like other thoughts before I say something.

Yes?

Mr. NOT AFRAID. Welcome, Senator Baucus. Always a pleasure. Leroy Not Afraid, member of the Crow legislative branch, and also I am the Chairman of the Health and Human Services Committee. I represent the Apsaalooke or Lodge Grass District.

I think one of the things that has not been mentioned today is dental care. I believe at this time, and I—my condolences to the CEO for the mess he came into; I mean, he has only been here 4½ months, and the wheels are turning. But, as stated earlier, we have a long ways to go.

I believe at this time, for dental care, a lot of children and elderly have to wait for the October 1st fiscal year date for Contract Health Services to make referrals to specialists in Billings, because the money is gone; it is in the red. And the only way that folks can be treated in dental is through emergency care, extraction; there is hardly any preventive maintenance.

I believe the dental department is down to one dentist, last I heard. One for the adults and one for children, when I believe earlier this year they had up to three dentists for the adults. So I believe that is an area of neglect.

My other comment would be, Senator, the lady—I was in line with her this morning, my wife and I; we were in line with her. She was ahead of us by two persons. We stood in line since 6:30 this morning, and by the time 8 o'clock rolled around and we were trying to see the IHS because of our own health, my childrens' health issues and my wife's, we were turned away; and that was this morning. The issues are very real. I mean, standing in line for an hour and a half and not having our treaty obligations by the United States being upheld is a problem.

Now, my wife and I are fortunate to have health insurance, so now we have to take our business elsewhere. We want to keep our money here, but now we have to exercise our option to go to Hardin or Billings. It has always been my intent to keep our dollars here, but, if the doctors are not available on the immediate or on the short term, then we just—and we are not alone in this story. Our constituents are turned away on a daily basis. And I know our CEO is working hard to bring our doctor back, but it is a very real situation this Wednesday.

Thank you, Senator.

The CHAIRMAN. Thank you. I regret that there were no doctors here whom we could talk to; that would have been very helpful.

Yes, sir.

Mr. KINGFISHER. My name is Quentin Kingfisher. I come from the Northern Cheyenne tribe.

Some of our patient accounts are used to help fund the hospital here, and I just want to underscore everything that has been said here. But I just want to say that we want to be able to have a certain amount of certainty that our people are going to be served here continuously in addition to the problems that we are trying to solve here. And I want to offer my prayers to that end, that we will be able to come up with a workable solution that will help not only our people, because, in this conversation here, it is all about this tribe. But we do not want to be ignored as well, and our voice needs to be heard today. And I thank you for inviting us, and I will contact our people, and we will get a statement together too. Thank you.

The CHAIRMAN. You are very, very welcome. Thank you.

Mr. BLACK EAGLE. Senator?

The CHAIRMAN. Yes.

Mr. BLACK EAGLE. Senator Baucus, I would like to make a comment after listening to everybody's comments. You know, it all boils down to, I believe as a general comment, inadequate funding for Indian country in general, not just Crow-Northern Cheyenne, but across Indian country.

Quite often in appropriations, we are put into a cookie-cutter type of appropriation for Indian country. And one of the unique—every tribe is unique, and we are too. And you know, all of the treaties with the United States were mostly military up until Acts of Congress after May 7, 1868, when we ceded a lot of the 38 million acres of Wyoming and from Bozeman this way to make sure that Montana had the territory. And now a lot of ranchers and farmers enjoy that part of the country.

And for those reasons and other reasons, and the treaties that we signed with the United States, there are obligations by the United States to provide that health care. And the inadequacy of funding comes from that, and we are probably—native American people in this country, the first Americans, are categorized under the Interior Department, which is, as you know, the wildlife and parks, the national parks.

When you look at that—I often look at that, because we are part of that. And I often wonder why we are designated under fish and wildlife in this country, when we should be under the State Department. And so, just a thought about when appropriations are set aside for Native Americans, it should be the State Department, because we have treaty obligations and we have made it possible for this country to become the United States.

The CHAIRMAN. Yes, there is no doubt that that is true.

Okay. I am going to have to say, the one point I want to make here is there is an election coming up, and some candidates for public office are more inclined to agree with you than some others. I need not say any more, except, vote for people whom you think will work for you more than people who are not going to work for you. You have to make that decision, whom you think is going to work more for you. And it is very important that you do that. You can only lead a horse to water. We are talking about appropriations

here. You want to lead that horse to drink the right water and appropriate some dollars.

All right. Before we wrap up here, though, I have something else that I want to suggest here. We have to find some solutions, and I am not sure just exactly what the best approach is, so here is what I am suggesting. I would like the tribe to come up with a list of three or four or five categories that need to be addressed. Maybe it is dialysis, maybe it is OB-GYN; I do not know what it is, but four, five, six things. Maybe it is a process issue, like consultation on a certain number of areas. Then I would like IHS to do the same thing. Where does the IHS think it can make improvements? I would like both to try; IHS to reference that CMS survey and identify which recommendations you think make sense, are appropriate, and which ones may be off-base. And I would like to get that from you, say, what is today? This is the 8th or 9th of August, something like that; let us say it is a couple months. Is that fair? Two months?

Mr. PRETTY ON TOP. Fine.

Mr. BLACK EAGLE. Yes.

The CHAIRMAN. This is August.

Mr. PRETTY ON TOP. Before elections?

The CHAIRMAN. Before the elections? No, it does not make much difference to me about that. But let us say by the end of November, November 30th.

And then I am going to look at that—and I want you also to be thinking about benchmarks. Like what criteria we can agree to use to indicate what will make it a success here. That is, how many doctors are there here today, and is the number of doctors a good sort of benchmark say a year from now. If we have three or four doctors today, is that right, maybe let us see how many doctors we have one year from now. If we have how many nurses, let us see how many nurses we have a year from now. Get these various categories that will be good health indicators; doctors and nurses is one. What do we have—dialysis might be another—a year from now?

Mr. BLACK EAGLE. Dental?

The CHAIRMAN. Dental could be another.

Mr. JEFFERSON. Behavioral health?

The CHAIRMAN. Behavioral and mental health. We need some criteria here like how many patients we have seen, so that a year from now we can benchmark it and see what progress we have made in each of these areas.

And, in developing these lists, I would like you to work with me and my staff, and we can talk about this every month to make sure we are doing all this.

This is the area of follow-up and making sure we are actually doing something, not just talking.

Yes, do you have an idea?

Ms. SCHILDT. Yes. Actually I am an IHS certified trainer. My name is Sandy Schildt. I am from the Blackfeet Reservation. And I wanted to come to this because—thank God for Facebook. I saw this was happening, so I drove down last night. And my thing is, I have been writing reports assessing our Indian hospitals and clinics, whether it is tribal or IHS. And, when I send in my reports

to the Area Director, there is no effective response. So I am just saying I really, truly believe our tribes need to get more involved, because we are losing, and there is no one to protect us. I sent the same letter to Dr. Roubideaux, to President Obama, to the Center for Indian Affairs; and it is hard to reach people. And so, it is just a big battle. It is bad with a lot of issues, but health care is a major one.

So we actually face the same problems as the Crow and the Northern Cheyenne, and I would just like to say, I hope we get to start having more input. And like what you guys want to do, Mr. Pretty On Top, I really believe we need more input, because I have been writing letters since 2008. No effective response, period.

The CHAIRMAN. Right.

Ms. SCHILDT. And so I just—I drove down here from Browning. I am glad to sit here and listen, because it is the same issues.

The CHAIRMAN. I was going to ask that question. How is Browning? I want to ask you that question: is it any different from Crow?

Ms. SCHILDT. No, it is the same exact issues. Of course we have a pill epidemic. We have major problems, and the lack of funding.

And actually in the letter I wrote to the Area Director were the solutions that were at our fingertips. So I do not understand why it is not acted on. That is why I think we need the tribes to become involved in that.

The CHAIRMAN. Right.

Ms. SCHILDT. And it is at our fingertips; there is no reason it should go on for another 5 years.

The CHAIRMAN. Well, I thank you for that. There is no question in my mind that tribes should become much more involved in decisions made by, not just IHS, but other agencies that affect the Native Americans.

The BIA for example, I just think a lot more should be delegated to the tribes. Tribes should make a lot more decisions themselves, be much more fully consulted, because they know what is going on. You know, they are here, the agencies are there, so we need much more of that.

And what I would like you to do, Mr. Chairman, Ms.—I am sorry, I did not get your name.

Ms. SCHILDT. Sandy.

The CHAIRMAN. Sandy—

Ms. SCHILDT. Schildt.

The CHAIRMAN. Oh, Cheyenne. You are correct in asking IHS for something, and, if you do not get a response, let me know so we can—

Ms. SCHILDT. Actually, I wrote your office twice with the same letter. I wrote to the Governor, I wrote to International Affairs, I wrote to Congress. I wrote to every chain of command to make a difference, because, you know, I hear “lack of funding” a lot.

The CHAIRMAN. Yes.

Ms. SCHILDT. That is so true. But the reason we have lack of funding is, if we had the solutions that I was writing—I was trained in IHS, why do we ignore that?

The CHAIRMAN. Right.

Ms. SCHILDT. So how do I reach you?

The CHAIRMAN. How do you reach me? I will tell you right now.

Ms. SCHILDT. Okay, good. Thank you for listening. And I am sorry; I did not want to embarrass you.

The CHAIRMAN. That's okay.

Ms. SCHILDT. It is just—I am just trying to get the point across.

The CHAIRMAN. I admire you for driving all the way down here from Browning to come here to this.

Ms. SCHILDT. It is a long drive.

The CHAIRMAN. That says a lot; that is a long distance.

Okay. Here is the best way to reach me; there are two ways, a lot of ways. One is just to call me up, and I will give you my telephone number.

Ms. SCHILDT. Can I ask you, are you going to come to all reservations? Like, will you be coming to Blackfeet Country or—

The CHAIRMAN. No, I do not have other tribes on my schedule at this point.

Here is another way to reach me: I'll give you my personal, private e-mail. It is not my office e-mail, it is my personal, private e-mail; it goes only to me.

If you write to that e-mail address, and you get no response, there is only one person to blame, me, because that goes only to me. Now when I get e-mails, I will respond, but I may also have somebody like Richard or Kelly get back to you.

But I encourage all of you: do not forget, you are all my employers. I am just a hired hand; I work for all of you. So it is important that you tell me what you need and what you want so I can do a better job. And I try to do as good as I can anyway, but I can still do an even better job the more I hear from you.

And I know this is tough—resources, money, it is a huge part of this. I will do what I can. But I think we may be able to better work on some of these resource issues the more we also work on these criteria, these benchmarks, and these categories.

Another category is obesity. I mean, there is diabetes. I am sure that is going to be something: number of diabetics treated, and trying to get it down. That is probably another category we are going to have to work on.

But I am serious about this. Let's get going here. And I think a lot of people otherwise are kind of cynical. Well gee, we had this nice hearing, all this and that, and not much really happens. Well I am determined something is going to happen, but I might be leaning on you guys and gals. I will make it happen. Okay?

I would like Richard to stand, Richard and Kelly, quickly. You all know Richard; Richard is one of our top guys. And Kelly is one of my health care people. So kind of get to know them; they are really good.

Okay. Now I also—Rachel, do you want to say something for Jon?

Ms. COURT. Yes, thank you.

The CHAIRMAN. This is Rachel Court, everybody, who works for our Senator, Jon Tester.

Ms. COURT. Thank you. Thank you, Senator Baucus.

I am Regional Director out of Billings. And I know most of you, growing up in Hardin, and so it is nice to be here in Crow Country, as always, for me.

And this is just a message from Jon. I know you are hungry, so I am going to hurry up and say it and be done.

He says, "Thank you for inviting me to share a few words, and thank you for bringing attention to an important issue that we all work on: health care access in Indian country. Indian country has unique challenges when it comes to health care. That is why I have twice brought folks from Washington to Montana to talk specifically about improving health care for Montana's Native population, both on and off the reservation. That is why I have voted for the Affordable Care Act that permanently reauthorizes the Indian Health Care Improvement Act, a bill that I was proud to cosponsor. That landmark bill modernizes services delivery in Indian country, expands funding for IHS, and brings Native American health care closer in line with the rest of the country. I will continue working to improve access to care in Indian country until everyone has access to quality health care. Thanks again, and please keep in touch. Respectfully, your Senator, Jon Tester."

The CHAIRMAN. Thank you, Rachel. Thank you, Jon, for that statement.

Now what I am doing here with the Crow is also going to be the same with the Blackfeet and all Montana tribes. So now I have to figure out a way to get to them so they do the same as you. But you will do the same for all, right?

Mr. MCSWAIN. Right.

The CHAIRMAN. Okay, all Montana tribes.

Mr. MCSWAIN. True.

Ms. SCHILDT. So—

The CHAIRMAN. And I—sorry.

Ms. SCHILDT. So how soon will the tribes start working to make decisions on selections with IHS?

The CHAIRMAN. Well—

Ms. SCHILDT. What is the first step? What do we have to do so it does not go on?

The CHAIRMAN. First of all—well, two things. First I want the list from each of the tribes. And, if selection is one of the most important matters, then that tribe will put that on the list.

But in addition, things are going to come up from time to time that are not anticipated, and we will just have to deal with those, like selection. It may not be on the list, but there is a selection issue. We will just have to deal with it.

But I am asking you first for the list—not a long list, no more than a half-dozen items; obviously the most important half-dozen items.

And then you, Mr. McSwain, I would just ask you to do the same. From your perspective, what better health care is needed, and what needs to be done. That would be great too.

So by November 30th, and what is the best address?

Ms. O'LOUGHLIN. We can send a follow-up letter.

The CHAIRMAN. Well, we will send a follow-up letter to Mr. Chairman and Mr. McSwain and to the other tribes, and follow up on it.

This is going to be—we are going to make a difference here. Okay, I have nothing else to add.

Does anybody else want to say something in response to something that was said? Did somebody say anything outrageous that needs to be addressed?

Mr. BLACK EAGLE. Just maybe some closing remarks.

The CHAIRMAN. Okay, thank you, Mr. Chairman.

Mr. BLACK EAGLE. Thank you, Senator Baucus, for taking the time to be here and also the guests who are here. And I also want to thank IHS, the CEO and AOO and the rest of the staff who are here who made it possible to have this Senate hearing here. And, again, we are really honored.

The CHAIRMAN. You bet, Mr. Chairman. Everything is teamwork and partnership. Nothing of consequence is ever accomplished by somebody trying to do something alone. It is all teamwork, it is all partnership, and we are all here working together. And I just urge us to keep open minds, keep working. We are going to make some headway here.

Thank you, everybody.

AUDIENCE SPEAKER. Hello?

The CHAIRMAN. The hearing is adjourned.

AUDIENCE SPEAKER. Can I say something before you leave?

The CHAIRMAN. Oh yes, sure. Go ahead. I am sorry, I did not see you.

AUDIENCE SPEAKER. I am from the Northern Cheyenne Reservation.

The CHAIRMAN. Yes.

AUDIENCE SPEAKER. And it seems none of the representatives from the clinic are here, but anyway I think the ladies' clinic needs to be addressed in terms of their decisions. I personally do not go there because of the quality of—I mean the medical professionals who deal with patients in Lame Deer. It is like, when people go there for medical reasons, they have to stay there, as the one gentleman says, all day long. And then some of them just leave. And also on the basis of diagnoses, they do not seem to have physicians there who specialize in certain areas like they do on the outside, like some people specialize in certain fields. It is just more like they are country doctors with a black bag with aspirins and Tylenol and such.

But maybe, somewhere along the line, they can address the Lame Deer IHS, because a lot of people have gone there who have been misdiagnosed by giving them painkillers, which eventually led to, I hate to say it, but a lot of people have died from being misdiagnosed.

The CHAIRMAN. Yes, it happens.

AUDIENCE SPEAKER. So I was wondering, something along the line of just IHS—

The CHAIRMAN. Another thought I had is, frankly, this is long-term, but trying to help figure out ways to get local kids excited about pursuing a medical career. Maybe a doctor, maybe a nurse, maybe something so they are more likely to want to, after they receive their training, come back and live here. And what I just suggest is that the tribes—it is a presumptuous suggestion—maybe some way put in place incentives in school to get kids interested in medicine. Again, it could be a nurse, or physician's assistant, or

maybe a doctor, just something so they go away for training, and, boy, they can hardly wait to come back home and serve the people.

AUDIENCE SPEAKER. Maybe with all this talk about the funding, they can have funding to hire qualified physicians so there will not be all these problems.

The CHAIRMAN. Okay. Thanks everybody for taking the time. We are going to work together. Use that address, that telephone number, and work together. Thank you, everybody.

The hearing is adjourned.

[Whereupon, at 1:30 p.m., the hearing was concluded.]



# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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### Field Hearing Statement of Senate Finance Committee Chairman Max Baucus (D-Mont.) Regarding Indian Country Health Care

There is a Crow Proverb that teaches us, "People's eyes say words that the tongue cannot pronounce."

A hospital should be a place of healing and relief, but here at Crow-Northern Cheyenne Hospital, far too many eyes tell a story of pain, frustration and disappointment. Stories like the one I heard from a man who was denied his medication without any explanation or alternative treatment plan – medication he needed to treat rheumatoid arthritis – a condition that, when left untreated, can lead to increased risk of heart attacks and even death.

After months of inquiries at Indian Health Service, he and his family learned that the problem stemmed from a failure to communicate by the doctor, the hospital and the pharmacist. The patient had done everything right, but he still couldn't get the medication his doctor prescribed. I know that this patient is not alone.

American Indians and Alaska Natives have a life expectancy that is about five years shorter than that of the general population. Access to quality health care can help folks live longer, but it is increasingly difficult to provide this kind of care with shortages as high as 20 percent for IHS doctors and 15 percent for nurses and dentists.

And health is not just physical. Native Americans and Alaska Natives are more likely to die from alcohol-related diseases or commit suicide than any other racial group, yet here at the Crow hospital, there are only three mental health providers.

Flooding last year led to evacuations, damaged more than 50 homes, and left people without clean water for months. The physical damage is apparent, but the psychological effects often go unrecognized.

Imagine being uprooted from your home and unsure when you'll be able to return. When you turn to the hospital for help, you're told you have to wait months to see a clinician, if at all. Imagine losing a child to suicide and being unable to get any professional help. Many of you don't have to use your imaginations at all. You've lived it.

Many also know all too well that one in three American Indian women have been raped in their lifetimes – twice the national average. Each one of those numbers is a mother, daughter, sister or friend. That's why I fought hard to include language in the Violence Against Women Act the Senate passed earlier this year to give tribes more power to prosecute sexual predators, and I am hopeful the House will act soon.

So, I was shocked to hear stories of staff at this very hospital refusing to conduct full sexual assault examinations or provide rape kits to victims. It is appalling enough to deny much needed care to victims who have already suffered severe trauma. These refusals also make it harder to build evidence to prosecute attackers and prevent them from hurting more women in the future.

The problems are serious, and they demand serious solutions. That is why we are here today.

We made important progress when we passed the health reform law, known as the Affordable Care Act. That law also made the Indian Health Care Improvement Act permanent, which is a big win for tribal health care. The law gives IHS the authority to expand tribal mental and behavioral health services. It provides financial incentives to help tribes recruit and retain clinicians. American Indians will also have access to many other benefits in the law if they choose to purchase private insurance plans in the insurance exchanges. I want to hear your feedback as we continue to implement these programs.

Of course, none of what we have done, or hope to do can be accomplished without funding. The Administration requested a discretionary appropriation of more than \$4 billion for Indian Health Service in its 2013 budget. That would be an increase of nearly to \$116 million over last year's appropriation.

Third-party reimbursements and mandatory appropriations for the special Indian diabetes program bring the total to \$5.5 billion. A significant chunk of that money will go toward contract services that purchase care from outside providers when IHS is unable to meet patients' needs. In 2010, funding shortfalls led to nearly 220 thousand denials for contract health services. Every one of those denials means a patient goes without care, so this funding is sorely needed.

Still, funding care outside of IHS doesn't help us provide higher quality care at reservation hospitals like this one. The Crow people deserve to be able to use the Crow hospital that was built to serve them. In 2010, the Center for Medicare and Medicaid Services conducted a survey at this hospital and issued a 900-page plan.

Many solutions lie in that plan, so we need to understand what is being done to implement the plan and what more is needed to put it into action. We must use all available resources to make sure we are doing the best we can, every single day, to turn the statistics around.

It's not going to be easy, and it's not going to happen overnight. But just as the eyes in this room tell a story of pain and disappointment, they also tell a story of determination and hope.

Each one of you is here because you care. You want to see a change, and you are part of the solution. Please grab a fact sheet on how to submit testimony on your way out today. We want to make your voices part of the record.

Our goal is to begin a new era of providing not only affordable health care, but quality health care. Health care that can change the vicious cycles American Indians suffer daily. So let us begin our journey today together and learn from what we hear. Let's think creatively. Don't be afraid to throw out ideas. I look forward to gathering information today and implementing a plan for improvement in the coming months.

###

**EXECUTIVE BRANCH OF THE APSÁALOOKE NATION**

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Cedric Black Eagle, Chairman  
Calvin Coolidge Jefferson, Vice-Chairman  
Scott Russell, Secretary  
Darrin Old Coyote, Vice-Secretary

**TESTIMONY OF CEDRIC BLACK EAGLE  
CHAIRMAN, CROW NATION**

before the

**COMMITTEE ON FINANCE  
UNITED STATES SENATE**

**FIELD HEARING ON  
HEALING IN INDIAN COUNTRY:  
ENSURING ACCESS TO QUALITY HEALTH CARE**

**August 8, 2012**

**INTRODUCTION**

Shoodashee! Good morning Chairman Baucus, members and staff of the Senate Finance Committee. Welcome to the Crow Reservation, home of the Apsaalooke Nation, also known as the Crow Tribe of Indians. Thank you for the opportunity to share the views and concerns of the Crow Nation on the Indian Health Service and the current state of healthcare on the Crow Indian Reservation.

**BACKGROUND**

The Crow Nation is a sovereign government located in southeastern Montana. The Crow Nation has three formal treaties with the federal government, concluding with the Fort Laramie Treaty of May 7, 1868. The Crow Reservation originally encompassed most of Wyoming and southeastern Montana. Through a series of treaties, agreements, and unilateral federal laws over a 70 year span, Crow territory was reduced by 92% to its current 2.2 million acre area.

Today, there are over 13,000 enrolled citizens of the Crow Nation, with approximately 8,000 of those residing within the exterior boundaries of the Reservation. Additionally, a recent study indicates that the tribal population will exceed 20,000 citizens by 2015, which will add

further stress to our fragile developing economy, and sharply increase the level of basic human services needed by our population.

Our goal is to bring more of our citizens to return home to live and resume their role in the tribal community and our culture. We have long emphasized the importance of education and obtaining a college degree to our tribal members, and we want to be able to tell them that if they come home to work for their people, they will not want for basic services such as accessible and quality health care. We also want to see Crow Tribal members hired for positions at the Crow Service Unit when they have worked hard to become qualified to serve their community and fellow tribal members. The recent hire of Clayton Old Elk as CEO of the Crow Service Unit is commendable and is a notable step in the right direction.

The Crow Service Unit serves the highest user population within the Billings Indian Health Service Area. As of FY 2010, we served a user population of 13,469 individuals, and there is no doubt that number should be much higher today. The Northern Cheyenne Service Unit serves an additional 6560 individuals, many of whom come to Crow-Northern Cheyenne Hospital for services that are not available at the Lame Deer Clinic. The urban Indian population in Billings places an additional burden on the Crow-Northern Cheyenne Hospital for services that are not available or are limited at the Indian Health Board clinic in Billings.

#### *1. The State of Accessible Quality Health Care at the Crow Service Unit*

As noted by Dr. Yvette Roubideaux, the current director of Indian Health Service, “[t]he provision of health care services to American Indians and Alaska Natives is a key component of the federal government’s trust responsibility[.]” The stated goal of the Indian Health Service, as set out in its mission statement, is “to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.” I must say that today, as things are, the Indian Health Service is deficient in this trust responsibility to the Crow Nation. The needed services are not readily accessible to the Crow people on a consistent basis.

Over the past two years, I have written a number of letters to Dr. Roubideaux detailing the concerns of the Crow Tribe regarding the state of the Crow Service Unit. I have met, along with key tribal staff, with Dr. Roubideaux and her staff, as well as Billings Area and Crow Service Unit staff, to continue this dialogue. We have had fairly consistent monthly meetings with Billings Area staff, and weekly update meetings with the Service Unit staff. Our response from Headquarters has been minimal. We were informed that they have delegated response to the Billings Area office. However, as many of our concerns directly implicated performance and accountability of the Billings Area office, we feel that headquarters should be more responsive to the Crow Tribe, rather than delegating its response to Area Office staff. To date, we have not received a responsive reply in writing from Dr. Roubideaux.

## a. CMS Survey

In September 2010, CMS conducted a survey of the Crow-Northern Cheyenne Hospital that confirmed and documented what the Crow Tribe conveyed to Dr. Roubideaux in our initial meeting with her on August 25, 2010 -- both physical plant issues as well as internal management policy and accountability failures. Through the survey, CMS found and documented a number of shocking and significant shortcomings in the facility. The findings are set out in a stack of papers that is approximately nine inches thick, and range from shortcomings in the facilities to recordkeeping to quality patient care issues reflected in a sampling of patient charts. Our concern is that if the Crow-Northern Cheyenne Hospital loses its accreditation with CMS, we will see a further scaling back of even the very basic services that are offered today. Our community cannot afford to lose any additional services or funding at the Crow Service Unit. Even more importantly, the deficiencies documented by CMS are cause for alarm because they reflect a facility that has been poorly managed and neglected in many key areas, which has impacted the level of patient care ultimately delivered to the community served by the facility.

In short, the facility that the majority of the Crow people rely on is broken, has been poorly managed, and in many cases presents a danger to the health and welfare of the Crow people. We have yet to receive any verification as to whether the Corrective Action Plan that was to be implemented has been accepted, or whether a comprehensive Corrective Action Plan actually exists.

## b. Community Concerns

One of the main areas of concern for my administration is the ongoing and consistent volume of patient complaints that are brought to our attention. We believe that there are many good and dedicated individuals working for the Crow Service Unit. I want to commend the dedication of many Crow Service Unit employees who have continued to work to improve the system through many upheavals and challenges, especially over the most recent several years. However, even the best team will fail without consistent leadership and a system which holds individual employees accountable for their failures. And the lack of accountability leads to repeat violations of patient rights, which reflects badly on the entire Crow Service Unit.

Community members bring a wide variety of issues to my office, but one of the most consistent issues is the perception that providers do not listen, and do not treat them with respect. A communication barrier may exist because of cultural differences. This can be alleviated with appropriate training, which the Crow Tribe can and has begun to assist with. However, there may be a deeper seated issue than simple lack of cultural sensitivity. When multiple patients, consistently, are not given routine tests and screenings, and are repeatedly sent home with aspirin or ibuprofen, and finally go to an off-reservation facility to be admitted immediately and treated for life-threatening conditions within hours of being sent home from the Crow hospital, something is very wrong. There is more than a simple breakdown in communication. There is a pattern of disregarding legitimate patient concerns.

Our community members repeatedly inform us that they finally lost patience with being sent home from the Crow hospital with ibuprofen and went to an off-reservation facility. This

often means incurring substantial medical bills that they will be personally responsible. They also report that outside providers are consistently appalled at the reported dismissal of serious health complaints, acute symptoms, and the lack of follow-up and monitoring of serious health issues by providers at the Crow Service Unit.

Every Crow Tribal member has the right to be seen by a provider for his/her medical issues, to be treated and, when possible, healed. If complete healing is not possible, then the individual has a right to be made comfortable and to be returned to the fullest physical and mental functionality as possible. It should not matter if that person is an addict, or if they are overweight. These are diseases within themselves, but they are often treated as an excuse to abbreviate communication with a patient, to curtail treatment, and to disregard the patient's legitimate needs. This absolutely has to stop. It is a violation of medical ethics and a violation of the trust responsibility that is owed to every Crow Tribal member.

Another issue is the amount of time that it takes to see a provider for even basic health issues. The understaffing and unavailability of providers is an issue that must be addressed more aggressively. We understand that there are additional providers coming on board, and we are encouraged by that news. We hope that permanent staff will be brought in to address the chronic physician and midlevel provider shortage at the Crow Service unit. Temporary contract doctors have been used to fill the gaps, but these place additional strains on our already tight budget. Additionally, these temporary doctors do not develop the connections with and knowledge about their patients that are ideal, and do not instill the trust of the individual patients or the community as a whole.

c. Limited Availability of Outpatient Services Impacts the Service Unit

Currently, the Crow-Northern Cheyenne Hospital is not operating a walk-in outpatient clinic. Patients have to come in the morning and sign up for appointments for that day. Patients come in at 7:30 a.m. to line up for the appointments window, which opens at 8:00. When the available slots are filled, there are no additional patients scheduled for outpatient clinic that day. Patients cannot call in to make appointments. This system is inadequate at best. Some patients who cannot get into outpatient end up in the Emergency Room, often for serious but not emergency issues. This compromises the level of service provided by the Emergency Room. One patient reported a wait time of 6 hours at the ER within the past month. The patient finally left without being seen.

Patients with private insurance or who have Medicare or Medicaid coverage are choosing to go elsewhere to receive health care, because of the unpredictability of whether a provider or an appointment will be available to them at the Crow Service Unit. Third party billing has declined dramatically over the past two years as outpatient services have been changed and limited in various ways. (See Exhibit 1) For example, in 2010, the total collected from Medicare/Medicaid and private insurance was \$7,106,472.00. In 2011, the total was \$7,291,109. The total collected to date in 2012 is \$5,664,955. The decline in third party billing collections is most dramatic in Medicare collections, where \$2,130,212 was collected in 2010, \$1,717,974

collected in 2011, and \$869,655 collected to date in 2012. In short, the scaling back of services and availability of outpatient care has forced patients with the ability to go elsewhere – and pay – to leave the Crow Service Unit. The decline in third party collections will impact the hospital by causing a decline in revenue, and, ultimately, a decline in the user population, if this trend continues.

2. *Budget Increases are Needed to Maintain and Upgrade the Service Unit Facilities and to Address Crow Patients' Health Care Needs*

I read last week that President Obama has requested a 2.7 percent increase in the Indian Health Service budget for FY 2013. That is, indeed, good news, and a step in the right direction. I hope every member of the Finance Committee will vote in support of this proposed increase because it is justified. However, the need is far greater and requires a systematic dedication of additional resources over more than just one budgetary year.

Several items needed by the Crow Service Unit, for which funding is currently not available within our budgets include:

- An upgrade for the outdated phone system for the hospital and clinics - \$350,000
- The hospital and clinics have approximately \$2 million in upgrades for medical equipment. We currently receive \$130K/year for medical equipment replacement, which barely makes a dent in the need.
- Replace existing dental operator's records to digital - \$500,000 – this would enable dental to use EHR.
- We currently have \$2,740,432.00 in deficiencies for the hospital and clinics, which includes various building deficiencies that need to be addressed.
- The Indian Health Care Improvement Act, as permanently reauthorized through the Affordable Care Act, authorized Indian Health Service to operate dialysis services. However, there is no funding provided for these programs. We currently transport our tribal members who receive dialysis three times a week to either Billings, MT or Sheridan, WY – distances averaging anywhere from 30-70 miles or more each way, over roads that are often nearly impassable during the harsh Montana winter months. Funding for dialysis onsite at Crow Agency would improve the quality of life and the long-term prognosis for these patients.

Furthermore, we were informed by Area Office staff that the Emergency Room services are basically unfunded. This puts an additional demand of approximately \$5 million on the Crow Service Unit budget. Because Crow is a Critical Access Hospital, meaning that the ER cannot turn anyone away for ER services, this is an additional burden on a budget that is already insufficient to meet the health needs of the Crow Tribe. Emergency Room services should be

fully funded and appropriations should be made to provide for the services provided to all members of the community.

The Catastrophic Health Emergency Fund ("CHEF") is another area where additional funds are needed. This fund provides for accidents and serious medical emergencies where the costs are unforeseeable. However, there are shortfalls each year which are then deducted from the Service Unit's budget. According to figures provided by the Billings Area Office, in FY 2010, unfunded CHEF costs were \$135,210; in FY 2011, the unfunded CHEF costs were \$1,033,462, and in FY 2012, the unfunded costs to date are \$319,072. (See Exhibit 2).

The current budget shows a fairly consistent rate of funding for most areas of service, operations, and facilities. (See Exhibit 3). However, it is telling that as the years progress, our population increases and places higher demands on the services and providers available. The facility needs repairs and upgrades as it ages. The needed expansions in services and additional providers, as well as scheduled upgrades and repairs to the facility are not funded. The current budget has already been shown to be insufficient, as the Service Unit has consistently operated with a shortfall of around \$2 million each year, which is then made up from the following year's third party collections.

### 3. *The Indian Health Service Model is in Need of Reform and Reorganization*

The current system is top heavy. It is failing Indian Country. Tribes and tribal governments are blamed by our members, but we are largely powerless to make the changes that are actually needed to ensure access to quality health care for our citizens. Although some tribes have the means to supplement the federal monies available and provide health insurance for their members, that is not the case for many tribes, such as the Crow Tribe. The Indian Health Care Improvement Act, as reauthorized, enables Tribes to secure federal health insurance for their employees, but there is a cost associated with these programs. Unfortunately, this type of an expense is simply not an option for tribes with little to no budget for these types of benefits.

Staffing and management have been ongoing challenges for the Crow Service Unit. There have been a number of leadership shuffles over the past several years, with many acting CEOs, and many CEOs who only stayed in the position for one or two years before being ousted. The instability in leadership have been devastating to the morale of the staff at the facility. In order to bring the Crow Service Unit to the level it needs to be, strong, stable leadership is needed. We are hopeful that the new CEO, Clayton Old Elk, who is also a Crow Tribal member, will be able to implement the changes needed to bring improvement.

## CONCLUSION

The people of the Crow Nation deserve and have a right to quality health care. The federal government has a trust responsibility to provide this service, both by the terms of treaties executed between the Crow Tribe and the federal government, as well as pursuant to federal statutes and regulations. Today, the situation here is alarming on many levels. The reality is that

people are suffering, and many are dying because they simply do not have access to the health care that they need to survive and thrive. We have a facility that is deteriorating without the funding needed to keep it running properly, and to expand and upgrade it to meet the needs of a rapidly growing population.

The Crow Service Unit has been plagued by a revolving door in leadership, which has prevented accountability for the issues plaguing this facility. The funding for the Service Unit is inadequate and does not sufficiently provide for the services and facilities needed by our user population. The Billings Area has repeatedly told us, over the past two years, that they have implemented new structures, brought in new personnel, to help address the longstanding problems. In our view, the leadership of the Billings Area Office has been incompetent and has done little to hold accountable those individuals who have prevented change and improvements needed. The Crow Tribe has no confidence in the Billings Area at this point in time, and we believe a full outside administrative audit needs to be conducted as soon as possible. We have asked for this to happen repeatedly, and we still believe it is needed. These issues need immediate, prolonged, and thoughtful attention.

## Exhibit 1

2010 Collections CR	Medicare	Medicaid	Private Ins	Total PI/M/M
Total	2,130,212	3,564,092	1,412,168	7,106,472
2011 Collections CR	Medicare	Medicaid	Private Ins	Total PI/M/M
Total	\$1,717,974	\$3,899,117	\$1,674,017	\$7,291,109
2012 Collections	\$869,655	\$3,686,698	\$1,108,603	\$5,664,955

Exhibit 2

**CROW SERVICE UNIT CONTRACT HEALTH SERVICE INFO FY10 - FY12 (ytd)**

	<b>FY2010</b>	<b>FY2011</b>	<b>FY2012</b>
Recurring Allowance	\$ 7,404,533	\$ 7,404,533	\$ 7,970,332
CHEF Funded	\$ 1,009,727	\$ 1,901,276	\$ 781,281
CHEF Unfunded	\$ 135,210	\$ 1,033,462	\$ 319,072

Exhibit 3

CROW SERVICE UNIT			
SERVICES	FY 2010	FY 2011	FY 2012
HOSPITALS & CLINICS	\$ 14,696,131	\$ 14,696,132	\$ 14,672,618
DENTAL	\$ 1,415,637	\$ 1,415,637	\$ 1,413,372
MENTAL HEALTH	\$ 662,396	\$ 662,396	\$ 661,336
ALCOHOL & SUB ABUSE	\$ 1,391,726	\$ 1,391,725	\$ 1,389,498
PUBLIC HEALTH NURSING	\$ 727,335	\$ 725,880	\$ 724,719
HEALTH EDUCATION	\$ 266,103	\$ 265,571	\$ 265,146
COMMUNITY HEALTH REPRESENTATIVES	\$ 629,509	\$ 628,250	\$ 627,245
DIRECT OPERATIONS	\$ 10,959	\$ 10,937	\$ 10,920
CONTRACT SUPPORT COSTS	\$ 683,488	\$ 682,121	\$ 591,435
CONTRACT HEALTH SERVICES	\$ 7,404,534	\$ 7,404,534	\$ 7,970,332
<b>TOTAL SERVICES APPROPRIATION</b>	<b>\$ 27,887,818</b>	<b>\$ 27,883,183</b>	<b>\$ 28,326,621</b>
<b>FACILITIES</b>			
ENVIRONMENTAL HEALTH SUPPORT	\$ 101,863	\$ 175,469	\$ 193,246
FACILITIES SUPPORT	\$ 411,959	\$ 1,338,566	\$ 1,008,111
MAINTENANCE & IMPROVEMENT	\$ 254,435	\$ 250,618	\$ 263,187
EQUIPMENT	\$ 146,579	\$ 139,441	\$ 136,568
<b>TOTAL FACILITIES APPROPRIATION</b>	<b>\$ 914,836</b>	<b>\$ 1,904,094</b>	<b>\$ 1,601,112</b>
<b>GRAND TOTAL</b>	<b>\$ 28,802,654</b>	<b>\$ 29,787,277</b>	<b>\$ 29,927,733</b>

CROW SERVICE UNIT			
	FY 2010	FY 2011	FY 2012
Services Appropriation	\$ 27,887,818	\$ 27,883,183	\$ 28,326,621
Facilities Appropriation	\$ 914,836	\$ 1,904,094	\$ 1,601,112
<b>Grand Total</b>	<b>\$ 28,802,654</b>	<b>\$ 29,787,277</b>	<b>\$ 29,927,733</b>

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**STATEMENT OF  
ROBERT MCSWAIN**

**DEPUTY DIRECTOR  
FOR MANAGEMENT OPERATIONS  
INDIAN HEALTH SERVICE**

**BEFORE THE  
FINANCE COMMITTEE  
OF THE  
UNITED STATES SENATE**

**FIELD HEARING ON  
HEALING IN INDIAN COUNTRY:  
ENSURING ACCESS TO QUALITY HEALTH CARE**

**August 8, 2012**

**STATEMENT OF THE INDIAN HEALTH SERVICE**

Mr. Chairman and Members of the Committee:

Good Morning. I am Robert McSwain, Deputy Director for Management Operations of the Indian Health Service (IHS). I am pleased to have the opportunity to testify before the Senate Finance Committee on operations of the Crow/Northern Cheyenne IHS Hospital.

The IHS plays a unique role in the Department of Health and Human Services (HHS) because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives (AI/ANs). The mission of the IHS, in partnership with AI/AN people, is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. The IHS provides comprehensive health service delivery to approximately 2.2 million AI/ANs through a network of 29 federally operated Hospitals, 66 health centers, 41 health stations, and 2 school health centers, and 16 Tribally operated Hospitals, 166 Alaska Village Clinics, 74 health stations and 4 school health centers. In support of the IHS mission, the IHS and Tribes provide access to functional, well maintained and accredited health care facilities and staff housing in 35 states. This health system often represents the only source of health care for many AI/AN individuals, especially for those who live in the most remote and poverty-stricken areas of the United States.

The IHS has, as we all recognize, a challenging mission – and one that has grown

more so as a result of population growth, rising healthcare costs, and greater incidence of chronic conditions and their underlying risk factors, such as diabetes and childhood obesity, among Indian people. The circumstances in many of our communities – poverty, unemployment, and crime – often exacerbate the challenges we face. We have made great strides in assisting Tribes taking over management of health programs through the Indian Self-Determination and Educational Assistance Act (Public Law 93-638). Tribes now manage over half of the IHS budget and are demonstrating how new ideas and increased flexibility in managing these healthcare services can result in innovative and more effective healthcare programs.

#### **Overview of the Billings Area IHS**

The Billings Area IHS was established to serve the Indian Tribes in Montana and Wyoming. Within the Billings Area, IHS brings health care to approximately 80,000 Indians living in both rural and urban areas. The Area Office located in Billings, Montana, is the administrative headquarters for eight service units consisting of three hospitals, fourteen health clinics, and two health stations. The Area has two Self-Governance Tribes.

Each facility incorporates a comprehensive health care delivery system. The hospitals, health centers, and satellite clinics provide inpatient and outpatient care and conduct preventive and curative clinics. Direct care and contract care

expenditures are used to augment care not available in the local IHS facilities. The Billings Area has an active research effort through the Epidemiology Program operated by the Montana-Wyoming Tribal Leaders Council. Research projects deal with diabetes, cardiovascular disease, cancer, and the application of health risk appraisals in all communities.

Tribal involvement is a major objective of the program, and several Tribes do assume partial or full responsibility for their own health care through contractual arrangements with the Billings Area IHS. Tribally managed facilities include health clinics operated by the Chippewa-Cree Tribes located in Rocky Boy, Montana, and the Confederated Salish and Kootenai Tribes located in Pablo, Montana.

The Billings Area and the Crow/Northern Cheyenne Hospital, a facility serving the Crow Nation and Northern Cheyenne Tribe, face several challenges, including difficulties associated with providing care in rural, remote, and impoverished communities.

I would like to discuss our progress to date in clearly defining and effectively addressing the challenges facing the Billings Area and the Crow Service Unit with specific focus on the Crow/Northern Cheyenne Hospital. The hospital serves the Crow Nation and Northern Cheyenne Tribe whose lands are located on adjoining reservations in Montana.

The Governing Body and the Crow/Northern Cheyenne Hospital Chief Executive Officer (CEO) have made improvements in strengthening Tribal relations with the two tribal governments and are now focused on overall structure, system, and process improvements supporting the healthcare programs. The Governing Body created an action plan to institutionalize the needed improvements into the structure and operations of the Governing Body and the Crow/Northern Cheyenne Hospital. The improvements have touched every element of the Crow/Northern Cheyenne Hospital and include:

- Successful recruitment of a new administrative team. In March of 2012, a new CEO was hired. The CEO has recruited and filled several Executive management staff positions including the Clinical Director, Director of Nursing, and Business Office Manager. The Administrative Officer (AO) and Chief Financial Officer positions have been advertised and a selection panel has been issued with qualified applicants. A selection has been made for the Chief Pharmacy Officer position with a tentative Enter On Duty date of October 1, 2012.
- The Northern Plains Regional Human Resources (NPHR) Director is now located in the Billings Area Office. Process improvements are being made through IHS Hiring Initiatives with progress in implementing the Office of Personnel Management's (OPM) directives for improving HR operations. Specifically, the OPM has established an improvement goal throughout the Federal Government to reduce the time it takes to fill a vacancy for an available position to 80 calendar days or less. The NPHR Office currently maintains an

average hiring timeframe of 60 days, which is well under the 80 day benchmark. The Billings Area has fully implemented the HHS requirement to utilize the USA Staffing for all vacancy announcements. These improvements have assisted in reducing the hiring times for many critical vacancies.

- A monthly meeting was established with representatives of the two Tribes and respective Tribal Health Officials for communication purposes and to work in partnership in addressing short-term and long-term issues and concerns.
- A weekly Governing Body meeting was established with the Crow/Northern Cheyenne Hospital to provide direction and assist the new CEO in addressing administrative, access, quality care, and customer service issues.
- An Action Plan was established through the weekly Governing Body meetings to improve organization performance; monitor clinical initiatives; and address management, planning, and resource issues; and to monitor the Balanced Scorecard indicators.
- The Billings Area IHS Director of Field Operations and Area Chief Medical Officer continue to assist the Hospital CEO with the administrative and medical leadership needs.

We have a Billings Area Director and Crow/Northern Cheyenne Hospital CEO who are committed to bringing the kinds of changes needed at the Area and Service Unit level by working to hold individuals accountable for their performance. The efforts to identify and address the management and performance problems at the Crow/Northern Cheyenne Hospital over the past five months demonstrate a

commitment by the Area Director, Governing Body, and the CEO to make meaningful progress. At the same time, the Governing Body and the Hospital must also respond to unexpected demands, including emergencies due to severe weather and crises due to unplanned staffing shortages which was the case recently in disruption of services/care that resulted in temporary limitations on inpatient care and suspension of Obstetric services. These disruptions of key services are being addressed through the overall current management improvements and the services/care are scheduled to be resumed shortly.

Effective collaboration between IHS and the two Tribes is essential to helping us achieve our shared goals, and I am grateful for the commitment the Crow Nation and the Northern Cheyenne Tribe have made to focus on the challenges facing the Billings Area and work with IHS to develop solutions.

### **Conclusion**

Today, IHS in partnership with Crow/Northern Cheyenne Hospital leadership and Tribes, is focused on helping ensure better customer service, promoting ethical behavior, ensuring fairness and accountability in performance management, strengthening financial management, improving Tribal consultation, and improving the quality of services delivered to patients. While the situation at the Crow/Northern Cheyenne Hospital is improving, our focus on change and better outcomes for patients is continuing. We have made, and will continue to make, specific

improvements at the Crow/Northern Cheyenne Hospital in partnership with the Tribes we serve.

Mr. Chairman, thank you again for your long-standing commitment to improve Indian health, in the Billings Area and throughout IHS, and for the opportunity to testify today.

I will be happy to answer any questions you may have.

**EXECUTIVE BRANCH OF THE APSÁALOOKE NATION**

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Crow Country

Cedric Black Eagle, Chairman  
Calvin Coolidge Jefferson, Vice-Chairman  
Scott Russell, Secretary  
Darrin Old Coyote, Vice-Secretary

**TESTIMONY OF HENRY PRETTY ON TOP  
CABINET HEAD FOR HEALTH AND HUMAN SERVICES,  
CROW TRIBE OF INDIANS – APSAALOOKE NATION**

before the

**COMMITTEE ON FINANCE  
UNITED STATES SENATE**

**FIELD HEARING ON  
HEALING IN INDIAN COUNTRY:  
ENSURING ACCESS TO QUALITY HEALTH CARE**

**August 8, 2012**

**INTRODUCTION**

Good morning and welcome to Finance Committee Chairman Baucus, committee staff, and honored guests. Thank you for the opportunity to speak today to the ongoing issues surrounding the provision of health care to the people of the Apsaalooke Nation, and our ongoing struggles with accessing quality health care here in Crow Country.

**BACKGROUND**

The Crow-Northern Cheyenne Hospital serves a user population well in excess of our on-reservation population of approximately 8,000 tribal members. The Crow-Northern Cheyenne Hospital also serves members of the Northern Cheyenne Tribe, as well as other Native Americans in the area, including a significant number of individuals from various other tribes who reside in Billings, MT, approximately 60 miles away.

Members of the Crow Tribe, particularly those living on or near the Crow Reservation, face many challenges in accessing quality health care. The Indian Health Service, as we all know, has been historically underfunded. Due to many historical factors beyond our control today, our tribal members suffer disproportionately from a number of diseases – notably,

diabetes, heart disease, alcoholism, and mental illness. It is noteworthy that services to address the most pressing needs of our community are currently seriously lacking or nonexistent. I will address these in more detail below.

The bottom line is that our ancestors signed treaties with the federal government ceding many millions of acres, including prime areas of Yellowstone National Park, the Paradise Valley, and the Powder River Basin, in exchange for goods and services, including health care for themselves and their descendants. We see IHS as perhaps the first prepaid healthcare system. Today, we are still fighting to see this promise fulfilled. It is imperative that the Indian Health Service live up to its obligation to provide quality health care to the Crow people. Our tribal members have the right to be treated with dignity and respect by Indian Health Service employees, and to have their medical issues addressed and treated.

#### *1. CMS Survey*

In 2010, Center for Medicare/Medicaid Services (“CMS”) conducted a survey of the Crow-Northern Cheyenne Hospital. The CMS Survey identified thousands of issues, making findings in nearly every area. Indeed, the findings were so extensive that CMS did not finish the survey, and likely would have made additional findings had there been sufficient time to conclude its investigation. The Crow Tribe was very concerned about the potential threat to our facility’s accreditation with CMS. We understand that the loss of this accreditation would mean that the services that we already find insufficient would be scaled back even further because of the inability to collect third-party billings if accreditation were lost. We have repeatedly asked for updates on CMS and the progress of a corrective action plan. We have received monthly updates on Crow Service Unit staffing and activity from Crow Service Unit and Billings Area staff, and have had weekly updates when possible from Service Unit staff, but we have never received an actual, straightforward answer as to the status of the hospital’s review by CMS and what we, the Tribe and our members, can expect.

We understand that addressing the many areas in which CMS reported findings will take time, and this is why we have been working with IHS staff to stay updated, to inform the community of progress where it is warranted, and to offer assistance and support wherever it is appropriate. However, we are nearly two years into the corrective action effort, and the complaints and concerns reported by members of the community continue to come in, and the improvements that should be evident remain to be seen.

#### *2. Closure of Inpatient and OB Services*

In Spring 2011, the Crow Reservation was hit by a catastrophic flood. The flood impacted the community of Crow Agency, as well as virtually every other area of the Crow Reservation and surrounding communities. During this time, the Crow-Northern Cheyenne hospital was rendered inaccessible because of flooded roads. The hospital remained closed for several weeks because of the impact on water and sewer infrastructure that persisted even after

roads were reopened and the hospital was physically accessible again. Inpatient services at the hospital remained closed for several months and even today, over a year later, remain available only on a very limited basis. The last report we received was that up to three beds out of 24 were available. This hardly qualifies as reopening inpatient services.

After the flood, and after the hospital reopened, OB/GYN unit delivery services remained unavailable, along with the inpatient services. Today, fourteen months later, Crow Indians still cannot deliver their babies on the Crow Indian Reservation. It has been this way since May 2011. Expectant mothers are sent to Billings, Hardin, or Sheridan, depending on their residence and any potential complications in their delivery. This is upsetting to many community members who want to be able to give birth on the Reservation. It also presents an additional burden on contract health care funds, which are already limited.

In addition to forcing tribal members to travel long distances to be admitted for inpatient and OB delivery services, it also forces family members to bear the substantial expense of travelling off-reservation to support their relatives who are hospitalized, or to greet new relatives when they are born. It should also be noted that, even when faced with the additional burdens of traveling off-reservation to receive basic services that are in high demand by our community, many of these patients choose to continue to receive services off-reservation – especially those who are eligible for third-party payment, such as Medicare/Medicaid, and those with private insurance.

When patients go off-reservation to receive services, they encounter dramatically shorter wait times and a more respectful level of provider interaction and customer service. In short, the failure to provide these services is driving many revenue-generating patients away permanently. The drastic reduction in third party billing in FY 2012 to date is a very real reflection of the Crow Service Unit's reduction in services. Our revenue base is deteriorating as a result, and it will take years to remedy what has been lost over the past 14 months. We should be able to rely on third-party billing revenue to supplement the budget, but this will not be a viable option if the current situation continues.

### *3. Staffing Shortages and Management Issues*

Understaffing of the Crow Service Unit continues to present a challenge to patients who need access to health care providers. There are some dedicated providers at Crow, but there are not enough of them. The shortage in staffing means long wait times for our community members, many of whom simply are not able to be seen by a physician when they should be. It also results in compromising emergency room services, as many individuals put off medical care, or are unable to dedicate the time it takes to be seen by outpatient providers, until their condition becomes acute and they are forced to go the Emergency Room, where they will face unacceptable wait times, as well. In order to address understaffing, Crow Service Unit and Billings Area staff have informed us that they have brought in a number of contract providers, or "locums". The locums are costly, and place a high demand on an already challenged service unit

budget. There is no question that they are necessary, but the long term effect of this short term staffing solution is likely to be disastrous.

When we ask IHS administrators why we cannot attract a sufficient number of quality, permanent providers to work at the Crow Service Unit, they tell us that it is difficult to staff the hospital because few providers want to live and work in a place like the Crow Reservation. We find this difficult to believe, as other hospitals in our region, and in more remote regions within the State of Montana, do not have the same staffing shortages that we have here. The truth, in our opinion, is that the Billings Area Office has mismanaged the Crow Service Unit, and the Crow-Northern Cheyenne Hospital has gained a bad reputation within the medical community. Many good doctors simply don't want to work here. Many good doctors have left the Service Unit over the years because of the poor management by the Area Office, as well as the lack of adequate funding to perform the services the patients need to be healed. Good doctors, understandably, are frustrated when they are prevented from doing their jobs, fulfilling their medical ethical duties, by insufficient funding. The administration at the Billings Area Office needs to be held accountable for its failures to the patients of the Crow Service Unit. We need reform in administration, to restore the credibility and reputation of this facility. Only then will we be able to attract dedicated, quality providers to meet the needs of the Crow Nation.

#### *4. Hiring Qualified Crow Indian Applicants*

Another recent event that has raised our concern is the refusal to hire qualified Crow Tribal members for supervisory positions. In 2010, the Crow Tribe recommended an individual for the position of Administrative Officer, and the individual was highly qualified and notably dedicated to returning home after over a decade of service at IHS headquarters. Instead, IHS officials – the Acting CEO at the time, the incoming CEO, and individuals at the Area Office level – determined that the best hire would be a different individual. IHS went against the Crow Tribe's recommendation after we engaged in consultation and made our recommendation. The result was the hiring of an individual who was apparently not qualified and who has been on administrative leave for over a year, leaving a key administrative position unfilled during a period of numerous challenges for the Crow Service Unit. This is inexcusable.

Unfortunately, the situation described in the paragraph above is not an isolated incident. Several months ago, we were informed of another Crow Tribal member who applied at least twice for a supervisory position, Chief of Pharmacy. Although the individual in question is highly qualified, and was indeed the only qualified applicant for the position who made the roster, she was not hired because "some other staff members are uncomfortable" with her potential hire. During our discussion of the Tribe's concerns about the staffing of this position with IHS administrative staff, no viable or legal reason for not hiring this individual was provided. During our most recent discussion about this individual, we were told that IHS is now recruiting a Navajo pharmacist to fill this position because of her expertise with cumedin. To our knowledge, we have never staffed the Chief Pharmacist position based on expertise with cumedin. This situation borders on absurd and it needs to be addressed at a higher level, as the Area Office has been unresponsive, paying lipservice to our concerns about these types of issues.

Personal and office politics continue to prohibit accountability and reform at the patient care provider level and prevent qualified Crow Indians from filling leadership positions in the Crow Service Unit. Playing interoffice politics and accommodating staff members' personal issues does not demonstrate responsible hiring practices. We also believe that the individual preferences of some staff pharmacists go back to their comfort level under the supervision of the previous Chief Pharmacist who was forced to retire because of her unprofessional and unconscionable mismanagement of the pharmacy at the Crow Service Unit, which was well-documented over the years.

We want to see those Crow Tribal members who have worked hard to achieve their credentials supported in their goals to fill positions such as these, where they can work to improve the quality of patient care provided to their fellow tribal members. If other staff are threatened by bringing qualified Crows into leadership positions, perhaps they do not belong in the Indian Health Service, much less at the Crow Service Unit.

5. *Ambulance Contract and Possible Misuse of Contract Health Care Dollars*

One of the chief areas of concern that we have identified is the contract for ambulance services with Big Horn County. This contract has been in place for a number of years. The Crow Tribe was never consulted when it was initially executed. Through an ongoing effort to find answers about this contract, its terms, and how monies designated for providing services to Crow Tribal members are being allocated to a program administered by the County government, and located off the reservation, we have been putting the pieces of this puzzle together over the past several months.

We were finally able to get a copy of the contract, and have confirmed that a substantial amount of money from the Crow Service Unit's contract health care budget is diverted to make payment to Big Horn County for ambulance services. Although the tribal contribution to this service is substantial, our tribal members still face long wait times when an ambulance is called, and this wait time has resulted in individuals dying while they wait for service. Additionally, when tribal events such as rodeos, Indian relays, and Ultimate Warrior are scheduled, the County requires payment for an ambulance to be on call – the ambulance that we are already paying for out of our Contract Health Care budget.

We have serious ongoing concerns with the status of the ambulance contract in place between the Crow Service Unit and Big Horn County. In addition to the concerns outlined above, it should be noted that this contract allows a doctor employed by the Crow Service Unit to also receive significant additional individual financial benefit even as a significant proportion of the services paid for with Service Unit funds are being provided to nontribal members throughout Big Horn County. We will continue our investigation into this area, and would ask for support and cooperation from Indian Health Service in determining how the funding that currently is going out to the County will benefit Crow Tribal members more directly in the future.

#### 6. *Mental Health and Substance Abuse Services are Insufficient*

The past year has been a difficult one for our communities in Crow Country. Just over a year ago, we mourned the first death in what would be a string of five homicides on the Crow Reservation. Over the fall months of 2011, our community was in shock due to the unprecedented number of violent episodes and losses that took place here within a very short time period. Within a two week period at the beginning of 2012, we lost several tribal members to substance abuse-related illnesses, and four tribal members died in an alcohol-related crash on the reservation. Each of these deaths was preventable at some level. There are many factors that led to these tragic incidents, and each situation is unique. But one consistent factor is mental health issues that go untreated and services that are largely inaccessible. The fact that we have only three providers for mental health services at the Crow Service Unit speaks to the unmet needs faced by our population.

I bring these tragedies to your attention to highlight and underscore the severe need we have for substance abuse treatment services, and for mental health services. As you are aware, the issues of mental health and substance abuse are fundamentally intertwined in nearly every case. The sheer volume of death on our reservation within the past year, and the young ages of many of the deceased individuals has also traumatized our community at every level. The impact of these losses is far-reaching, and unprecedented on the Crow Reservation.

There is a high demand from Crow Tribal members for mental health services and for grief counseling. For the vast majority of tribal members who suffer from mental illness, they are only able to access these services when it is ordered by a court – in other words, when things have already gone terribly, often irretrievably, wrong. The program and services offered by Crow –Northern Cheyenne hospital are staffed by several dedicated individuals, but the needs far exceed their capacity.

Dr. Earl Sutherland was initially hired specifically to staff the Lodge Grass clinic and provide mental health services to community members. However, late in 2011, he was temporarily appointed as Acting Clinical Director. At one point, a Crow family that lost two teenage children in separate, tragic, incidents within a four-month period called Dr. Sutherland to try to make an appointment with him for counseling, but he failed to even return the family's calls. We understand that qualified staff are often stretched very thin at the Crow Service Unit, and are called on to wear many different hats. However, given the many traumatic events that have taken place within the Crow Reservation over the past year, we question the judgment of whoever decided to appoint Dr. Sutherland to an administrative position. It seems obvious to us that Dr. Sutherland should have been directed to prioritize performing the services he was hired to provide at the location that he was hired to work in. We requested that Dr. Sutherland be removed from his appointment as Acting Clinical Director and he was soon formally relieved of that appointment. We question the judgment of those who made that appointment in the first place. Taking mental health providers out of rotation and making them unavailable to a struggling, traumatized population will not improve the mental health conditions of the Crow people.

## CONCLUSION

Administration of a troubled facility like the Crow-Northern Cheyenne hospital needs to be responsive and carefully tailored to bring about improved quality patient care to the Crow people. We need to hold medical staff accountable and require them to treat staff and patients in a professional, courteous, and respectful manner. Simply plugging in empty spots in the administration with anyone who says they are available will not solve our community's problems or improve the hospital. Until our community members stop bringing the same complaints to us at the same volume, we will not stop advocating for reform and accountability at every level.



## COMMUNICATIONS

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### **Comments for the Record**

### **Senate Finance Committee**

### **Healing in Indian Country: Ensuring Access to Quality Health Care**

Wednesday, August 8, 2012, 11:00 AM MDT

By Michael G. Bindner  
Center for Fiscal Equity  
4 Canterbury Square, Suite 302  
Alexandria, VA 22304

Chairman Baucus and Ranking Member Hatch, thank you for the opportunity to submit these comments for the record to the Senate Finance Committee. As always, our comments are in the context of our four part tax reform plan:

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of \$100,000 and single filers earning \$50,000 per year to fund net interest payments, debt retirement and overseas and strategic military spending and other international spending, with graduated rates between 5% and 25% in either 5% or 10% increments. Heirs would also pay taxes on distributions from estates, but not the assets themselves, with distributions from sales to a qualified ESOP continuing to be exempt.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

The effects on various tribes and territories will vary. We will address each in turn. OASI provisions are, of course, not relevant to this analysis. Our analysis draws heavily from our comments of May 15<sup>th</sup> of this year, which addressed tax reform rather than health. As you recall, we stated:

*Native American tribes will be affected in the same manner as states. To the extent that they have a tribal tax system, they will likely bring it into conformity with the federal system. Tribes which exist mainly on casino revenue, where members pay no direct taxes, can still benefit from harmonizing with the federal tax reforms we outline here. This is especially the case if an NBRT is adopted with offsets for employers who perform or fund social welfare functions in lieu of payment of taxes.*

*Our proposal replaces TANF with privately or publicly provided adult education, with participants funded at the minimum wage and receiving the same refundable child tax credit as workers, along with the same health plan as employees of the provider organization. This feature could also be used to replace Tribal TANF, allowing participants to achieve real education rather than job training for low wage work. This is especially the case if program participants can then transition into either technical education or even college – where the employer pays a wage while paying tuition in exchange for both a NBRT credit and a work requirement/student loan.*

To the extent that health care is provided publicly, it will be provided through training programs or through sponsored agencies who replace what the private system would otherwise provide on the reservation. This would be especially true for providing care to senior citizens.

Tribal employers would, of course, have the same federal tax structure as non-tribal employers in both Indian country and in the nation at large. Tribal employers and non-tribal employers in Indian country will feel the same impacts as anyone else resulting from health care reform, especially if the stock market decides that private health insurance is unsustainable. If this happens, the Indian Health Service could either remain separate, along with the Veterans Health Service, or be incorporated into any subsidized Public Option or Single Payer System. While Veterans' health will be subsidized by the high income surtax, Indian Health may or may not be. If funded by the Net Business Receipts Tax, then tribal and non-tribal employer in Indian country would have the same offsets available to them for providing alternate health care services for employees and/or retirees.

Among our recommendations is the strengthening of regional government, which will include the distribution of federal land, with Native People's getting first claim to any land they hold by treaty, which could be retained to be used or rented or sold. It is anticipated that ownership and control of this land will make all nations richer and will end the need for a taxpayer subsidized system, although the structure of the Indian Health Service could then be transferred to tribal governments to be run by each tribal nation with their own revenue from extraction, land rent or gaming. We suspect that if the nations controlled the service without interference and federal funding constraints, but with adequate resources through regaining their birthright, that quality would dramatically increase (provided they went with a tribal based rather than an employer based system).

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.



## National Indian Health Board



August 22, 2012

The Honorable Max Baucus  
Chairman, Committee on Finance  
United States Senate

The Honorable Orrin Hatch  
Ranking Member, Committee on Finance  
United States Senate

Re: Statement in Response to Committee on Finance Field Hearing on Healing in Indian  
Country: Ensuring Access to Quality Health Care

Dear Chairman Baucus and Senator Hatch:

On behalf of the National Indian Health Board (NIHB), I respectfully submit the recommendations attached to this letter. In addition to the tribal recommendations provided at the Committee on Finance Field Hearing on August 8 at Crow Agency, NIHB would like to share the views and concerns of the National Indian Health Board on the Special Diabetes Program for Indians and the ongoing need to protect the Indian Health Service budget from cuts enacted through the sequestration process. These important issues play a critical role in improving American Indian/Alaska Native (AI/AN) access to quality health care.

Established in 1972, the NIHB serves all federally-recognized tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the federal trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. The NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.

I respectfully ask that you consider the two additional recommendations we highlight in the attached statement. If NIHB can be of assistance, please contact NIHB's Legislative Director Jennifer Cooper at (202) 507-4076 or [jcooper@nihb.org](mailto:jcooper@nihb.org) and Jeremy Marshall, NIHB Senior Legislative Associate, at (202) 507-4078 or [jmarshall@nihb.org](mailto:jmarshall@nihb.org).

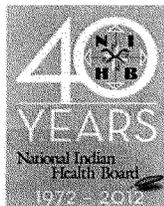
Sincerely,

Cathy Abramson  
NIHB Chairperson



926 Pennsylvania Avenue, SE 1 Washington, DC 20003 1 202-507-4070 1 202-507-4071 fax 1 [www.nihb.org](http://www.nihb.org)

*The Red Feather of Hope and Healing*



## National Indian Health Board



**Senate Committee on Finance  
Field Hearing on Healing in Indian Country:  
Ensuring Access to Quality Health Care  
Written Comments for the Hearing Record  
Submitted by the National Indian Health Board**

**August 22, 2012**

Established in 1972, the NIHB serves all 566 federally-recognized Tribal Governments by advocating for the improvement of health care delivery, as well as upholding the federal government's trust responsibility to Tribes. The NIHB strives to advance the quantity and quality of health care and the adequacy of funding for health services delivered directly by the Indian Health Service or by Tribes and Tribal Organizations to American Indians and Alaska Native (AI/AN) people. The NIHB is the only national organization solely devoted to the improvement of Indian health care on the behalf of the Tribes.

We support the recommendations provided at the Field Hearing at Crow Agency, including the improvement of accessible quality health care as well as budget increases needed to maintain and upgrade the Crow Service Unit. From a national perspective, we would like to highlight two additional recommendations: reauthorization of the Special Diabetes Program for Indians and protection of the Indian Health Service budget.

### **I. THE SPECIAL DIABETES PROGRAM FOR INDIANS**

Diabetes is a devastating disease that affects people of every age, race, and nationality. The growing epidemic of diabetes represents one of Indian Country's greatest health challenges. In some AI/AN communities, more than half of adults aged 18 and older have diagnosed diabetes, with prevalence rates reaching as high as 60%. In Montana, approximately 48,000 people, -6% of the population- have diagnosed diabetes and many of them suffer from serious diabetes related complications and conditions. On a national level, diabetes costs \$174 billion annually, and these costs are expected to nearly triple in the next 25 years. In Montana, the direct and indirect costs of diabetes were approximately \$508 million in 2007.

In response, Congress established the Special Diabetes Program for Indians (SDPI) in 1997. The SDPI addresses the disproportionate burden of Type 2 diabetes on AI/AN populations. This



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*The Red Feather of Hope and Healing*

program is producing a significant return on the federal investment and has become our nation's most strategic and effective federal initiative to combat diabetes and its complications. The program currently supports over 450 Indian Health Service, Tribal and Urban programs in 35 states. The SDPI is currently set to expire in September 2013.

With leadership and guidance from the Indian Health Service Division of Diabetes Treatment and Prevention and Tribal Leaders, the SDPI grant programs use proven, evidence-based, and community-driven diabetes treatment and prevention strategies that address each stage of the disease. Since its inception, the SDPI has allowed the Indian health system to build and enhance diabetes treatment and prevention programs. AI/ANS continue to work toward a common purpose in fighting this terrible disease.

**a. *Impact of SDPI in Indian Country***

These numbers are staggering. SDPI is making a real difference in our communities by providing funding for diabetes prevention, education and treatment programs. Consider these outcomes:

- A1c numbers have been reduced by 1.1% resulting in a 40% reduction in the risk of diabetes related complications;
- Bad cholesterol levels have declined, reducing the risk of cardiovascular complications by 20 -50 %;
- The overall incidence rate of End Stage Renal Disease in American Indian Alaska Natives fell by 27.7%, impacting Medicare costs in a real way.

To fully understand the impact of this program, consider the incredible story of Faye Filesteel, Assiniboine tribal member who benefited from the Fort Belknap Healthy Heart Project. Faye was diagnosed with diabetes in 2005. Her mother had diabetes and so does her son, but it wasn't until she joined the Healthy Heart Program that she began to really understand the disease. At the Healthy Heart Program, she learned that there were things she could do to control and even reverse her diabetes. With the education and support of the program staff and the support from her peers with diabetes in the classes, she was determined to do all she could do to take better care of herself.

Since starting with the program she has made changes to her diet and she's eating healthier. She's committed to a healthy lifestyle - walking outside when the weather was good and using the treadmill at the Diabetes Center when the weather was bad. She even signed up to walk with the Healthy Heart group in the 2010 Icebreaker Marathon in Great Falls. Having seen first-hand the damage that diabetes can do, Faye is grateful that she had access to the Diabetes Center and the Healthy Heart Program so soon after she was diagnosed. Faye's results have been so positive that her doctor told her that soon she would likely not need to take metformin anymore.

Conversely, NIHB is also aware of the stark reality that AI/ANS face in fighting diabetes where there is a lack of additional funding and resources. For example, at the Crow Service Unit, funding is not adequate for the Indian Health Service to provide dialysis services. The Crow Nation currently transports tribal members who receive dialysis three times a week to either Billings, MT or Sheridan, WY—distances averaging anywhere from 30-70 miles or more each

way, over roads that are often nearly impassable during the harsh Montana winter months. Increased funding for dialysis services at Crow Nation would improve the quality of life and the long-term prognosis for these tribal patients. In similar situations where there was a shortage in funding, SDPI grantees have successfully utilized SDPI funding to fight diabetes; resulting in skilled expertise coming into the communities and solid infrastructure addressing the overwhelming need for health care resources. I urge the Senate Finance Committee to consider the success AI/AN communities are having in the fight to end diabetes and to reauthorize the SDPI this year so programs currently established can continue to address the diabetes disparities throughout Indian Country.

***b. Ensure Continued Success By Reauthorizing SDPI This Year.***

Despite our ability to demonstrate a real return on the federal investment, SDPI is set to expire if Congress doesn't renew it once again. A multi-year renewal NOW of the SDPI will provide resources to AI/AN communities to continue to make clinical improvements and increase access to quality diabetes care. Renewal will ensure continued measurable improvements in the prevention and treatment of diabetes. With renewal of SDPI, Indian Country can continue to address the serious threat of Type 2 diabetes to future generations by replicating successful programs in additional tribal communities.

Senator Baucus, you have been such a champion for this program in Congress, and I am grateful for the opportunity to thank you for all you have done for our tribal communities in ensuring the federal commitment to SDPI remains strong. We look forward to continuing to work with you to support your efforts again this year.

**II. INDIAN HEALTH SERVICE BUDGET CUTS AND SEQUESTRATION**

***a. Protect the Indian Health Service Budget from Reductions and Avoid Sequestration.***

First, it cannot be overstated how thankful the NIHB is to this Congress for the passage of a 6% increase in funding to Indian Health Service for Fiscal Year 2012. Over the last three years, Congress and the Administration have made their commitments to Indian health and the fulfillment of the federal trust responsibility clear by ensuring that the Indian Health Service receives annual increases. As a result, Indian Health Service has been able to treat more patients than ever before, and the American Indians/Alaska Natives (AI/ANs) have made small, but real gains in health status. NIHB applauds you for your dedication to upholding the sacred trust between the U.S. government and Tribes. Together, we must protect this recent progress.

I hope that every member of Congress will support the President's proposed increase of 2.7 % in the Indian Health Service budget for FY 2013. Under the discretionary spending limits of the *Budget Control Act of 2011*, this recommendation by the President is a \$115.9 million increase over the FY 2012 enacted Indian Health Service appropriations. Where many other budget

accounts saw deep cuts, this increase acknowledges the critical health needs of our tribal communities and represents the continued commitment to honor the federal government's legal obligation and sacred responsibility to provide health care to AI/ANs. However, the need is far greater and requires a systematic multi-year budgetary dedication of additional resources.

Since the Indian Health Service is currently funded, on average, at just 56.5% of need, this level of funding will not allow the agency to address the stark health disparities between AI/ANs and the U.S. general population. The increase in the tribal population places higher demands on the services and providers available in aging tribal health facilities in need of repairs and upgrades. While many tribal health facilities consistently operate with an annual funding shortfall, scheduled upgrades and repairs to aging facilities and services provided are not fully funded. Although some tribes have the means to supplement the federal monies available, this is not the case for many tribes.

NIHB is very concerned about the possibility of cuts to the Indian Health Service budget enacted through the sequestration process. As a discretionary budget line, the Indian Health Service budget is subject to the across the board cuts to discretionary funding under sequestration. Any budget cuts will have harmful affects on the health care delivery system to AI/ANs and may result in an increased loss of life. The NIHB asks Congress to work to exempt the Indian Health Service budget from any cuts and avoid sequestration as even small cuts have a large impact.

While we recognize the budget realities we face as a nation, the NIHB believes that a greater funding increase for the Indian Health Service is critically important and can be achieved. On behalf of the 566 federally-recognized Tribes, I urge Congress to protect the Indian Health Service budget by ensuring that the Indian Health Service continues to receive a budget increase. Increases in current services are the budget increments needed to enable the Indian health care delivery system to continue operating at its current level. Without additional increases to base funding, the Indian health system would experience a decrease in its ability to care for the tribal population. In this hard economic environment, a multi-year budget increase for the Indian Health Service is needed more than ever.

#### ***b. Sequestration Impact on the Indian Health Service budget***

Another issue of concern is the potential of a sequester next year due to Congressional inaction. Although the vast majority of federal spending is subject to across-the-board cuts, certain programs are either exempt from sequestration or subject to special rules under sequestration. Many safety-net programs are exempt from these funding reductions or limits entirely; such as Social Security, Medicaid, the Children's Health Insurance Program (CHIP), and the Supplemental Nutrition Assistance Program (SNAP).

Other programs are subject to special rules and reduction limits. For example, Medicare may only be achieved in up to a 2% reduction in provider payments. Medicare beneficiaries would likely not see a change in their coverage. The Indian Health Service also falls under special rules. Under sequestration, it is possible that the Indian Health Services and Indian Health Facilities accounts may see cuts of up to 2% in appropriated funding annually between FY 2013 and FY

2021. If the Indian Health Service budget was cut by the full 2% in the sequestration process, it would lose \$86 million. Most dangerous about this process is that certain preventative and other services accounts like scholarships and health education would be targeted for reductions to salvage hospital and clinic accounts in order to preserve the levels of care provided.

If Congress cannot avoid sequestration through alternative methods of deficit reduction, the NIHB implores Congress to make the Indian Health Service completely exempt from sequestration. NIHB urges you to begin work with your colleagues in Congress to act this year in stopping the sequestration process so that these devastating cuts do not reduce the Indian Health Service budget next January.

