

Testimony of
Kay A. Culbertson, Executive Director
Denver Indian Health and Family Services
Before the
Senate Committee on Indian Affairs
And
House Resources Committee
On Senate Bill 556,
Indian Health Care Improvement Act
July 16, 2003

Good Morning Senate Committee on Indian Affairs Chairman Ben Nighthorse Campbell, Vice Chairman Daniel Inouye, House Resources Chairperson Richard Pombo and other distinguished committee members. My name is Kay Culbertson; I am an enrolled member of the Fort Peck Assiniboine/Sioux Tribes located in Poplar, Montana. I am the Executive Director for Denver Indian Health and Family Services located in Denver, Colorado and also serve on the board of directors for the National Council of Urban Indian Health. On behalf of the many tribal members who reside off reservation, I would like to thank you for the opportunity to provide testimony regarding the proposed reauthorization of the Indian Health Care Improvement Act. There are currently 36 urban Indian health programs located throughout the United States, with each program offering a variety of medical services through many creative and innovative delivery types. For

today, I will focus on the impact of the reauthorization and proposed amendments to the Indian Health Care Improvement Act, S.556.

History

The legal doctrine associated with the federal trust relationship and other federal policies of this country serve as the legal basis for providing health services to American Indian people. The federal policies of this country have resulted in a significant population of American Indian people living in cities throughout this country.

Prior to the 1950s, most American Indian people lived on reservations or in tribal jurisdictional areas such as Oklahoma. In the 1950s and 1960s, the federal policies of the United States began to terminate its legal obligations to Indian tribes, resulting in policies and programs to assimilate Indian people into the mainstream of American society. This philosophy produced the Bureau of Indian Affairs Relocation and Employment Assistance Programs which relocated Indian families from reservations to various cities across the country including Denver.

Health care was usually provided for six months through the private sector, unless the family was relocated to a city near a reservation with an Indian Health Service (IHS) facility service area, such as Rapid City, Phoenix, and Albuquerque. Eligibility for IHS was not forfeited due to Federal Government relocation. The American Indian and Policy Review Commission found that in the 1950s and 1960s, the BIA relocated over 160,000 American Indians to cities.

As you know the 2000 census reports that 66% of American Indians live in urban areas. As opportunities for employment, education and housing become more strained on reservations we anticipate that these percentages will continue to increase over the next ten years. It should be added that the American Indian population is widely considered

the most undercounted group in the Census. Although the total number of Indians may actually be low, our experience is that the percentage of Indians living on reservations compared to those who reside on reservation is accurate.

Since Denver was one of the original relocation cities it has a significant Indian population. A segment of Denver's Indian population is a result of men and women who settled here after serving in the armed forces. Another segment came to Denver because at one time there was a Bureau of Indian Affairs area office located in the metropolitan area. Many Indian people moved from the reservation to the Denver area with the hope of attaining the "American Dream". Today, Denver continues to be a hub for Indian people. Denver's Indian population is estimated at 38,000 and is comprised of people who have lived in Denver for over 30 years producing 2nd and are 3rd generation Denver natives as well as those who are transient and move to and from the reservation on a regular basis. The primary reason for moving continues to be "hope for a better future".

Denver Indian Health and Family Services was created as the result of a needs assessment conducted by the Denver Native Americans United. Denver Indian Health and Family Services was incorporated in 1978, as a non-profit Indian organization and received funding from the Indian Health Service to provide outreach and referral services to the Indian community. With a staff of two people, the agency gathered and provided information to Indian people in accessing health care in the Denver metropolitan area. Eventually, DIHFS began to provide limited health care through volunteer nurses and doctors and grew into a full scale clinic entering into an agreement with Denver Health and Human Services. The number of uninsured and inability to charge American Indian patients placed a much larger financial burden on the organization and clinic services

were discontinued in 1991. Unfortunately, the health care needs of the community exceeded the funding limits of the agency.

In 1996, DIHFS entered into an agreement with a local community clinic to provide services at a limited cost; however, the agency could only allow two visits per year and the patients were responsible for their own laboratory and x-ray costs. This arrangement made it difficult to provide health care and much needed follow-up to persons with chronic medical problems such as diabetes. The community voiced the need for additional health care. Not just any health care but health care that was culturally sensitive and available through an Indian organization or provider.

At a 1998 strategic planning retreat for the DIHFS board of directors planted the seeds to begin the process of providing medical services to the Indian community on site. The board of directors stressed the importance of taking slow steps to providing health care. The board of directors insisted that the services be provided by DIHFS, that patients would receive more health education, that the delivery of services be provided in a manner that was comfortable to Indian patients, that the financial pitfalls of the past be avoided and that we maintain our identity as an Indian provider and an Indian clinic. In March of 1999, a young Indian physician, Dr. Lori Kobrine, took on the task of laying the foundation for our clinic. Through her efforts our clinic met the requirements for state licensure. She worked 20 hours a week providing limited medical services to the community. Our clinic continues to grow.

Since the spring of 2000 our clinic has been staffed with a full time nurse practitioner and a volunteer physician who provide medical services on a full time basis to the community. The medical services include immunizations, acute emergencies, well

child physicals, physicals, women's basic health, diabetes management and screening and other health services that do not require a specialist or may be life threatening. DIHFS also provides mental health and substance abuse counseling, substance abuse prevention, case management services for victims of crime, energy assistance, diabetes case management, diabetes prevention, weight loss support groups, fitness programs, prescription assistance, emergency dental, and referrals to meet other community health needs. In this short time, DIHFS patient load is over 2000 with over 280 Indian people registered with our diabetes program.

In providing services we have encountered barriers that tribes may not face. Ninety two (92%) percent of the patients seen in our clinic do not have absolutely no insurance, Medicaid, Medicare, or SCHIP included. It is interesting to note that patients who do have insurance and are not employed full time are retired military or federal service employees. Only 8% of our patients are employed full time and of those patients only 1.5% has health insurance. Often Indian people who come to an urban area have a misconception that urban Indian health programs are virtually the same as the Indian Health Service or tribal health programs on the reservation and may not elect to sign up for health care benefits. Colorado residents, as a whole, have found that many employers are no longer paying for health coverage benefits and they cannot afford to pay for their own health care benefits, hospitals in the area are limiting emergency services for indigent persons to life and death situations. Our patients who have health insurance do not utilize their providers due to increasing co-pay amounts or deductibles. This leaves Indian patients with nowhere to go during an emergency situation that does is not life threatening i.e. a broken arm. We are often times the only safety net for Indian people in

the Denver area and our funding is severely inadequate and our services are limited in scope. DIHFS does not currently have an affiliation with a health maintenance organization (HMO) because we do not have 24 hour coverage nor hospital admission privileges. These issues also do not allow us to generate third party billing from Medicaid because the State of Colorado contracts with HMO's to provide services to the Medicaid beneficiaries.

Impact of S. 556

Overall, I wholeheartedly applaud the amendments included in S.556 with regard to improving the health status of American Indian people who reside off reservation in urban areas. Senator Campbell, the findings outlined in the beginning text clearly indicate that a major goal of the United States is 'to provide the quantity and quality of health services with which will permit the health status of Indians regardless of where they live, to be raised to the highest possible level, that is no less than that of the general population, and to provide for the maximum participation of Indian Tribes, Tribal Organizations and Urban Indian Organizations in the planning, delivery and management of those health services". The National Steering Committee agreed with those findings and went on to add that "population growth of Indian people that began in the later part of the twentieth century increases the need for federal health care services". Population growth in tribal and urban communities and the ever increasing move from tribal/rural communities to major urban centers must behoove both Congress and tribes to address the health needs of enrolled tribal members who no longer reside on the reservation but continue to maintain their tribal identity. The task of congress, Indian Health Service, tribal and urban Indian health providers is the same, to remedy the severe health

conditions of Indians, many of which were caused directly or indirectly by the United States. It can be argued that those treaty and trust obligations must extend to those tribal members who reside off reservation by force or choice. Although, this will not happen overnight, S. 556 has many improvements that will start to help in the elimination of health disparities for all Indian people.

Title I

Under the proposed language in Title I, Section 123, urban programs are not eligible to apply for chronic shortage demonstration projects. Urban programs are not immune to the same chronic shortages of health professionals that IHS and Tribal Health Programs face. I urge you to consider additional language in the title to include the urban programs as possible sites for demonstration projects.

Section 127, Mental Health Training and Community Education Programs includes urban Indian programs in the study of mental health providers that will develop the training criteria for those providers but fails to ensure that urban Indian health providers are included in the development and technical assistance for community education. This is a concern because any development or technical assistance for urban programs will ultimately result in a loss of services because we are often left out of training and technical assistance programs that are provided for tribal and IHS personnel. Any and all training dollars are taken out of direct service line items.

Title II

Urban Indian Health Programs are not authorized in the current or proposed legislation in sections 201 and 202 to benefit from the Indian Health Care Improvement Fund (IHCIF) or the Catastrophic Health Emergency Fund (CHEF). Lack of authorization

for urban ICHF requires that urban programs divert funding from their current contracts to address community health needs or seek other funding sources outside of the Indian Health Service. If urban Indian health programs are authorized to access IHCF there would be more of a focus on development and provision of services to Indian patients versus the total patient population that also includes insured non-Indian patients who are seen in their clinic. IHCF for urban Indian health programs also would reduce the need for urban Indian health programs to diversify their funding sources to the extent that some programs have, e.g. one program has as many as 60 different funding sources. The administrative savings would benefit any urban Indian health program. Currently tribal members who reside in the Denver metropolitan area, without any type of insurance, who may happen to have a catastrophic illness or a victim of a disaster really have only three options 1. Seek care at their home reservation and wait for up to 6 months until the tribal/IHS contract health care eligibility guidelines apply; 2. Apply for Medicaid and other indigent care insurance; 3. Nothing.

Section 211 addresses the critical need for youth services regardless of where Indian children reside. Authorization for funding additional youth program services in urban areas is critically needed. Often urban youth do not have access to extended families or social ties that will help them to make the critical transition into adulthood. Urban youth are often marginalized in identity issues and experience conflicts in meshing their role in mainstream society and keeping a balance of their traditional beliefs and values intact. They often times suffer a much higher drop out rate. The dropout rate for American Indian youth in Colorado is 4.9% for males and 5.2% for females, the highest of any ethnic group identified and more than double the number of dropouts in the overall

population. We have found that many youth seeking our counseling services have a co-occurrence of depression with drug/alcohol problems.

In section 212, Prevention, Control, and Elimination of Communicable and Infectious Diseases, urban programs are included in the consultation and reporting processes but limits project and technical assistance funding available to tribes and tribal organizations.

Section 213 eliminates urban Indian health programs from authorization of funding for critical services primarily home and community based services, public health functions and traditional health care. These services are highly needed within urban Indian health centers. Although, the population may not be located in an isolated rural community, a need exists to be able to provide in-home care to elderly and disabled persons who are not able to navigate the urban area due to lack of transportation or failing health.

Title III

This section is limited to facility construction, maintenance and enhancement. Unlike tribes and Indian Health Service, both current and proposed legislation does not permit urban programs to participate in the facility priority system for funding of health clinics. Several urban Indian health programs have either purchased or built their own facilities through commercial bans, capital improvement funds or utilization of third party revenue received. However, these types of funding are often difficult to secure and most times not available to limited direct service and outreach/referral programs. This ensures that the community has a stable location. Urban centers that lease are faced with

increasing rental costs and no sense of ownership by the community. Programs that have had to move have found it very expensive and time consuming.

Title IV

This section speaks to the federal trust responsibility through the authorization to disregard payments received by tribes, tribal organizations and urban programs in determining funding appropriations for health care and services to Indians. In recent years Indian health programs have not received adequate funding to provide comprehensive services to Indian people. Although, it appears that appropriations have increased, these increases have not allowed for medical inflation increases, general inflation increases, salary increases or population growth.

This section also authorizes urban Indian health programs to recover reasonable charges for services for individuals who have private or public medical insurance. This is key for urban health programs to receive reimbursement from health insurance, Managed Care Organizations, CHIP, Medicare and Medicaid when the Indian patient is enrolled with the plan but the urban Indian health organization is considered to be an “out of network provider”.

Title V

Title V is the heart and soul for the urban Indian health programs. This legislation created 36 urban Indian health programs and 12 urban alcohol a.k.a. “NIAAA” programs. The legislation also serves as the guidelines for creating other urban Indian health programs.

Items of note include the ability of current programs to create satellite clinics to better address the health needs of the Indian community. This is vital because many programs are located in large metropolitan cities such as Los Angeles, San Francisco, Chicago or Denver and have a large concentration of Indian people in their area.

Section 509 authorizes, for the first time, grants to these programs for the lease, purchase, renovation, construction or expansion of these facilities. It also establishes a revolving facilities loan fund that will be used solely for the purposes of urban facilities. The proposed fund would be self-sustaining. Facilities funding is a great need for almost every urban Indian health program. An important note in this section is that the urban programs do not have access to funds for maintenance and improvement of their facilities. The program in Boston currently resides in a very old State institution that utilizes skeleton keys for some of its offices. Denver Indian Health and Family Services recently needed additional office space and if it were not for the good fortune of my father being a construction contractor and volunteering his services along with a friend, we would not have had been able to add an office, a group therapy room, an additional examination room, a laboratory and another waiting area for medical patients.

Section 511 deals only with the issue of substance abuse; however throughout Title VII urban Indian health programs and urban Indians are included in this behavioral health section. Not to discount the substance abuse needs of urban Indians, it would better serve the urban Indians to be carried throughout Title VII because of its comprehensive look at both mental health and substance abuse issues for Indian people.

Section 512, the permanency of the Oklahoma City and Tulsa Clinics Demonstration project is vital. These programs have served as role models for other

urban Indian health programs. It is important to note that they have been able to retain their identity as “Indian Clinics” while still enjoying many of the benefits of being treated as direct care service unit. It is my belief that if tribes are able to contract these programs, services will become fragmented and the populations who receive care through these clinics will ultimately lose much needed health services.

The transference of Urban NIAAA Programs is authorized within section 513. These funds must be transferred immediately. These funds were scheduled to be transferred nearly 10 years ago. Because the NIAAA’s have not been transferred the urban communities have lost much needed funding for the provision of substance abuse services. Several tribes or tribal organizations have contracted those funds and those monies are lost forever. It is urged that a moratorium be placed on the ability of the tribes to contract any substance abuse funds until the remaining NIAAA dollars are transferred. It is also urged that these programs should be designated as “Urban Indian Substance Abuse Programs” and thereby distinguish them from the Urban Indian Health Programs to ensure that duplication of administrative and granting authorities do not exist.

Section 514 provides for increased consultation between IHS, HCFA and other DHHS divisions. As has been demonstrated in other areas of Indian policy making, close consultation with Indian organizations leads to better results, less confusion and a higher level of cooperation and efficiency on the part of everyone involved.

Federal Tort Claims Act Coverage should cover urban Indian organizations who receive funding under through this title. This would appropriately grant the urban Indian organizations coverage that is currently enjoyed by other Indian organizations that receive federal funding. Elimination of the high cost of malpractice insurance lessens a

major barrier to outreach and referral programs in their efforts to become direct medical service providers. It also assists with defraying the increasing costs of medical malpractice for direct service providers and allows for already scarce funding to be used for direct care.

Section 516 authorizes the development and construction of two residential treatment centers for urban Indian youth in each state where a need exists and where there is a lack of culturally competent residential treatment services for youth. It is vital to “catch” these youth in the early stages of behavioral health problems. Often times sending the youth to a tribal facility is not an option either because of distance or shortage of beds. As mental health and substance abuse needs continue to grow and State facilities and funding are cut, we must find a way to address these needs for our youth.

Section 517 allows for the Secretary of Health and Human Services to permit Title V funded organizations to use facilities or equipment owned by the federal government and authorizes the donation of excess property of the IHS or GSA to such organizations. This has the potential to greatly expand our capabilities and resources to urban Indian communities.

Section 518 Grants for Diabetes Prevention, Treatment and Control formalizes the existing diabetes authorizations in the Indian Health Care Improvement Act. Diabetes continues to run rampant in Indian people regardless of tribal affiliation and residential status. These grants have allowed urban programs to extend an increase of medical services to diabetics. In our clinic we have now weight loss support groups, a fitness training and facility, increased dental assistance, increased prescription assistance and more.

Section 601 establishes the Indian Health Service as an agency of the Public Health Service. The elevation of the department to an agency within the Public Health Service can dramatically serve to raise the awareness of Indian health issues within a vast bureaucracy.

Title VII

Urban Indian health programs are included throughout this title. As treatment modalities and research improve, it has become increasingly more difficult to separate out purely substance abuse and mental health issues. The combined section of broader behavioral health will allow for greater flexibility in meeting the needs of Indian people with behavioral health issues.

This title also authorizes behavioral health treatment specifically for Indian women and fetal alcohol programs to be extended to urban programs for the first time. The special needs of Indian women, as well as the devastating effect of fetal alcohol syndrome are as common among the urban Indian population as the reservation population.

Title VIII

Section 807 addresses the health services that may be provided to non-eligible persons. This is of great concern to tribal members who live off reservation. It allows for non-Indian step children and non-Indian spouses to receive services. Allowing access to already stretched services has potential to take away from legitimate tribal members regardless of where they reside. It appears wholly unfair that tribal members who reside off reservation are subject to minimal care while a non-Indian on their reservation may receive comprehensive services and possible access to contract health care services.

The establishment of a National Bi-Partisan Commission on Indian Health Care Entitlement is welcome. Healthcare for Indian people must be viewed as an entitlement versus a discretionary program.

Distinguished gentlemen and ladies, on behalf of my community and all tribal members who live away from the reservation, I thank you once again for the opportunity to provide testimony on S. 556 and urban Indian health programs. I would like to close with this statement. The United States continues to have a legal obligation to fulfill with Indian people, our ancestors signed treaties with this government that included the provision of health care for their descendents in exchange for this great Country. Whether an Indian lives off or on the reservation should not be an issue. These obligations should follow our people regardless of where they may live. If all urban Indian people were to return home today and exercise their right to those health benefits how will the federal government meet the treaty and trust responsibilities?