S. HRG. 109–162

# INDIAN HEALTH CARE IMPROVEMENT ACT

## JOINT HEARING

BEFORE THE

## COMMITTEE ON INDIAN AFFAIRS
## UNITED STATES SENATE

AND THE

## COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS
## UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

ON

**S. 1057**

INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2005

JULY 14, 2005
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APPENDIX

# INDIAN HEALTH CARE IMPROVEMENT ACT

**THURSDAY, JULY 14, 2005**

U.S. SENATE, COMMITTEE ON INDIAN AFFAIRS, MEETING JOINTLY WITH THE COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

*Washington, DC.*

The committee met, pursuant to notice, at 10:16 a.m. in room 106 Dirksen Senate Building, Hon. John McCain (chairman of the Committee on Indian Affairs) and Hon. Michael B. Enzi (chairman of the Committee on Health, Education, Labor and Pensions), presiding.

Present: Senators McCain, Enzi, Cantwell, Coburn, Dorgan, Inouye, Isakson, Kennedy, Murkowski, Murray and Reed.

## STATEMENT OF HON. MICHAEL B. ENZI, U.S. SENATOR FROM WYOMING, CHAIRMAN, COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

Senator ENZI. I am going to call to order this historic joint meeting of the Committee on Indian Affairs and the Committee on Health, Education, Labor and Pensions. Today's hearing will focus on the state of Indian health care and specifically the Indian Health Care Improvement Act.

We will be welcoming Senator McCain here shortly, and the rest of the members of the Indian Affairs Committee to our HELP Committee meeting room. Senator Kennedy and I started a policy of punctuality and we are continuing that. We will go ahead and make our comments and then they can make theirs when they arrive.

Earlier this year, Senator McCain did approach me about holding a joint committee hearing on the state of Indian health care. I immediately accepted, as health care is important, perhaps the most important issue facing tribes today, in fact, facing all people today. Today's hearing will enable us to chart our current progress and discuss what we can do to increase the services that are available to address the physical and emotional problems that continue to plague American Indians and Alaska Natives.

When the Indian Health Care Improvement Act was first signed into law in 1976, it was written to address the findings of surveys and studies that indicated that the health status of American Indians and Alaska Natives was far below that of the general population. It continues to be a matter of serious concern that, as the health status of most Americans continues to rise, the status of

American Indians and Alaska Natives has not kept pace with the general population.

Studies show that American Indians and Alaska Natives die at a higher rate than other Americans from alcoholism, tuberculosis, auto accidents, diabetes, homicide and suicide. In addition, a safe and adequate water supply and waste disposal facilities, something we all take for granted, is not available in 12 percent of American Indian and Alaska Native homes, as opposed to 1 percent in the rest of the Nation.

Several years ago, residents of the Wind River Reservation in Central Wyoming faced a drinking water shortage that threatened the health and safety of everybody in the area, so drinking water was donated to tribal members and local residents. The lack of these basic services makes life even harsher for these people and contributes to those already-high death rates. Coming from Wyoming, I know full well the problems we encounter in the effort to provide quality health care to all people of my home State.

As I noted during my visits to the Wind River Reservation, their problems are not unique. They have an impact on all those who live on reservations from coast to coast. We need to take a varied approach to address each of those problems separately. Clearly, people of different ages have different problems.

A multifaceted approach to solving each of the problems will require a systematic, as well as financial approach. Local, State and national governments and agencies must work together with tribal leaders to focus our resources where they will do the most good. That kind of approach has the greatest chance of being successful.

I appreciate all the witnesses taking time out of their busy schedules to be with us today. In addition, of course, I would like to welcome Richard Brannan, the chairman of the Northern Arapaho Business Council of Fort Washakie, WY. No one knows better than he does the problems faced by those living on reservations and by those who rely on the Indian Health Service for their health care needs. I am very pleased he was able to make the journey and to share his experiences with us today.

I look forward to his comments and those of the entire list of witnesses. Each of you has a perspective and a point of view to share that only you can provide. I look forward to hearing a summary of your prepared remarks so that we can address the underlying issues during our question and answer session.

To the members of the joint committees, we have a longstanding tradition on the HELP Committee that opening statements are made by the Chairman and Ranking Member, and due to the combined number of members of both committees and the fact that we have three panels and the fact that we begin voting again at 3 p.m., I would respectfully submit or ask that the tradition apply for today's hearing, but all members' full statements will be made a part of the record, as will all witnesses full statements be made a part of the record.

In addition, members may use the question and answer period to make remarks. I did mention that this is an historic situation of having the two committees that have an intense interest in Indian health working together to come up with some solutions. I really appreciate Chairman McCain suggesting that, and following

through on it. I think this will be the first time that this has actually been done outside of Energy and Water. This is probably an appropriate place to do it.

[Text of S. 1057 follows:]

II

109TH CONGRESS
1ST SESSION

# S. 1057

To amend the Indian Health Care Improvement Act to revise and extend that Act.

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IN THE SENATE OF THE UNITED STATES

MAY 17, 2005

Mr. MCCAIN (for himself and Mr. DORGAN) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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# A BILL

To amend the Indian Health Care Improvement Act to revise and extend that Act.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Indian Health Care Improvement Act Amendments of 2005''.

**SEC. 2. INDIAN HEALTH CARE IMPROVEMENT ACT AMENDED.**

(a) IN GENERAL.—The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

**"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

''(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

''(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

**''SEC. 2. FINDINGS.**

''Congress makes the following findings:

''(1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

''(2) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to en-

courage the maximum participation of Indians in the planning and management of those services.

''(3) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

''(4) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

**''SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.**

''Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

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

''(2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010 or successor objectives;

''(3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

''(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;

''(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination; and

''(6) to provide funding for programs and facilities operated by Indian Tribes and Tribal Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

**''SEC. 4. DEFINITIONS.**

''For purposes of this Act:

''(1) The term 'accredited and accessible' means on or near a reservation and accredited by a national or regional organization with accrediting authority.

''(2) The term 'Area Office' means an administrative entity, including a program office, within the Service through which services and funds are pro-

vided to the Service Units within a defined geographic area.

''(3) The term 'Assistant Secretary' means the Assistant Secretary of Indian Health.

''(4)(A) The term 'behavioral health' means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services.

''(B) The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(5) The term 'California Indians' means those Indians who are eligible for health services of the Service pursuant to section 806.

''(6) The term 'community college' means—

''(A) a tribal college or university, or

''(B) a junior or community college.

''(7) The term 'contract health service' means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

''(8) The term 'Department' means, unless otherwise designated, the Department of Health and Human Services.

''(9) The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—

''(A) controlling—

''(i) development of diabetes;

''(ii) high blood pressure;

''(iii) infectious agents;

''(iv) injuries;

''(v) occupational hazards and disabilities;

''(vi) sexually transmittable diseases; and

''(vii) toxic agents; and

''(B) providing—

''(i) fluoridation of water; and

''(ii) immunizations.

''(10) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, op-

tometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, and any other health profession.

''(11) The term 'health promotion' means—

''(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in conformity with physical and mental capacity;

''(D) making available suitable housing, safe water, and sanitary facilities;

''(E) improving the physical, economic, cultural, psychological, and social environment;

''(F) promoting adequate opportunity for spiritual, religious, and Traditional Health Care Practices; and

''(G) providing adequate and appropriate programs, including—

"(i) abuse prevention (mental and physical);

"(ii) community health;

"(iii) community safety;

"(iv) consumer health education;

"(v) diet and nutrition;

"(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;

"(vii) environmental health;

"(viii) exercise and physical fitness;

"(ix) avoidance of fetal alcohol disorders;

"(x) first aid and CPR education;

"(xi) human growth and development;

"(xii) injury prevention and personal safety;

"(xiii) behavioral health;

"(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;

"(xv) personal health and wellness practices;

''(xvi) personal capacity building;

''(xvii) prenatal, pregnancy, and infant care;

''(xviii) psychological well-being;

''(xix) reproductive health and family planning;

''(xx) safe and adequate water;

''(xxi) safe housing, relating to elimination, reduction, and prevention of contaminants that create unhealthy housing conditions;

''(xxii) safe work environments;

''(xxiii) stress control;

''(xxiv) substance abuse;

''(xxv) sanitary facilities;

''(xxvi) sudden infant death syndrome prevention;

''(xxvii) tobacco use cessation and reduction;

''(xxviii) violence prevention; and

''(xxix) such other activities identified by the Service, a Tribal Health Program, or an Urban Indian Organization, to promote achievement of any of the objectives described in section 3(2).

''(12) The term 'Indian', unless otherwise designated, means any person who is a member of an Indian tribe or is eligible for health services under section 806, except that, for the purpose of sections 102 and 103, the term also means any individual who—

''(A)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside; or

''(ii) is a descendant, in the first or second degree, of any such member;

''(B) is an Eskimo or Aleut or other Alaska Native;

''(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

''(D) is determined be an Indian under regulations promulgated by the Secretary.

''(13) The term 'Indian Health Program' means—

''(A) any health program administered directly by the Service;

''(B) any Tribal Health Program; or

''(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of April 30, 1908 (25 U.S.C. 47), commonly known as the 'Buy Indian Act'.

''(14) The term 'Indian Tribe' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(15) The term 'junior or community college' has the meaning given the term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

''(16) The term 'reservation' means any federally recognized Indian Tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (25 U.S.C. 1601 et seq.).

''(17) The term 'Secretary', unless otherwise designated, means the Secretary of Health and Human Services.

''(18) The term 'Service' means the Indian Health Service.

''(19) The term 'Service Area' means the geographical area served by each Area Office.

''(20) The term 'Service Unit' means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

''(21) The term 'telehealth' has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

''(22) The term 'telemedicine' means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

''(23) The term 'Traditional Health Care Practices' means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to Western healing sciences) which embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness

and which call upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony.

''(24) The term 'tribal college or university' has the meaning given the term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1059c(b)(3)).

''(25) The term 'Tribal Health Program' means an Indian Tribe or Tribal Organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(26) The term 'Tribal Organization' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(27) The term 'Urban Center' means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V of this Act, as determined by the Secretary.

"(28) The term 'Urban Indian' means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:

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

"(B) The individual is an Eskimo, Aleut, or other Alaskan Native.

"(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

"(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

"(29) The term 'Urban Indian Organization' means a nonprofit corporate body that (A) is situated in an Urban Center; (B) is governed by an Urban Indian-controlled board of directors; (C) provides for the participation of all interested Indian

groups and individuals; and (D) is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

# "TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

**"SEC. 101. PURPOSE.**

''The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and Urban Indian Organizations involved in the provision of health services to Indians.

**"SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.**

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities, Tribal Health Programs, or Urban Indian Organizations to assist such entities in meeting the costs of—

''(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

''(A) to enroll in courses of study in such health professions; or

''(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

''(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

''(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

''(b) FUNDING.—

''(1) APPLICATION.—The Secretary shall not make a grant under this section unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe pursuant to this Act. The Secretary shall give

a preference to applications submitted by Tribal Health Programs or Urban Indian Organizations.

''(2) AMOUNT OF FUNDS; PAYMENT.—The amount of a grant under this section shall be determined by the Secretary. Payments pursuant to this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations issued pursuant to this Act. To the extent not otherwise prohibited by law, funding commitments shall be for 3 years, as provided in regulations issued pursuant to this Act.

**''SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.**

''(a) SCHOLARSHIPS AUTHORIZED.—The Secretary, acting through the Service, shall provide scholarship grants to Indians who—

''(1) have successfully completed their high school education or high school equivalency; and

''(2) have demonstrated the potential to successfully complete courses of study in the health professions.

''(b) PURPOSES.—Scholarships provided pursuant to this section shall be for the following purposes:

''(1) Compensatory preprofessional education of any recipient, such scholarship not to exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued under this Act).

''(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years. An extension of up to 2 years (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued pursuant to this Act) may be approved.

''(c) OTHER CONDITIONS.—Scholarships under this section—

''(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school;

''(2) shall not be denied solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; and

''(3) shall not be denied solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

**"SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.**

''(a) IN GENERAL.—

''(1) AUTHORITY.—The Secretary, acting through the Service, shall make scholarship grants to Indians who are enrolled full or part time in accredited schools pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Services Act (42 U.S.C. 2541), except as provided in subsection (b) of this section.

''(2) ALLOCATION BY FORMULA.—Except as provided in paragraph (3), the funding authorized by this section shall be allocated by Service Area by a formula developed in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. Such formula shall consider the human resource development needs in each Service Area.

''(3) CONTINUITY OF PRIOR SCHOLARSHIPS.—Paragraph (2) shall not apply with respect to individual recipients of scholarships provided under this section (as in effect 1 day prior to the date of enactment of the Indian Health Care Improvement Act Amendments of 2005) until such time as the individual completes the course of study that is supported through such scholarship.

''(4) CERTAIN DELEGATION NOT ALLOWED.—The administration of this section shall be a responsibility of the Assistant Secretary and shall not be delegated in a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(b) ACTIVE DUTY SERVICE OBLIGATION.—

''(1) OBLIGATION MET.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year-for-year obligation, by service in one or more of the following:

''(A) In an Indian Health Program.

''(B) In a program assisted under title V of this Act.

''(C) In the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional

shortage area and addresses the health care needs of a substantial number of Indians.

''(2) OBLIGATION DEFERRED.—At the request of any individual who has entered into a contract referred to in paragraph (1) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

''(A) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service under this subsection.

''(B) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

''(C) The active duty service obligation will be served in the health profession of that individual in a manner consistent with paragraph (1).

''(D) A recipient of a scholarship under this section may, at the election of the recipient, meet the active duty service obligation described in paragraph (1) by service in a program specified under that paragraph that—

''(i) is located on the reservation of the Indian Tribe in which the recipient is enrolled; or

''(ii) serves the Indian Tribe in which the recipient is enrolled.

''(3) PRIORITY WHEN MAKING ASSIGNMENTS.—Subject to paragraph (2), the Secretary, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in paragraph (1), shall give priority to assigning individuals to service in those programs specified in paragraph (1) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(c) PART-TIME STUDENTS.—In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

''(1) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the Area Office;

''(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

''(A) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the Area Office); or

''(B) 2 years; and

''(3) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254*l*(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

''(d) BREACH OF CONTRACT.—

''(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date

of enactment of the Indian Health Care Improvement Act Amendments of 2005 if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1) an individual breaches a written contract by failing either to begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the

individual an amount determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) WAIVERS AND SUSPENSIONS.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the affected Area Office, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, determines that—

''(A) it is not possible for the recipient to meet that obligation or make that payment;

''(B) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

''(C) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

''(5) EXTREME HARDSHIP.—Notwithstanding any other provision of law, in any case of extreme

hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

''(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

**''SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.**

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants to at least 3 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

''(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

''(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

"(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

"(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

"(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

"(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

"(7) to the maximum extent feasible, employs qualified Indians in the program.

"(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

"(1) in an Indian Health Program;

"(2) in a program assisted under title V of this Act; or

''(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

**''SEC. 106. FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.**

''(a) IN GENERAL.—

''(1) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

''(2) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 104.

''(3) APPLICATION.—An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—A Tribal Health Program receiving a grant under subsection (a) shall provide

scholarships to Indians in accordance with the requirements of this section.

''(2) COSTS.—With respect to costs of providing any scholarship pursuant to subsection (a)—

''(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

''(B) 20 percent of such costs may be paid from any other source of funds.

''(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions contemplated by this Act.

''(d) CONTRACT.—In providing scholarships under subsection (b), the Secretary and the Tribal Health Program shall enter into a written contract with each recipient of such scholarship. Such contract shall—

''(1) obligate such recipient to provide service in an Indian Health Program or Urban Indian Organization, in the same Service Area where the Tribal Health Program providing the scholarship is located, for—

''(A) a number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

''(B) such greater period of time as the recipient and the Tribal Health Program may agree;

''(2) provide that the amount of the scholarship—

''(A) may only be expended for—

''(i) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

''(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), with such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and not to exceed, for any year of attendance for which the scholarship is provided, the total

amount required for the year for the purposes authorized in this clause; and

''(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);

''(3) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

''(4) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

''(e) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under subsection (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level

as determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives

an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Tribal Health Programs involved or on the basis of information collected through such other means as the Secretary deems appropriate.

''(f) RELATION TO SOCIAL SECURITY ACT.—The recipient of a scholarship under this section shall agree, in providing health care pursuant to the requirements herein—

''(1) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to a program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX or title XXI of such Act; and

''(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance

under title XIX, or the State child health plan under title XXI, of such Act to provide service to individuals entitled to medical assistance or child health assistance, respectively, under the plan.

''(g) CONTINUANCE OF FUNDING.—The Secretary shall make payments under this section to a Tribal Health Program for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Tribal Health Program has not complied with the requirements of this section.

**''SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.**

''(a) EMPLOYMENT PREFERENCE.—Any individual who receives a scholarship pursuant to section 104 or 106 shall be given preference for employment in the Service, or may be employed by a Tribal Health Program or an Urban Indian Organization, or other agencies of the Department as available, during any nonacademic period of the year.

''(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.—Periods of employment pursuant to this subsection shall not be counted in determining fulfillment of the service obligation incurred as a condition of the scholarship.

''(c) TIMING; LENGTH OF EMPLOYMENT.—Any individual enrolled in a program, including a high school program, authorized under section 102(a) may be employed by the Service or by a Tribal Health Program or an Urban Indian Organization during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

''(d) NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department.

**''SEC. 108. CONTINUING EDUCATION ALLOWANCES.**

''In order to encourage health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian Health Program or an Urban Indian Organization and to provide their services in the rural and remote areas where a sig-

nificant portion of Indians reside, the Secretary, acting through the Service, may provide allowances to health professionals employed in an Indian Health Program or an Urban Indian Organization to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

**"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.**

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall maintain a Community Health Representative Program under which Indian Health Programs—

"(1) provide for the training of Indians as community health representatives; and

"(2) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

"(b) DUTIES.—The Community Health Representative Program of the Service, shall—

"(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality

health care, health promotion, and disease prevention services to the Indian communities served by the Program;

''(2) in order to provide such training, develop and maintain a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

''(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

''(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for continuing education;

''(4) maintain a system that provides close supervision of Community Health Representatives;

''(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and

''(6) promote Traditional Health Care Practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

**''SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.**

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish and administer a program to be known as the Service Loan Repayment Program (hereinafter referred to as the 'Loan Repayment Program') in order to ensure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian Health Programs and Urban Indian Organizations.

''(b) ELIGIBLE INDIVIDUALS.—To be eligible to participate in the Loan Repayment Program, an individual must—

''(1)(A) be enrolled—

''(i) in a course of study or program in an accredited educational institution (as determined by the Secretary under section 338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254*l*–1(b)(1)(c)(i))) and be scheduled to complete such course of study in

the same year such individual applies to participate in such program; or

''(ii) in an approved graduate training program in a health profession; or

''(B) have—

''(i) a degree in a health profession; and

''(ii) a license to practice a health profession;

''(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

''(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

''(C) meet the professional standards for civil service employment in the Service; or

''(D) be employed in an Indian Health Program or Urban Indian Organization without a service obligation; and

''(3) submit to the Secretary an application for a contract described in subsection (e).

''(c) APPLICATION.—

''(1) INFORMATION TO BE INCLUDED WITH FORMS.—In disseminating application forms and contract forms to individuals desiring to participate

in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (*l*) in the case of the individual's breach of contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Service to enable the individual to make a decision on an informed basis.

''(2) CLEAR LANGUAGE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

''(3) TIMELY AVAILABILITY OF FORMS.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure

that such individuals have adequate time to carefully review and evaluate such forms and information.

''(d) PRIORITIES.—

''(1) LIST.—Consistent with subsection (k), the Secretary shall annually—

''(A) identify the positions in each Indian Health Program or Urban Indian Organization for which there is a need or a vacancy; and

''(B) rank those positions in order of priority.

''(2) APPROVALS.—Notwithstanding the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

''(A) give first priority to applications made by individual Indians; and

''(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

''(i) individuals recruited through the efforts of an Indian Health Program or Urban Indian Organization; and

''(ii) other individuals based on the priority rankings under paragraph (1).

''(e) RECIPIENT CONTRACTS.—

''(1) CONTRACT REQUIRED.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in paragraph (2).

''(2) CONTENTS OF CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (C), the Secretary agrees—

''(I) to pay loans on behalf of the individual in accordance with the provisions of this section; and

''(II) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a Tribal Health Program or Urban Indian Organization as provided in clause (ii)(III); and

"(ii) subject to subparagraph (C), the individual agrees—

"(I) to accept loan payments on behalf of the individual;

"(II) in the case of an individual described in subsection (b)(1)—

"(aa) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

"(bb) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); and

"(III) to serve for a time period (hereinafter in this section referred to as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of

such individual's profession in an Indian Health Program or Urban Indian Organization to which the individual may be assigned by the Secretary;

''(B) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under subparagraph (A)(ii)(III);

''(C) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

''(D) a statement of the damages to which the United States is entitled under subsection (*l*) for the individual's breach of the contract; and

''(E) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—

''(1) the Secretary's approving, under subsection (e)(1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

''(2) the Secretary's disapproving an individual's participation in such Program.

''(g) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

''(A) tuition expenses;

''(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

''(C) reasonable living expenses as determined by the Secretary.

''(2) AMOUNT.—For each year of obligated service that an individual contracts to serve under subsection (e), the Secretary may pay up to $35,000 or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act, whichever is more, on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

''(A) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

''(B) provides an incentive to serve in Indian Health Programs and Urban Indian Organizations with the greatest shortages of health professionals; and

''(C) provides an incentive with respect to the health professional involved remaining in an Indian Health Program or Urban Indian Orga-

nization with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

''(3) TIMING.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(4) REIMBURSEMENTS FOR TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual, the Secretary—

''(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the total amount of loan repayments made for the taxable year involved; and

''(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

''(5) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

''(h) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

''(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other Service manpower programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

''(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

''(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or Urban Indian Organizations pursuant to contracts entered into under this section, shall—

''(1) ensure that the staffing needs of Tribal Health Programs and Urban Indian Organizations receive consideration on an equal basis with programs that are administered directly by the Service; and

''(2) give priority to assigning individuals to Indian Health Programs and Urban Indian Organizations that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(*l*) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary under this section and has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract if that individual—

''(A) is enrolled in the final year of a course of study and—

''(i) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is

enrolled (such level determined by the educational institution under regulations of the Secretary);

''(ii) voluntarily terminates such enrollment; or

''(iii) is dismissed from such educational institution before completion of such course of study; or

''(B) is enrolled in a graduate training program and fails to complete such training program.

''(2) OTHER BREACHES; FORMULA FOR AMOUNT OWED.—If, for any reason not specified in paragraph (1), an individual breaches his or her written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (e)(2), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: $A=3Z(t-s/t)$ in which—

''(A) 'A' is the amount the United States is entitled to recover;

''(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the indi-

vidual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Secretary of the Treasury;

''(C) 't' is the total number of months in the individual's period of obligated service in accordance with subsection (f); and

''(D) 's' is the number of months of such period served by such individual in accordance with this section.

''(3) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deductions in medicare payments pursuant to section 1892 of the Social Security Act.

''(4) TIME PERIOD FOR REPAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

''(5) RECOVERY OF DELINQUENCY.—

''(A) IN GENERAL.—If damages described in paragraph (4) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

''(i) use collection agencies contracted with by the Administrator of General Services; or

''(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

''(B) REPORT.—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

''(m) WAIVER OR SUSPENSION OF OBLIGATION.—

''(1) IN GENERAL.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible

or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

''(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

''(3) HARDSHIP WAIVER.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

''(4) BANKRUPTCY.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

''(n) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be submitted to Congress under section 801, a report concerning

the previous fiscal year which sets forth by Service Area the following:

''(1) A list of the health professional positions maintained by Indian Health Programs and Urban Indian Organizations for which recruitment or retention is difficult.

''(2) The number of Loan Repayment Program applications filed with respect to each type of health profession.

''(3) The number of contracts described in subsection (e) that are entered into with respect to each health profession.

''(4) The amount of loan payments made under this section, in total and by health profession.

''(5) The number of scholarships that are provided under sections 104 and 106 with respect to each health profession.

''(6) The amount of scholarship grants provided under section 104 and 106, in total and by health profession.

''(7) The number of providers of health care that will be needed by Indian Health Programs and Urban Indian Organizations, by location and profession, during the 3 fiscal years beginning after the date the report is filed.

''(8) The measures the Secretary plans to take to fill the health professional positions maintained by Indian Health Programs or Urban Indian Organizations for which recruitment or retention is difficult.

**''SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.**

''(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the 'LRRF'). The LRRF shall consist of such amounts as may be collected from individuals under section 104(d), section 106(e), and section 110(*l*) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF. All amounts collected, appropriated, or earned relative to the LRRF shall remain available until expended.

''(b) USE OF FUNDS.—

''(1) BY SECRETARY.—Amounts in the LRRF may be expended by the Secretary, acting through the Service, to make payments to an Indian Health Program—

''(A) to which a scholarship recipient under section 104 and 106 or a loan repayment pro-

gram participant under section 110 has been assigned to meet the obligated service requirements pursuant to such sections; and

''(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 104, 106, or section 110.

''(2) BY TRIBAL HEALTH PROGRAMS.—A Tribal Health Program receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or recruit and employ, directly or by contract, health professionals to provide health care services.

''(c) INVESTMENT OF FUNDS.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary of Health and Human Services determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(d) SALE OF OBLIGATIONS.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

**''SEC. 112. RECRUITMENT ACTIVITIES.**

''(a) REIMBURSEMENT FOR TRAVEL.—The Secretary, acting through the Service, may reimburse health professionals seeking positions with Indian Health Programs or Urban Indian Organizations, including individuals considering entering into a contract under section 110 and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

''(b) RECRUITMENT PERSONNEL.—The Secretary, acting through the Service, shall assign one individual in each Area Office to be responsible on a full-time basis for recruitment activities.

**''SEC. 113. INDIAN RECRUITMENT AND RETENTION PROGRAM.**

''(a) IN GENERAL.—The Secretary, acting through the Service, shall fund, on a competitive basis, innovative demonstration projects for a period not to exceed 3 years to enable Tribal Health Programs and Urban Indian Organizations to recruit, place, and retain health professionals to meet their staffing needs.

''(b) ELIGIBLE ENTITIES; APPLICATION.—Any Tribal Health Program or Urban Indian Organization may submit an application for funding of a project pursuant to this section.

**''SEC. 114. ADVANCED TRAINING AND RESEARCH.**

''(a) DEMONSTRATION PROGRAM.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian Health Program or Urban Indian Organization for a substantial period of time to pursue advanced training or research areas of study for which the Secretary determines a need exists.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian Health Program or Urban Indian Organization for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the United States shall be entitled to recover from

such individual an amount to be determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

''(c) EQUAL OPPORTUNITY FOR PARTICIPATION.—Health professionals from Tribal Health Programs and Urban Indian Organizations shall be given an equal opportunity to participate in the program under subsection (a).

**''SEC. 115. QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.**

''(a) GRANTS AUTHORIZED.—For the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians, the Secretary, acting through the Service, shall provide grants to the following:

''(1) Public or private schools of nursing.

''(2) Tribal colleges or universities.

''(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

''(b) USE OF GRANTS.—Grants provided under subsection (a) may be used for one or more of the following:

''(1) To recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses.

''(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

''(3) To provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians.

''(4) To provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses.

''(5) To provide any program that is designed to achieve the purpose described in subsection (a).

''(c) APPLICATIONS.—Each application for funding under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

''(d) PREFERENCES FOR GRANT RECIPIENTS.—In providing grants under subsection (a), the Secretary shall extend a preference to the following:

''(1) Programs that provide a preference to Indians.

''(2) Programs that train nurse midwives or advanced practice nurses.

''(3) Programs that are interdisciplinary.

''(4) Programs that are conducted in cooperation with a program for gifted and talented Indian students.

''(e) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide one of the grants authorized under subsection (a) to establish and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

''(f) ACTIVE DUTY SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assist-

ance described in paragraph (1) or (2) of subsection (b) that is funded by a grant provided under subsection (a). Such obligation shall be met by service—

''(1) in the Service;

''(2) in a program of an Indian Tribe or Tribal Organization conducted under the Indian Self-Determination and Education Assistance Act (including programs under agreements with the Bureau of Indian Affairs);

''(3) in a program assisted under title V of this Act; or

''(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health shortage area and addresses the health care needs of a substantial number of Indians.

**''SEC. 116. TRIBAL CULTURAL ORIENTATION.**

''(a) CULTURAL EDUCATION OF EMPLOYEES.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian Tribes in each Service Area receive educational instruction in the history and culture of such Indian Tribes and their relationship to the Service.

''(b) PROGRAM.—In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—

''(1) be developed in consultation with the affected Indian Tribes, Tribal Organizations, and Urban Indian Organizations;

''(2) be carried out through tribal colleges or universities;

''(3) include instruction in American Indian studies; and

''(4) describe the use and place of Traditional Health Care Practices of the Indian Tribes in the Service Area.

**''SEC. 117. INMED PROGRAM.**

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, is authorized to provide grants to colleges and universities for the purpose of maintaining and expanding the Indian health careers recruitment program known as the 'Indians Into Medicine Program' (hereinafter in this section referred to as 'INMED') as a means of encouraging Indians to enter the health professions.

''(b) QUENTIN N. BURDICK GRANT.—The Secretary shall provide one of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N.

Burdick Indian Health Programs', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

''(c) REGULATIONS.—The Secretary, pursuant to this Act, shall develop regulations to govern grants pursuant to this section.

''(d) REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program which—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary and secondary schools and community colleges located on reservations which will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the Indian Tribes and Indian communities which will be served by the program;

''(3) provides summer preparatory programs for Indian students who need enrichment in the subjects

of math and science in order to pursue training in the health professions;

''(4) provides tutoring, counseling, and support to students who are enrolled in a health career program of study at the respective college or university; and

''(5) to the maximum extent feasible, employs qualified Indians in the program.

**''SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.**

''(a) GRANTS TO ESTABLISH PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such community colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on or near a reservation or in an Indian Health Program.

''(2) AMOUNT OF GRANTS.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $100,000.

''(b) GRANTS FOR MAINTENANCE AND RECRUITING.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

''(2) REQUIREMENTS.—Grants may only be made under this section to a community college which—

''(A) is accredited;

''(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

''(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

''(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and

''(ii) stipulate certifications necessary to approve internship and field placement opportunities at Indian Health Programs;

''(D) has a qualified staff which has the appropriate certifications;

''(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

''(F) agrees to provide for Indian preference for applicants for programs under this section.

''(c) TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

''(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs; and

''(2) providing technical assistance and support to such colleges.

''(d) ADVANCED TRAINING.—

''(1) REQUIRED.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses

of study which provide advanced training for any health professional who—

''(A) has already received a degree or diploma in such health profession; and

''(B) provides clinical services on or near a reservation or for an Indian Health Program.

''(2) MAY BE OFFERED AT ALTERNATE SITE.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

''(e) FUNDING PRIORITY.—Where the requirements of subsection (b) are met, funding priority shall be provided to tribal colleges and universities in Service Areas where they exist.

**''SEC. 119. RETENTION BONUS.**

''(a) BONUS AUTHORIZED.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, an Indian Health Program or Urban Indian Organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

''(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

"(2) the Secretary determines is needed by Indian Health Programs and Urban Indian Organizations;

"(3) has—

"(A) completed 3 years of employment with an Indian Health Program or Urban Indian Organization; or

"(B) completed any service obligations incurred as a requirement of—

"(i) any Federal scholarship program; or

"(ii) any Federal education loan repayment program; and

"(4) enters into an agreement with an Indian Health Program or Urban Indian Organization for continued employment for a period of not less than 1 year.

"(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

"(c) DEFAULT OF RETENTION AGREEMENT.—Any health professional failing to complete the agreed upon

term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(*l*)(2)(B).

''(d) OTHER RETENTION BONUS.—The Secretary may pay a retention bonus to any health professional employed by a Tribal Health Program if such health professional is serving in a position which the Secretary determines is—

''(1) a position for which recruitment or retention is difficult; and

''(2) necessary for providing health care services to Indians.

**''SEC. 120. NURSING RESIDENCY PROGRAM.**

''(a) ESTABLISHMENT OF PROGRAM.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian Health Program or Urban Indian Organization, and have done so for a period of not less than 1 year, to pursue advanced training. Such program shall include a combination of education and work study in an Indian Health Program or Urban Indian Organiza-

tion leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse), a bachelor's degree (in the case of a registered nurse), or advanced degrees or certifications in nursing and public health.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian Health Program or Urban Indian Organization for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

**''SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA.**

''(a) GENERAL PURPOSES OF PROGRAM.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in Alaska under which the Service—

''(1) provides for the training of Alaska Natives as health aides or community health practitioners;

''(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

''(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

''(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

''(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

''(2) in order to provide such training, develop a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

''(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

''(C) promotes the achievement of the health status objectives specified in section 3(2);

''(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

''(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services.

''(c) NATIONAL COMMUNITY HEALTH AIDE PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Service, is authorized to establish a national Community Health Aide Program in accordance with subsection (a), except as provided in paragraphs (2) and (3), without reducing funds for the Community Health Aide Program for Alaska.

''(2) LIMITED CERTIFICATION.—Except for any dental health aide in the State of Alaska, the Secretary, acting through the Community Health Aide Program of the Service, shall ensure that, for a period of 4 years, dental health aides are certified only to provide services relating to—

''(A) early childhood dental disease prevention and reversible dental procedures; and

''(B) the development of local capacity to provide those dental services.

''(3) REVIEW.—

''(A) IN GENERAL.—During the 4-year period described in paragraph (2), the Secretary, acting through the Community Health Aide Program of the Service, shall conduct a review of the dental health aide program in the State of Alaska to determine the ability of the program to address the dental care needs of Native Alaskans, the quality of care provided (including any training, improvement, or additional oversight needed), and whether the program is appropriate and necessary to carry out in any other Indian community.

''(B) REPORT.—After conducting the review under subparagraph (A), the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources of the House of Representatives a report describing any finding of the Secretary under the review.

''(C) FUTURE AUTHORIZATION OF CERTIFICATIONS.—Before authorizing any dental procedure not described in paragraph (2)(A), the Secretary shall consult with Indian tribes, Tribal Organizations, Urban Indian Organizations, and other interested parties to ensure

that the safety and quality of care of the Community Health Aide Program are adequate and appropriate.

**''SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.**

''The Secretary, acting through the Service, shall, by contract or otherwise, provide training for Indians in the administration and planning of Tribal Health Programs.

**''SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.**

''(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

''(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—

''(1) to provide direct clinical and practical experience at a Service Unit to health profession students and residents from medical schools;

''(2) to improve the quality of health care for Indians by assuring access to qualified health care professionals; and

''(3) to provide academic and scholarly opportunities for health professionals serving Indians by

identifying all academic and scholarly resources of the region.

''(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area which will be served by the program.

**''SEC. 124. NATIONAL HEALTH SERVICE CORPS.**

''(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

''(1) remove a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization; or

''(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, Indian Tribes, or Tribal Organizations, has ensured that the Indians receiving services from such member will experience no reduction in services.

''(b) EXEMPTION FROM LIMITATIONS.—National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service shall be exempt from the full-time equivalent limitations of the National Health Service Corps and the Service

when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

**"SEC. 125. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.**

''(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.

''(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

''(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 1 year. Such contract or grant may be renewed for an additional 1-year period upon the approval of the Secretary.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges

and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

''(e) ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

''(f) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

''(g) DEFINITION.—For the purposes of this section, the term 'educational curriculum' means 1 or more of the following:

''(1) Classroom education.

''(2) Clinical work experience.

''(3) Continuing education workshops.

**"SEC. 126. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.**

''(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

''(b) POSITIONS.—The positions referred to in subsection (a) are—

''(1) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

''(A) elementary and secondary education;

''(B) social services and family and child welfare;

''(C) law enforcement and judicial services; and

''(D) alcohol and substance abuse;

''(2) staff positions within the Service; and

''(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations (without re-

gard to the funding source), and Urban Indian Organizations.

''(c) TRAINING CRITERIA.—

''(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or Urban Indian Organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

''(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding Traditional Health Care Practices is provided.

''(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, or assist the Indian Tribe, Tribal Organization, or Urban Indian Organization to develop and implement, a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

''(e) PLAN.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').

**''SEC. 127. AUTHORIZATION OF APPROPRIATIONS.**

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

# ''TITLE II—HEALTH SERVICES

**''SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.**

''(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in health status and health resources of all Indian Tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian Tribes with the highest levels

of health status deficiencies and resource deficiencies:

''(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

''(B) Preventive health, including mammography and other cancer screening in accordance with section 207.

''(C) Dental care.

''(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

''(E) Emergency medical services.

''(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

''(G) Accident prevention programs.

''(H) Home health care.

''(I) Community health representatives.

''(J) Maintenance and repair.

''(K) Traditional Health Care Practices.

''(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

''(c) ALLOCATION; USE.—

''(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service Units, Indian Tribes, or Tribal Organizations. The funds allocated to each Indian Tribe, Tribal Organization, or Service Unit under this paragraph shall be used by the Indian Tribe, Tribal Organization, or Service Unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian Tribe served by such Service Unit, Indian Tribe, or Tribal Organization.

''(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service Unit, Indian Tribe, or Tribal Organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and

with the active participation of, the affected Indian Tribes and Tribal Organizations.

''(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

''(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

''(A) the health status objectives set forth in section 3(2) are not being achieved; and

''(B) the Indian Tribe or Tribal Organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

''(2) AVAILABLE RESOURCES.—The health resources available to an Indian Tribe or Tribal Organization include health resources provided by the Service as well as health resources used by the Indian Tribe or Tribal Organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

''(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian Tribe or Tribal Organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian Tribe or Tribal Organization.

''(e) ELIGIBILITY FOR FUNDS.—Tribal Health Programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

''(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service Unit, including newly recognized or acknowledged Indian Tribes. Such report shall set out—

''(1) the methodology then in use by the Service for determining Tribal health status and resource deficiencies, as well as the most recent application of that methodology;

''(2) the extent of the health status and resource deficiency of each Indian Tribe served by the Service or a Tribal Health Program;

"(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian Tribes served by the Service or a Tribal Health Program; and

"(4) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service Unit, Indian Tribe, or Tribal Organization;

"(B) the number of Indians eligible for health services in each Service Unit or Indian Tribe or Tribal Organization; and

"(C) the number of Indians using the Service resources made available to each Service Unit, Indian Tribe or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

"(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian Tribes and Tribal Organizations.

''(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

**''SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.**

''(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

''(1) the amounts deposited under subsection (f); and

''(2) the amounts appropriated to CHEF under this section.

''(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

''(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

''(d) REGULATIONS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section to—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;

''(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) the 2000 level of $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medi-

cal care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

''(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

''(A) Service Units; or

''(B) whenever otherwise authorized by the Service, non-Service facilities or providers;

''(4) establish a procedure for payment from CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

''(5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

''(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C.

13) (commonly known as the 'Snyder Act'), or any other law.

''(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF.

**''SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.**

''(a) FINDINGS.—Congress finds that health promotion and disease prevention activities—

''(1) improve the health and well-being of Indians; and

''(2) reduce the expenses for health care of Indians.

''(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and Tribal Health Programs, shall provide health promotion and disease prevention services to Indians to achieve the health status objectives set forth in section 3(2).

''(c) EVALUATION.—The Secretary, after obtaining input from the affected Tribal Health Programs, shall submit to the President for inclusion in each report which

is required to be submitted to Congress under section 801 an evaluation of—

''(1) the health promotion and disease prevention needs of Indians;

''(2) the health promotion and disease prevention activities which would best meet such needs;

''(3) the internal capacity of the Service and Tribal Health Programs to meet such needs; and

''(4) the resources which would be required to enable the Service and Tribal Health Programs to undertake the health promotion and disease prevention activities necessary to meet such needs.

**''SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.**

''(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall determine—

''(1) by Indian Tribe and by Service Unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

''(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effective ongoing monitoring of disease indicators) each Service Unit should take to

reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian Tribes within that Service Unit.

''(b) DIABETES SCREENING.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and, in consultation with Indian Tribes, Urban Indian Organizations, and appropriate health care providers, establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a Tribal Health Program and may be conducted through appropriate Internet-based health care management programs.

''(c) FUNDING FOR DIABETES.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Amendments Care Improvement Act of 2005, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian Tribes. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate

pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of 2005 and for projects which are added and funded thereafter.

''(d) FUNDING FOR DIALYSIS PROGRAMS.—The Secretary is authorized to provide funding through the Service, Indian Tribes, and Tribal Organizations to establish dialysis programs, including funding to purchase dialysis equipment and provide necessary staffing.

''(e) OTHER DUTIES OF THE SECRETARY.—The Secretary shall, to the extent funding is available—

''(1) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

''(2) establish in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

''(3) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

**"SEC. 205. SHARED SERVICES FOR LONG-TERM CARE.**

''(a) LONG-TERM CARE.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations for, the delivery of long-term care and similar services to Indians. Such agreements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or other similar facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by such Indian Tribe or Tribal Organization.

''(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

''(1) may, at the request of the Indian Tribe or Tribal Organization, delegate to such Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated

proportionately between the Service and the Indian Tribe or Tribal Organization; and

''(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

''(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

''(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

**''SEC. 206. HEALTH SERVICES RESEARCH.**

''The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs. The Secretary shall also, to the maximum extent practicable, coordinate departmental research

resources and activities to address relevant Indian Health Program research needs. Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section. This funding may be used for both clinical and nonclinical research.

**"SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.**

"The Secretary, acting through the Service or Tribal Health Programs, shall provide for screening as follows:

"(1) Screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under accepted and appropriate national standards, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

"(2) Other cancer screening meeting accepted and appropriate national standards.

**"SEC. 208. PATIENT TRAVEL COSTS.**

"The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving

health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

''(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

''(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

''(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

**''SEC. 209. EPIDEMIOLOGY CENTERS.**

''(a) ADDITIONAL CENTERS.—In addition to those epidemiology centers already established as of the date of enactment of this Act, and without reducing the funding levels for such centers, not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, shall establish and fund an epidemiology center in each Service Area which does not yet have one to carry out the functions described in subsection (b). Any new centers so established may be operated by Tribal Health Programs, but such funding shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each Service Area epidemiology center established under this subsection shall, with respect to such Service Area—

''(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the Service Area;

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

''(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban In-

dian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

''(d) FUNDING FOR STUDIES.—The Secretary may make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct epidemiological studies of Indian communities.

**''SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.**

''(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—In addition to carrying out any other program for health promotion or disease prevention, the Secretary, acting through the Service, is authorized to award grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop comprehensive school health education programs for children from pre-school through

grade 12 in schools for the benefit of Indian and Urban Indian children.

''(b) USE OF FUNDS.—Funding provided under this section may be used for purposes which may include, but are not limited to, the following:

''(1) Developing and implementing health education curricula both for regular school programs and afterschool programs.

''(2) Training teachers in comprehensive school health education curricula.

''(3) Integrating school-based, community-based, and other public and private health promotion efforts.

''(4) Encouraging healthy, tobacco-free school environments.

''(5) Coordinating school-based health programs with existing services and programs available in the community.

''(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

''(7) Developing behavioral health wellness programs.

''(8) Developing chronic disease prevention programs.

''(9) Developing substance abuse prevention programs.

''(10) Developing injury prevention and safety education programs.

''(11) Developing activities for the prevention and control of communicable diseases.

''(12) Developing community and environmental health education programs that include traditional health care practitioners.

''(13) Violence prevention.

''(14) Such other health issues as are appropriate.

''(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications for funding provided pursuant to this section.

''(e) DEVELOPMENT OF PROGRAM FOR BIA FUNDED SCHOOLS.—

''(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, acting through the Service, and affected Indian Tribes and Tribal Organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.

''(2) REQUIREMENTS FOR PROGRAMS.—Such programs shall include—

''(A) school programs on nutrition education, personal health, oral health, and fitness;

''(B) behavioral health wellness programs;

''(C) chronic disease prevention programs;

''(D) substance abuse prevention programs;

''(E) injury prevention and safety education programs; and

''(F) activities for the prevention and control of communicable diseases.

''(3) DUTIES OF THE SECRETARY.—The Secretary of the Interior shall—

''(A) provide training to teachers in comprehensive school health education curricula;

''(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

''(C) encourage healthy, tobacco-free school environments.

**''SEC. 211. INDIAN YOUTH PROGRAM.**

''(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, is authorized to establish and administer a program to provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and Urban Indian preadolescent and adolescent youths.

''(b) USE OF FUNDS.—

''(1) ALLOWABLE USES.—Funds made available under this section may be used to—

''(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

''(B) develop and provide community training and education.

''(2) PROHIBITED USE.—Funds made available under this section may not be used to provide services described in section 707(c).

''(c) DUTIES OF THE SECRETARY.—The Secretary shall—

''(1) disseminate to Indian Tribes, Tribal Organizations, and Urban Indian Organizations information regarding models for the delivery of comprehensive health care services to Indian and Urban Indian adolescents;

''(2) encourage the implementation of such models; and

''(3) at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance in the implementation of such models.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications or proposals under this section.

**"SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.**

"(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, and after consultation with Indian Tribes, Tribal Organizations, Urban Indian Organizations, and the Centers for Disease Control and Prevention, may make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for the following:

"(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori.

"(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

"(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

"(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

''(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

''(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

''(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance; and

''(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and Urban Indians.

**''SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERVICES.**

''(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide funding under this Act to meet the ob-

jectives set forth in section 3 through health care-related services and programs not otherwise described in this Act, including—

''(1) hospice care;

''(2) assisted living;

''(3) long-term health care;

''(4) home- and community-based services; and

''(5) public health functions.

''(b) SERVICES TO OTHERWISE INELIGIBLE PERSONS.—Subject to section 807, at the discretion of the Service, Indian Tribes, or Tribal Organizations, services provided for hospice care, home- and community-based care, assisted living, and long-term care may be provided (subject to reimbursement) to persons otherwise ineligible for the health care benefits of the Service. Any funds received under this subsection shall not be used to offset or limit the funding allocated to the Service or an Indian Tribe or Tribal Organization.

''(c) DEFINITIONS.—For the purposes of this section, the following definitions shall apply:

''(1) The term 'home- and community-based services' means 1 or more of the following:

''(A) Homemaker/home health aide services.

''(B) Chore services.

''(C) Personal care services.

''(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

''(E) Respite care.

''(F) Training for family members.

''(G) Adult day care.

''(H) Such other home- and community-based services as the Secretary, an Indian tribe, or a Tribal Organization may approve.

''(2) The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

''(3) The term 'public health functions' means the provision of public health-related programs, functions, and services, including assessment, assurance, and policy development which Indian Tribes and Tribal Organizations are authorized and encouraged, in those circumstances where it meets their needs, to do by forming collaborative relationships

with all levels of local, State, and Federal Government.

**"SEC. 214. INDIAN WOMEN'S HEALTH CARE.**

"The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

**"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.**

"(a) STUDIES AND MONITORING.—The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems, such as nuclear resource development, petroleum contamination, and contamination of water source and of the food chain. Such studies shall include—

''(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

''(2) an analysis of the potential effect of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

''(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation on or near reservations or Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

''(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of the Indian Health Care Improvement Act Amendments of 2005 that directly or indirectly relate to the activi-

ties, practices, and conditions affecting the health or safety of such Indians; and

''(5) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

''(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and, in consultation with Indian Tribes and Tribal Organizations, develop health care plans to address the health problems studied under subsection (a). The plans shall include—

''(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

''(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

''(3) a program of education for Indians who, by reason of their work or geographic proximity to

such nuclear or other development activities, may experience health problems.

''(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

''(d) INTERGOVERNMENTAL TASK FORCE.—

''(1) ESTABLISHMENT; MEMBERS.—There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees):

''(A) The Secretary of Energy.

''(B) The Secretary of the Environmental Protection Agency.

''(C) The Director of the Bureau of Mines.

''(D) The Assistant Secretary for Occupational Safety and Health.

''(E) The Secretary of the Interior.

''(F) The Secretary of Health and Human Services.

''(G) The Director of the Indian Health Service.

''(2) DUTIES.—The Task Force shall—

''(A) identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

''(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

''(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

''(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—In the case of any Indian who—

''(1) as a result of employment in or near a uranium mine or mill or near any other environ-

mental hazard, suffers from a work-related illness or condition;

''(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

''(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such amounts paid to the Indian Health Program from the employer for providing medical care for such illness or condition.

**''SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.**

''(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2015, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing

contract health care services to members of federally recognized Indian Tribes of Arizona.

''(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

**''SEC. 216A. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.**

''(a) IN GENERAL.—Beginning in fiscal year 2003, the States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of North Dakota and South Dakota.

''(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if such curtailment is due to the provision of contract services in such States pursuant to the designation of such States as a contract health service delivery area pursuant to subsection (a).

**"SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES PROGRAM.**

"(a) FUNDING AUTHORIZED.—The Secretary is authorized to fund a program using the California Rural Indian Health Board (hereafter in this section referred to as the 'CRIHB') as a contract care intermediary to improve the accessibility of health services to California Indians.

"(b) REIMBURSEMENT CONTRACT.—The Secretary shall enter into an agreement with the CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 806(a) throughout the California contract health services delivery area described in section 218 with respect to high cost contract care cases.

"(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the CRIHB during such fiscal year.

"(d) LIMITATION ON PAYMENT.—No payment may be made for treatment provided hereunder to the extent payment may be made for such treatment under the Indian Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise

made available to the California contract health service delivery area for a fiscal year.

''(e) ADVISORY BOARD.—There is established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least one half of whom of whom are not affiliated with the CRIHB.

**''SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.**

''The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

**"SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.**

"(a) AUTHORIZATION FOR SERVICES.—The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

"(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

**"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.**

"The Service shall provide funds for health care programs and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs and facilities operated directly by the Service.

**"SEC. 221. LICENSING.**

"Health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the

Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

**"SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY CONTRACT HEALTH SERVICES.**

"With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

**"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.**

"(a) DEADLINE FOR RESPONSE.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

"(b) EFFECT OF UNTIMELY RESPONSE.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

''(c) DEADLINE FOR PAYMENT OF VALID CLAIM.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

**''SEC. 224. LIABILITY FOR PAYMENT.**

''(a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

''(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

''(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall have no further recourse against the patient who received the services.

**''SEC. 225. AUTHORIZATION OF APPROPRIATIONS.**

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

# "TITLE III—FACILITIES

## "SEC. 301. CONSULTATION: CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

"(a) PREREQUISITES FOR EXPENDITURE OF FUNDS.—Prior to the expenditure of, or the making of any binding commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall—

"(1) consult with any Indian Tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

"(2) ensure, whenever practicable and applicable, that such facility meets the construction standards of any accrediting body recognized by the Secretary for the purposes of the medicare, medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act by not later than 1 year after the date on which the construction or renovation of such facility is completed.

"(b) CLOSURES.—

''(1) EVALUATION REQUIRED.—Notwithstanding any other provision of law, no facility operated by the Service may be closed if the Secretary has not submitted to Congress at least 1 year prior to the date of the proposed closure an evaluation of the impact of the proposed closure which specifies, in addition to other considerations—

''(A) the accessibility of alternative health care resources for the population served by such facility;

''(B) the cost-effectiveness of such closure;

''(C) the quality of health care to be provided to the population served by such facility after such closure;

''(D) the availability of contract health care funds to maintain existing levels of service;

''(E) the views of the Indian Tribes served by such facility concerning such closure;

''(F) the level of use of such facility by all eligible Indians; and

''(G) the distance between such facility and the nearest operating Service hospital.

''(2) EXCEPTION FOR CERTAIN TEMPORARY CLOSURES.—Paragraph (1) shall not apply to any temporary closure of a facility or any portion of a

facility if such closure is necessary for medical, environmental, or construction safety reasons.

''(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a health care facility priority system, which shall—

''(i) be developed with Indian Tribes and Tribal Organizations through negotiated rulemaking under section 802;

''(ii) give Indian Tribes' needs the highest priority; and

''(iii) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E).

''(B) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of the Indian Health Care Improvement Act Amendments of 2005 shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as 1 of the 10 top-priority inpatient projects, 1 of the 10 top-pri-

ority outpatient projects, 1 of the 10 top-priority staff quarters developments, or 1 of the 10 top-priority Youth Regional Treatment Centers in the fiscal year 2005 Indian Health Service budget justification, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act.

''(2) REPORT; CONTENTS.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to Congress under section 801, a report which sets forth the following:

''(A) A description of the health care facility priority system of the Service, established under paragraph (1).

''(B) Health care facilities lists, including—

''(i) the 10 top-priority inpatient health care facilities;

''(ii) the 10 top-priority outpatient health care facilities;

''(iii) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment);

''(iv) the 10 top-priority staff quarters developments associated with health care facilities; and

''(v) the 10 top-priority hostels associated with health care facilities.

''(C) The justification for such order of priority.

''(D) The projected cost of such projects.

''(E) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

''(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing each report required under paragraph (2) (other than the initial report), the Secretary shall annually—

''(A) consult with and obtain information on all health care facilities needs from Indian Tribes, Tribal Organizations, and Urban Indian Organizations; and

''(B) review the total unmet needs of all Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health care facilities (including hostels and staff quarters), including needs for renovation and expansion of existing facilities.

''(4) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

''(5) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably integrated into the health care facility priority system.

''(d) REVIEW OF NEED FOR FACILITIES.—

''(1) INITIAL REPORT.—In the year 2006, the Government Accountability Office shall prepare and finalize a report which sets forth the needs of the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, for the facilities listed under subsection (c)(2)(B), including the needs for renovation and expansion of existing facilities. The Government Accountability Office shall submit the

report to the appropriate authorizing and appropriations committees of Congress and to the Secretary.

''(2) Beginning in the year 2006, the Secretary shall update the report required under paragraph (1) every 5 years.

''(3) The Comptroller General and the Secretary shall consult with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. The Secretary shall submit the reports required by paragraphs (1) and (2), to the President for inclusion in the report required to be transmitted to Congress under section 801.

''(4) For purposes of this subsection, the reports shall, regarding the needs of facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), be based on the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

''(5) The planning, design, construction, and renovation needs of facilities operated under contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be fully and equitably integrated into

the development of the health facility priority system.

''(6) Beginning in 2007 and each fiscal year thereafter, the Secretary shall provide an opportunity for nomination of planning, design, and construction projects by the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations for consideration under the health care facility priority system.

''(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

**''SEC. 302. SANITATION FACILITIES.**

''(a) FINDINGS.—Congress finds the following:

''(1) The provision of sanitation facilities is primarily a health consideration and function.

''(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of sanitation facilities.

''(3) The long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing sanitation facilities and other preventive health measures.

''(4) Many Indian homes and Indian communities still lack sanitation facilities.

''(5) It is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with sanitation facilities.

''(b) FACILITIES AND SERVICES.—In furtherance of the findings made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Under such authority, the Secretary, acting through the Service, is authorized to provide the following:

"(1) Financial and technical assistance to Indian Tribes, Tribal Organizations, and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the Indian Tribe, Tribal Organization, or Indian community.

"(2) Ongoing technical assistance and training to Indian Tribes, Tribal Organizations, and Indian communities in the management of utility organizations which operate and maintain sanitation facilities.

"(3) Priority funding for operation and maintenance assistance for, and emergency repairs to, sanitation facilities operated by an Indian Tribe, Tribal Organization or Indian community when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

"(c) FUNDING.—Notwithstanding any other provision of law—

''(1) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

''(2) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

''(3) unless specifically authorized when funds are appropriated, the Secretary shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

''(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purpose of providing sanitation facilities and services and place these funds into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(5) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to fund up to 100 percent of the amount of an Indian Tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

''(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

''(7) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned, or appropriated whereby the Department's applicable policies, rules, and regulations shall apply in the implementation of such projects;

''(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act; and

''(9) the Secretary of Health and Human Services shall, by regulation developed through rulemaking under section 802, establish standards applicable to the planning, design, and construction of sanitation facilities funded under this Act.

''(d) CERTAIN CAPABILITIES NOT PREREQUISITE.—The financial and technical capability of an Indian Tribe, Tribal Organization, or Indian community to safely operate, manage, and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

''(e) FINANCIAL ASSISTANCE.—The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities for operation, management, and maintenance of their sanitation facilities.

''(f) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities. If a sanitation facility serving a community that is operated by an Indian Tribe or Tribal Organization is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the

sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

''(g) ISDEAA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

''(1) any funds appropriated pursuant to this section; and

''(2) any funds appropriated for the purpose of providing sanitation facilities.

''(h) REPORT.—

''(1) REQUIRED; CONTENTS.—The Secretary, in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) shall submit to the President, for inclusion in each report required to be transmitted to Congress under section 801, a report which sets forth—

''(A) the current Indian sanitation facility priority system of the Service;

''(B) the methodology for determining sanitation deficiencies and needs;

''(C) the level of initial and final sanitation deficiency for each type of sanitation facility for each project of each Indian Tribe or Indian community;

''(D) the amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of new homes assisted with funds under the Native American Housing Assistance and Self-Determination Act, and to reduce the identified sanitation deficiency levels of all Indian Tribes and Indian communities to level I sanitation deficiency as defined in paragraph (4)(A); and

''(E) a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.

''(2) CRITERIA.—The criteria on which the deficiencies and needs will be evaluated shall be developed through negotiated rulemaking pursuant to section 802.

''(3) UNIFORM METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for, and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian Tribes and Indian communities.

''(4) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual, Indian Tribe, or Indian community sanitation facility to serve Indian homes are determined as follows:

''(A) A level I deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community—

''(i) complies with all applicable water supply, pollution control, and solid waste disposal laws; and

''(ii) deficiencies relate to routine replacement, repair, or maintenance needs.

''(B) A level II deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community substantially or recently complied with all applicable water supply, pollution control, and solid waste laws and any deficiencies relate to—

''(i) small or minor capital improvements needed to bring the facility back into compliance;

''(ii) capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

''(iii) the lack of equipment or training by an Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facilities.

''(C) A level III deficiency exists if a sanitation facility serving an individual, Indian Tribe or Indian community meets one or more of the following conditions—

''(i) water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;

''(ii) major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies; or

''(iii) there is no access to or no approved or permitted solid waste facility available.

''(D) A level IV deficiency exists if—

''(i) a sanitation facility of an individual, Indian Tribe, Tribal Organization, or Indian community has no piped water or sewer facilities in the home or the facility has become inoperable due to major component failure; or

''(ii) where only a washeteria or central facility exists in the community.

''(E) A level V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.

''(i) DEFINITIONS.—For purposes of this section, the following terms apply:

''(1) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

''(2) SANITATION FACILITIES.—The terms 'sanitation facility' and 'sanitation facilities' mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).

**"SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.**

''(a) BUY INDIAN ACT.—The Secretary, acting through the Service, may use the negotiating authority of section 23 of the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the 'Buy Indian Act'), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian Tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of sanitation facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to regulations adopted pursuant to section 802, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such a finding, shall consider

whether the Indian or Indian firm will be deficient with respect to—

''(1) ownership and control by Indians;

''(2) equipment;

''(3) bookkeeping and accounting procedures;

''(4) substantive knowledge of the project or function to be contracted for;

''(5) adequately trained personnel; or

''(6) other necessary components of contract performance.

''(b) LABOR STANDARDS.—

''(1) IN GENERAL.—For the purposes of implementing the provisions of this title, contracts for the construction or renovation of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part with funds made available pursuant to this title, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the 'Davis-Bacon Act'), unless such construction or renovation—

''(A) is performed by a contractor pursuant to a contract with an Indian Tribe or Tribal Organization with funds supplied through a contract or compact authorized by the Indian

Self-Determination and Education Assistance Act, or other statutory authority; and

''(B) is subject to prevailing wage rates for similar construction or renovation in the locality as determined by the Indian Tribes or Tribal Organizations to be served by the construction or renovation.

''(2) EXCEPTION.—This subsection shall not apply to construction or renovation carried out by an Indian Tribe or Tribal Organization with its own employees.

**''SEC. 304. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.**

''(a) IN GENERAL.—Notwithstanding any other provision of law, if the requirements of subsection (c) are met, the Secretary, acting through the Service, is authorized to accept any major expansion, renovation, or modernization by any Indian Tribe or Tribal Organization of any Service facility or of any other Indian health facility operated pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), including—

''(1) any plans or designs for such expansion, renovation, or modernization; and

''(2) any expansion, renovation, or modernization for which funds appropriated under any Federal law were lawfully expended.

''(b) PRIORITY LIST.—

''(1) IN GENERAL.—The Secretary shall maintain a separate priority list to address the needs for increased operating expenses, personnel, or equipment for such facilities. The methodology for establishing priorities shall be developed through negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.

''(2) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1).

''(c) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation, or modernization if—

''(1) the Indian Tribe or Tribal Organization—

''(A) provides notice to the Secretary of its intent to expand, renovate, or modernize; and

''(B) applies to the Secretary to be placed on a separate priority list to address the needs

of such new facilities for increased operating expenses, personnel, or equipment; and

''(2) the expansion, renovation, or modernization—

''(A) is approved by the appropriate area director of the Service for Federal facilities; and

''(B) is administered by the Indian Tribe or Tribal Organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

''(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—In addition to the requirements under subsection (c), for any expansion, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information developed through negotiated rulemaking under section 802, including additional staffing, equipment, and other costs associated with the expansion.

''(e) CLOSURE OR CONVERSION OF FACILITIES.—If any Service facility which has been expanded, renovated, or modernized by an Indian Tribe or Tribal Organization under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation, or modernization is completed, such Indian Tribe or Tribal Organization shall be entitled to

recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation, or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation, or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation, or modernization.

**"SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.**

''(a) FUNDING.—

''(1) IN GENERAL.—The Secretary, acting through the Service, in consultation with Indian Tribes and Tribal Organizations, shall make grants to Indian Tribes and Tribal Organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons pursuant to subsections (b)(2) and (c)(1)(C)). Funding made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term

'construction' includes the replacement of an existing facility.

''(2) AGREEMENT REQUIRED.—Funding under paragraph (1) may only be made available to a Tribal Health Program operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian Tribe or Tribal Organization).

''(b) USE OF FUNDS.—

''(1) ALLOWABLE USES.—Funding provided under this section may be used for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

''(A) located apart from a hospital;

''(B) not funded under section 301 or section 307; and

''(C) which, upon completion of such construction or modernization will—

''(i) have a total capacity appropriate to its projected service population;

''(ii) provide annually no fewer than 150 patient visits by eligible Indians and other users who are eligible for services in

such facility in accordance with section 807(c)(2); and

''(iii) provide ambulatory care in a Service Area (specified in the contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) with a population of no fewer than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(c)(2).

''(2) ADDITIONAL ALLOWABLE USE.—The Secretary may also reserve a portion of the funding provided under this section and use those reserved funds to reduce an outstanding debt incurred by Indian Tribes or Tribal Organizations for the construction, expansion, or modernization of an ambulatory care facility that meets the requirements under paragraph (1). The provisions of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1).

''(3) USE ONLY FOR CERTAIN PORTION OF COSTS.—Funding provided under this section may be used only for the cost of that portion of a con-

struction, expansion, or modernization project that benefits the Service population identified above in subsection (b)(1)(C) (ii) and (iii). The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to an Indian Tribe or Tribal Organization applying for funding under this section for a health care facility located or to be constructed on an island or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.

''(c) FUNDING.—

''(1) APPLICATION.—No funding may be made available under this section unless an application or proposal for such funding has been approved by the Secretary in accordance with applicable regulations and has forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding received under this section—

''(A) adequate financial support will be available for the provision of services at such facility;

''(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

''(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

''(2) PRIORITY.—In awarding funding under this section, the Secretary shall give priority to Indian Tribes and Tribal Organizations that demonstrate—

''(A) a need for increased ambulatory care services; and

''(B) insufficient capacity to deliver such services.

''(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary regarding such applications using the criteria developed during consultations pursuant to subsection (a)(1).

''(d) REVERSION OF FACILITIES.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, within 5 years after com-

pletion of the construction, expansion, or modernization carried out with such funds, to be used for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.

''(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

**''SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.**

''(a) HEALTH CARE DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, is authorized to enter into construction agreements under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services to Indians through facilities.

''(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

''(1) waive any leasing prohibition;

''(2) permit carryover of funds appropriated for the provision of health care services;

''(3) permit the use of other available funds;

''(4) permit the use of funds or property donated from any source for project purposes;

''(5) provide for the reversion of donated real or personal property to the donor; and

''(6) permit the use of Service funds to match other funds, including Federal funds.

''(c) REGULATIONS.—The Secretary shall develop and promulgate regulations not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005. If the Secretary has not promulgated regulations by that date, the Secretary shall develop and publish regulations, through rulemaking under section 802, for the review and approval of applications submitted under this section.

''(d) CRITERIA.—The Secretary may approve projects that meet the following criteria:

''(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

''(2) A significant number of Indians, including those with low health status, will be served by the project.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The project is economically viable.

''(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

''(e) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria developed pursuant to subsection (d).

''(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects in each of the following Service Units to the extent that such applications are timely filed and meet the criteria specified in subsection (d):

''(1) Cass Lake, Minnesota.

"(2) Clinton, Oklahoma.

"(3) Harlem, Montana.

"(4) Mescalero, New Mexico.

"(5) Owyhee, Nevada.

"(6) Parker, Arizona.

"(7) Schurz, Nevada.

"(8) Winnebago, Nebraska.

"(9) Ft. Yuma, California.

"(g) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

"(h) SERVICE TO INELIGIBLE PERSONS.—Subject to section 807, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 807 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

"(i) EQUITABLE TREATMENT.—For purposes of subsection (d)(1), the Secretary shall, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), use the same criteria that the Sec-

retary uses in evaluating facilities operated directly by the Service.

''(j) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities which are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

**''SEC. 307. LAND TRANSFER.**

''Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

**''SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.**

''The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used

for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(*l*) of the Indian Self-Determination and Education Assistance Act and regulations thereunder.

**"SEC. 309. STUDY ON LOANS, LOAN GUARANTEES, AND LOAN REPAYMENT.**

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of establishing a loan fund to provide to Indian Tribes and Tribal Organizations direct loans or guarantees for loans for the construction of health care facilities, including—

''(1) inpatient facilities;

''(2) outpatient facilities;

''(3) staff quarters;

''(4) hostels; and

''(5) specialized care facilities, such as behavioral health and elder care facilities.

''(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

''(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

''(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

''(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any 1 time;

''(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund;

''(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

''(6) whether acceptance by the Secretary of an assignment of the revenue of an Indian Tribe or Tribal Organization as security for any direct loan

or loan guarantee from the loan fund would be appropriate;

''(7) whether, in the planning and design of health facilities under this section, users eligible under section 807(c) may be included in any projection of patient population;

''(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

''(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

''(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

''(c) REPORT.—Not later than September 30, 2007, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources and the Committee on Energy and Commerce of the House of Representatives a report that describes—

''(1) the manner of consultation made as required by subsection (a); and

''(2) the results of the study, including any recommendations of the Secretary based on results of the study.

**''SEC. 310. TRIBAL LEASING.**

''A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

**''SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.**

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

''(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project; or

''(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project.

''(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization only if—

''(1) the Secretary first determines that the Indian Tribe or Tribal Organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

''(2) the Indian Tribe or Tribal Organization meets the need criteria which shall be developed through the negotiated rulemaking process provided for under section 802.

''(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10 year no-cost lease period.

''(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that

breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe's or Tribal Organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

''(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

''(f) DEFINITION.—For the purposes of this section, the term 'health facility' or 'health facilities' includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

**"SEC. 312. LOCATION OF FACILITIES.**

"(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands, or lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native, if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

"(b) DEFINITION.—For purposes of this section, the term 'Indian lands' means—

"(1) all lands within the exterior boundaries of any reservation; and

"(2) any lands title to which is held in trust by the United States for the benefit of any Indian Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation.

**"SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.**

"(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

"(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the negotiated rulemaking process provided for under section 802.

"(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a

maximum renovation cost threshold. The maximum renovation cost threshold shall be determined through the negotiated rulemaking process provided for under section 802.

**"SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.**

''(a) RENTAL RATES.—

''(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

''(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

''(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

''(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

''(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

''(b) DIRECT COLLECTION OF RENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

''(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise its authority to collect rents directly from such Federal employees.

''(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

''(C) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

''(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the maintenance (including capital repairs and replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

''(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election

under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally owned quarters, such retrocession shall become effective on the earlier of—

''(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

''(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

''(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

**''SEC. 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.**

''(a) APPLICABILITY.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.

''(b) EFFECT OF VIOLATION.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made in America' inscription or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to section 317, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

''(c) DEFINITIONS.—For purposes of this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

**''SEC. 316. OTHER FUNDING FOR FACILITIES.**

''(a) AUTHORITY TO ACCEPT FUNDS.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into a contract or compact under the Indian Self-Determination and Education

Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

''(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

''(c) TRANSFERRED FUNDS.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

''(d) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation, developed by rulemaking under section 802, for the planning, design, and construction of health care facilities serving Indians under this Act.

**''SEC. 317. AUTHORIZATION OF APPROPRIATIONS.**

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

# ''TITLE IV—ACCESS TO HEALTH SERVICES

**''SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH CARE PROGRAMS.**

''(a) DISREGARD OF MEDICARE, MEDICAID, AND SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian Health Program or by an Urban Indian Organization made under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XXI of the Social Security Act in preference to an Indian without such coverage.

''(c) USE OF FUNDS.—

''(1) SPECIAL FUND.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is enti-

tled by reason of a provision of the Social Security Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of titles XVIII, XIX, and XXI of the Social Security Act. Any amounts to be reimbursed that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with Indian Tribes being served by the Service Unit, be used for reducing the health resource deficiencies of the Indian Tribes. In making payments from such fund, the Secretary shall ensure that each Service Unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service Unit makes collections, are entitled by reason of a provision of the Social Security Act.

''(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply upon the election of a Tribal Health Program under subsection (d) to receive payments directly. No payment may be made out of the

special fund described in such paragraph with respect to reimbursement made for services provided during the period of such election.

''(d) DIRECT BILLING.—

''(1) IN GENERAL.—A Tribal Health Program may directly bill for, and receive payment for, health care items and services provided by such Indian Tribe or Tribal organization for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

''(2) DIRECT REIMBURSEMENT.—

''(A) USE OF FUNDS.—Each Tribal Health Program exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to section 401(c), but all amounts so reimbursed shall be used by the Tribal Health Program for the purpose of making any improvements in Tribal facilities or Tribal Health Programs that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide addi-

tional health care services, improvements in health care facilities and Tribal Health Programs, any health care-related purpose, or otherwise to achieve the objectives provided in section 3 of this Act.

''(B) AUDITS.—The amounts paid to an Indian Tribe or Tribal Organization exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be subject to all auditing requirements applicable to programs administered by an Indian Health Program.

''(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian Tribe or Tribal Organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an Urban Indian Organization receives funding from the Service under title V of this Act and receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, such Indian Tribe or Tribal Organization, or Urban Indian Organization, shall provide to the Service a list of each provider enrollment number (or other identifier)

under which it receives such reimbursements or payments.

''(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under a title of the Social Security Act.

''(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Sec-

retary upon the Secretary's acceptance of the withdrawal of participation in this program.

**"SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.**

''(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into contracts with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and administering programs on or near reservations and trust lands to assist individual Indians—

''(1) to enroll for benefits under title XVIII, XIX, or XXI of the Social Security Act and other health benefits programs; and

''(2) to pay premiums for coverage for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Tribe or Tribes).

''(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian Tribe or Tribal Organization pursuant to this section. Such conditions

shall include requirements that the Indian Tribe or Tribal Organization successfully undertake—

''(1) to determine the population of Indians eligible for the benefits described in subsection (a);

''(2) to educate Indians with respect to the benefits available under the respective programs;

''(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

''(4) to develop and implement methods of improving the participation of Indians in receiving the benefits provided under titles XVIII, XIX, and XXI of the Social Security Act.

''(c) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT PROGRAMS.—

''(1) AGREEMENTS WITH SECRETARY TO IMPROVE RECEIPT AND PROCESSING OF APPLICATIONS.—

''(A) AUTHORIZATION.—The Secretary, acting through the Service, may enter into an agreement with an Indian Tribe, Tribal Organization, or Urban Indian Organization which provides for the receipt and processing of applications by Indians for assistance under titles

XIX and XXI of the Social Security Act, and benefits under title XVIII of such Act, by an Indian Health Program or Urban Indian Organization.

''(B) REIMBURSEMENT OF COSTS.—Such agreements may provide for reimbursement of costs of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may, as appropriate, be added to the applicable rate per encounter or be provided as a separate fee-for-service payment to the Indian Tribe or Tribal Organization.

''(C) PROCESSING CLARIFIED.—In this paragraph, the term 'processing' does not include a final determination of eligibility.

''(2) AGREEMENTS WITH STATES FOR OUTREACH ON OR NEAR RESERVATION.—

''(A) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under title XIX or XXI of the Social Security Act, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as

the outstationing of eligibility workers, entering into agreements with Indian Tribes and Tribal Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are provided.

''(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting arrangements entered into between States and Indian Tribes and Tribal Organizations for such Indian Tribes and Tribal Organizations to conduct administrative activities under such titles.

''(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations.

''(e) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

''(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to Urban Indian Organizations with respect to populations served by such organizations

in the same manner they apply to grants and contracts with Indian Tribes and Tribal Organizations with respect to programs on or near reservations.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

''(A) consistent with the requirements imposed by the Secretary under subsection (b);

''(B) appropriate to Urban Indian Organizations and Urban Indians; and

''(C) necessary to effect the purposes of this section.

**''SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.**

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian Tribe, or Tribal Organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges as determined by the Secretary, and billed by the Secretary, an Indian Tribe, or Tribal Organization, in providing health services, through the Service, an Indian Tribe, or Tribal Organization to any individual to the

same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

''(1) such services had been provided by a nongovernmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the

United States, an Indian Tribe, or Tribal Organization under subsection (a).

''(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

''(e) ENFORCEMENT.—

''(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—

''(A) intervening or joining in any civil action or proceeding brought—

''(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or

''(ii) by any representative or heirs of such individual, or

''(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

''(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

''(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or Urban Indian Organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

''(g) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys' fees and costs of litigation.

''(h) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or

other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

''(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to Urban Indian Organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations with respect to populations served by such Indian Tribes and Tribal Organizations.

''(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

''(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or

Tribal law, including medical lien laws and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.).

**"SEC. 404. CREDITING OF REIMBURSEMENTS.**

"(a) USE OF AMOUNTS.—

"(1) RETENTION BY PROGRAM.—Except as provided in section 202(g) (relating to the Catastrophic Health Emergency Fund) and section 807 (relating to health services for ineligible persons), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 807, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an Urban Indian Organization, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such Urban Indian Organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

"(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

"(A) Titles XVIII, XIX, and XXI of the Social Security Act.

"(B) This Act, including section 807.

''(C) Public Law 87–693.

''(D) Any other provision of law.

''(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

**''SEC. 405. PURCHASING HEALTH CARE COVERAGE.**

''(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act, or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health benefits for Service beneficiaries, Indian Tribes, Tribal Organizations, and Urban Indian Organizations may use such amounts to purchase health benefits coverage for such beneficiaries in any manner, including through—

''(1) a tribally owned and operated health care plan;

''(2) a State or locally authorized or licensed health care plan;

''(3) a health insurance provider or managed care organization; or

''(4) a self-insured plan.

The purchase of such coverage by an Indian Tribe, Tribal Organization, or Urban Indian Organization may be based on the financial needs of such beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

''(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

**''SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.**

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

''(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any ar-

rangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

''(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

''(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

''(2) the quality of health care services provided to any Indian through the Service;

''(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

''(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

''(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

''(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Depart-

ment of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

''(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

**''SEC. 407. PAYOR OF LAST RESORT.**

''Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban Indian Organizations, notwithstanding any Federal, State, or local law to the contrary.

**''SEC. 408. NONDISCRIMINATION IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.**

''For purposes of determining the eligibility of an entity that is operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization to receive payment or reimbursement from any federally funded health care program for health care services it furnishes to an Indian. Such program must provide that such entity, meeting generally applicable State or other requirements applicable for participation, must be accepted as a pro-

vider on the same basis as any other qualified provider, except that any requirement that the entity be licensed or recognized under State or local law to furnish such services shall be deemed to have been met if the entity meets all the applicable standards for such licensure, but the entity need not obtain a license or other documentation. In determining whether the entity meets such standards, the absence of licensure of any staff member of the entity may not be taken into account.

**"SEC. 409. CONSULTATION.**

''(a) TRIBAL TECHNICAL ADVISORY GROUP (TTAG).—The Secretary shall maintain within the Centers for Medicaid & Medicare Services (CMS) a Tribal Technical Advisory Group, established in accordance with requirements of the charter dated September 30, 2003, and in such group shall include a representative of the Urban Indian Organizations and the Service. The representative of the Urban Indian Organization shall be deemed to be an elected officer of a tribal government for purposes of applying section 204(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1534(b)).

''(b) SOLICITATION OF MEDICAID ADVICE.—

''(1) IN GENERAL.—As part of its plan under title XIX of the Social Security Act, a State in which the Service operates or funds health care pro-

grams, or in which 1 or more Indian Health Programs or Urban Indian Organizations provide health care in the State for which medical assistance is available under such title, may establish a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of such title to and likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations.

''(2) MANNER OF ADVICE.—The process described in paragraph (1) should include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations. Such process may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its medicaid plan.

''(3) PAYMENT OF EXPENSES.—The reasonable expenses of carrying out this subsection shall be eligible for reimbursement under section 1903(a) of the Social Security Act.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as superseding existing advisory committees, working groups, or other advisory procedures established by the Secretary or by any State.

**''SEC. 410. STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).**

''(a) OPTIONAL USE OF FUNDS FOR INDIAN HEALTH PROGRAM PAYMENTS.—Subject to the succeeding provisions of this section, a State may provide under its State child health plan under title XXI of the Social Security Act (regardless of whether such plan is implemented under such title, title XIX of such Act, or both) for payments under this section to Indian Health Programs and Urban Indian Organizations operating in the State. Such payments shall be treated under title XXI of the Social Security Act as expenditures described in section 2105(a)(1)(A) of such Act.

''(b) USE OF FUNDS.—Payments under this section may be used only for expenditures described in clauses (i) through (iii) of section 2105(a)(1)(D) of the Social Security Act for targeted low-income children or other low-income children (as defined in 2110 of such Act) who are—

''(1) Indians; or

''(2) otherwise eligible for health services from the Indian Health Program involved.

''(c) SPECIAL RESTRICTIONS.—The following conditions apply to a State electing to provide payments under this section:

''(1) NO LIMITATION ON OTHER SCHIP PARTICIPATION OF, OR PROVIDER PAYMENTS TO, INDIAN HEALTH PROGRAMS.—The State may not exclude or limit participation of otherwise eligible Indian Health Programs in its State child health program under title XXI of the Social Security Act or its medicaid program under title XIX of such Act or pay such Programs less than they otherwise would as participating providers on the basis that payments are made to such Programs under this section.

''(2) NO LIMITATION ON OTHER SCHIP ELIGIBILITY OF INDIANS.—The State may not exclude or limit participation of otherwise eligible Indian children in such State child health or medicaid program on the basis that payments are made for assistance for such children under this section.

''(3) LIMITATION ON ACCEPTANCE OF CONTRIBUTIONS.—

''(A) IN GENERAL.—The State may not accept contributions or condition making of payments under this section upon contribution of

funds from any Indian Health Program to meet the State's non-Federal matching fund requirements under titles XIX and XXI of the Social Security Act.

''(B) CONTRIBUTION DEFINED.—For purposes of subparagraph (A), the term 'contribution' includes any tax, donation, fee, or other payment made, whether made voluntarily or involuntarily.

''(d) APPLICATION OF SEPARATE 10 PERCENT LIMITATION.—Payment may be made under section 2105(a) of the Social Security Act to a State for a fiscal year for payments under this section up to an amount equal to 10 percent of the total amount available under title XXI of such Act (including allotments and reallotments available from previous fiscal years) to the State with respect to the fiscal year.

''(e) GENERAL TERMS.—A payment under this section shall only be made upon application to the State from the Indian Health Program involved and under such terms and conditions, and in a form and manner, as the Secretary determines appropriate.

**''SEC. 411. SOCIAL SECURITY ACT SANCTIONS.**

''(a) REQUESTS FOR WAIVER OF SANCTIONS.—

''(1) IN GENERAL.—For purposes of applying any authority under a provision of title XI, XVIII, XIX, or XXI of the Social Security Act to seek a waiver of a sanction imposed against a health care provider insofar as that provider provides services to individuals through an Indian Health Program, the Indian Health Program shall request the State to seek such waiver, and if such State has not sought the waiver within 60 days of the Indian Health Program request, the Indian Health Program itself may petition the Secretary for such waiver.

''(2) PROCEDURE.—In seeking a waiver under paragraph (1), the Indian Health Program must provide notice and a copy of the request, including the reasons for the waiver sought, to the State. The Secretary may consider the State's views in the determination of the waiver request, but may not withhold or delay a determination based on the lack of the State's views.

''(b) SAFE HARBOR FOR TRANSACTIONS BETWEEN AND AMONG INDIAN HEALTH CARE PROGRAMS.—For purposes of applying section 1128B(b) of the Social Security Act, the exchange of anything of value between or among the following shall not be treated as remuneration

if the exchange arises from or relates to any of the following health programs:

''(1) An exchange between or among the following:

''(A) Any Indian Health Program.

''(B) Any Urban Indian Organization.

''(2) An exchange between an Indian Tribe, Tribal Organization, or an Urban Indian Organization and any patient served or eligible for service from an Indian Tribe, Tribal Organization, or Urban Indian Organization, including patients served or eligible for service pursuant to section 807, but only if such exchange—

''(A) is for the purpose of transporting the patient for the provision of health care items or services;

''(B) is for the purpose of providing housing to the patient (including a pregnant patient) and immediate family members or an escort incidental to assuring the timely provision of health care items and services to the patient;

''(C) is for the purpose of paying premiums, copayments, deductibles, or other cost-sharing on behalf of patients; or

''(D) consists of an item or service of small value that is provided as a reasonable incentive to secure timely and necessary preventive and other items and services.

''(3) Other exchanges involving an Indian Health Program, an Urban Indian Organization, or an Indian Tribe or Tribal Organization that meet such standards as the Secretary of Health and Human Services, in consultation with the Attorney General, determines is appropriate, taking into account the special circumstances of such Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations and of patients served by Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations.

**''SEC. 412. COST SHARING.**

''(a) COINSURANCE, COPAYMENTS, AND DEDUCTIBLES.—Notwithstanding any other provision of Federal or State law—

''(1) PROTECTION FOR ELIGIBLE INDIANS UNDER SOCIAL SECURITY ACT HEALTH PROGRAMS.—No Indian who is furnished an item or service for which payment may be made under title

XIX or XXI of the Social Security Act may be charged a deductible, copayment, or coinsurance.

''(2) PROTECTION FOR INDIANS.—No Indian who is furnished an item or service by the Service may be charged a deductible, copayment, or coinsurance.

''(3) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—The payment or reimbursement due to the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization under title XIX or XXI of the Social Security Act may not be reduced by the amount of the deductible, copayment, or coinsurance that would be due from the Indian but for the operation of this section.

''(b) EXEMPTION FROM MEDICAID AND SCHIP PREMIUMS.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for services under title XIX of the Social Security Act (relating to the medicaid program) or title XXI of such Act (relating to the State children's health insurance program) may be charged a premium, enrollment fee, or similar charge as a condition of receiving benefits under the program under the respective title.

''(c) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID ELIGIBILITY.—Notwithstanding any other provision

of Federal or State law, the following property may not be included when determining eligibility for services under title XIX of the Social Security Act:

''(1) Property, including real property and improvements, located on a reservation, including any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

''(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

''(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

''(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or

cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

''(d) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Income, resources, and property that are exempt from medicaid estate recovery under title XIX of the Social Security Act as of April 1, 2003, under manual instructions issued to carry out section 1917(b)(3) of such Act because of Federal responsibility for Indian Tribes and Alaska Native Villages shall remain so exempt. Nothing in this subsection shall be construed as preventing the Secretary from providing additional medicaid estate recovery exemptions for Indians.

**''SEC. 413. TREATMENT UNDER MEDICAID MANAGED CARE.**

''(a) PROVISION OF SERVICES, TO ENROLLEES WITH NON-INDIAN MEDICAID MANAGED CARE ENTITIES, BY INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.—

''(1) PAYMENT RULES.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of an Indian who is enrolled with a non-Indian medicaid managed care entity (as defined in subsection (c)) and who receives covered medicaid managed care services

from an Indian Health Program or an Urban Indian Organization, whether or not it is a participating provider with respect to such entity, the following rules apply:

"(i) DIRECT PAYMENT.—The entity shall make prompt payment (in accordance with rules applicable to medicaid managed care entities under title XIX of the Social Security Act) to the Indian Health Program or Urban Indian Organization at a rate established by the entity for such services that is equal to the rate negotiated between such entity and the Program or Organization involved or, if such a rate has not been negotiated, a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not such a Program or Organization.

"(ii) PAYMENT THROUGH STATE.—If there is no arrangement for direct payment under clause (i) or if a State provides for this clause to apply in lieu of clause (i), the State shall provide for payment to the

Indian Health Program or Urban Indian Organization under its State program under title XIX of such Act at the rate that would be otherwise applicable for such services under such program and shall provide for an appropriate adjustment of the capitation payment made to the entity to take into account such payment.

''(B) COMPLIANCE WITH GENERALLY APPLICABLE REQUIREMENTS.—

''(i) IN GENERAL.—Except as otherwise provided, as a condition of payment under subparagraph (A), the Indian Health Program or Urban Indian Organization shall comply with the generally applicable requirements of title XIX of the Social Security Act with respect to covered services.

''(ii) SATISFACTION OF CLAIM REQUIREMENT.—Any requirement for the submission of a claim or other documentation for services covered under subparagraph (A) by the enrollee is deemed to be satisfied through the submission of a claim or other documentation by the Indian

Health Program or Urban Indian Organization consistent with section 403(h).

''(C) CONSTRUCTION.—Nothing in this subsection shall be construed as waiving the application of section 1902(a)(30)(A) of the Social Security Act (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

''(2) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH PROGRAM OR URBAN INDIAN ORGANIZATION AS PRIMARY CARE PROVIDER.—In the case of a non-Indian medicaid managed care entity that—

''(A) has an Indian enrolled with the entity; and

''(B) has an Indian Health Program or Urban Indian Organization that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Program or Organization and the Program or Organization has the capacity to provide primary care services to such Indian, the Indian shall be allowed to choose such Program or Organization as the Indian's primary care provider under the entity.

''(b) OFFERING OF MANAGED CARE THROUGH INDIAN MEDICAID MANAGED CARE ENTITIES.—If—

''(1) a State elects to provide services through medicaid managed care entities under its medicaid managed care program; and

''(2) an Indian Health Program or Urban Indian Organization that is funded in whole or in part by the Service, or a consortium thereof, has established an Indian medicaid managed care entity in the State that meets generally applicable standards required of such an entity under such medicaid managed care program,

the State shall offer to enter into an agreement with the entity to serve as a medicaid managed care entity with respect to eligible Indians served by such entity under such program.

''(c) SPECIAL RULES FOR INDIAN MANAGED CARE ENTITIES.—The following are special rules regarding the application of a medicaid managed care program to Indian medicaid managed care entities:

''(1) ENROLLMENT.—

''(A) LIMITATION TO INDIANS.—An Indian medicaid managed care entity may restrict enrollment under such program to Indians and to members of specific Tribes in the same manner

as Indian Health Programs may restrict the delivery of services to such Indians and tribal members.

''(B) NO LESS CHOICE OF PLANS.—Under such program the State may not limit the choice of an Indian among medicaid managed care entities only to Indian medicaid managed care entities or to be more restrictive than the choice of managed care entities offered to individuals who are not Indians.

''(C) DEFAULT ENROLLMENT.—

''(i) IN GENERAL.—If such program of a State requires the enrollment of Indians in a medicaid managed care entity in order to receive benefits, the State shall provide for the enrollment of Indians described in clause (ii) who are not otherwise enrolled with such an entity in an Indian medicaid managed care entity described in such clause.

''(ii) INDIAN DESCRIBED.—An Indian described in this clause, with respect to an Indian medicaid managed care entity, is an Indian who, based upon the service area and capacity of the entity, is eligible to be

enrolled with the entity consistent with subparagraph (A).

''(D) EXCEPTION TO STATE LOCK-IN.—A request by an Indian who is enrolled under such program with a non-Indian medicaid managed care entity to change enrollment with that entity to enrollment with an Indian medicaid managed care entity shall be considered cause for granting such request under procedures specified by the Secretary.

''(2) FLEXIBILITY IN APPLICATION OF SOLVENCY.—In applying section 1903(m)(1) of the Social Security Act to an Indian medicaid managed care entity—

''(A) any reference to a 'State' in subparagraph (A)(ii) of that section shall be deemed to be a reference to the 'Secretary'; and

''(B) the entity shall be deemed to be a public entity described in subparagraph (C)(ii) of that section.

''(3) EXCEPTIONS TO ADVANCE DIRECTIVES.—The Secretary may modify or waive the requirements of section 1902(w) of the Social Security Act (relating to provision of written materials on advance directives) insofar as the Secretary finds that

the requirements otherwise imposed are not an appropriate or effective way of communicating the information to Indians.

''(4) FLEXIBILITY IN INFORMATION AND MARKETING.—

''(A) MATERIALS.—The Secretary may modify requirements under section 1932(a)(5) of the Social Security Act in a manner that improves the materials to take into account the special circumstances of such entities and their enrollees while maintaining and clearly communicating to potential enrollees their rights, protections, and benefits.

''(B) DISTRIBUTION OF MARKETING MATERIALS.—The provisions of section 1932(d)(2)(B) of the Social Security Act requiring the distribution of marketing materials to an entire service area shall be deemed satisfied in the case of an Indian medicaid managed care entity that distributes appropriate materials only to those Indians who are potentially eligible to enroll with the entity in the service area.

''(d) MALPRACTICE INSURANCE.—Insofar as, under a medicaid managed care program, a health care provider

is required to have medical malpractice insurance coverage as a condition of contracting as a provider with a medicaid managed care entity, an Indian Health Program, or an Urban Indian Organization that is a Federally-qualified health center under title XIX of the Social Security Act, that is covered under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.) is deemed to satisfy such requirement.

''(e) DEFINITIONS.—For purposes of this section:

''(1) MEDICAID MANAGED CARE ENTITY.—The term 'medicaid managed care entity' means a managed care entity (whether a managed care organization or a primary care case manager) under title XIX of the Social Security Act, whether pursuant to section 1903(m) or section 1932 of such Act, a waiver under section 1115 or 1915(b) of such Act, or otherwise.

''(2) INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'Indian medicaid managed care entity' means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Social Security Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization (as such terms are defined in section 4), or a consortium, which may be

composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

''(3) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'non-Indian medicaid managed care entity' means a medicaid managed care entity that is not an Indian medicaid managed care entity.

''(4) COVERED MEDICAID MANAGED CARE SERVICES.—The term 'covered medicaid managed care services' means, with respect to an individual enrolled with a medicaid managed care entity, items and services that are within the scope of items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

''(5) MEDICAID MANAGED CARE PROGRAM.—The term 'medicaid managed care program' means a program under sections 1903(m) and 1932 of the Social Security Act and includes a managed care program operating under a waiver under section 1915(b) or 1115 of such Act or otherwise.

**''SEC. 414. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.**

''(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation

as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

''(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

''(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

''(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

''(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

''(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

''(c) REPORT.—Not later then 3 years after the date of enactment of the Indian Health Act Improvement Act Amendments of 2005, the Secretary shall submit to the Committee of Indian Affairs and Committee on Finance of the Senate and the Committee on Resources and Committee on Ways and Means of the House of Representatives a report that includes—

''(1) the results of the study under this section;

''(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

''(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

''(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

**''SEC. 415. AUTHORIZATION OF APPROPRIATIONS.**

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

# ''TITLE V—HEALTH SERVICES FOR URBAN INDIANS

**''SEC. 501. PURPOSE.**

''The purpose of this title is to establish and maintain programs in Urban Centers to make health services more accessible and available to Urban Indians.

**''SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.**

''Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, Urban Indian Organizations to assist such organizations in the establishment and administration, within Urban Centers, of programs which meet the requirements set forth in this title. Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract

into which the Secretary enters with, or in any grant the Secretary makes to, any Urban Indian Organization pursuant to this title.

**"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.**

"(a) REQUIREMENTS FOR GRANTS AND CONTRACTS.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, Urban Indian Organizations for the provision of health care and referral services for Urban Indians. Any such contract or grant shall include requirements that the Urban Indian Organization successfully undertake to—

"(1) estimate the population of Urban Indians residing in the Urban Center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

"(2) estimate the current health status of Urban Indians residing in such Urban Center or centers;

"(3) estimate the current health care needs of Urban Indians residing in such Urban Center or centers;

''(4) provide basic health education, including health promotion and disease prevention education, to Urban Indians;

''(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of Urban Indians; and

''(6) where necessary, provide, or enter into contracts for the provision of, health care services for Urban Indians.

''(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting Urban Indian Organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

''(1) the extent of unmet health care needs of Urban Indians in the Urban Center or centers involved;

''(2) the size of the Urban Indian population in the Urban Center or centers involved;

''(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

''(4) the capability of an Urban Indian Organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

''(5) the satisfactory performance and successful completion by an Urban Indian Organization of other contracts with the Secretary under this title;

''(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an Urban Center or centers; and

''(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

''(c) ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.—The Secretary, acting through the Service, shall facilitate access to or provide health promotion and disease prevention services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under subsection (a).

''(d) IMMUNIZATION SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate

access to, or provide, immunization services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under this section.

''(2) DEFINITION.—For purposes of this subsection, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

''(e) BEHAVIORAL HEALTH SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, behavioral health services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under subsection (a).

''(2) ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an Urban Indian Organization until that organization has prepared, and the Service has approved, an assessment of the following:

''(A) The behavioral health needs of the Urban Indian population concerned.

''(B) The behavioral health services and other related resources available to that population.

''(C) The barriers to obtaining those services and resources.

''(D) The needs that are unmet by such services and resources.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) To provide outreach, educational, and referral services to Urban Indians regarding the availability of direct behavioral health services, to educate Urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to Urban Indians.

''(C) To provide outpatient behavioral health services to Urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.

''(D) To develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

''(f) PREVENTION OF CHILD ABUSE.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to or provide services for Urban Indians through grants to Urban Indian Organizations administering contracts entered into or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among Urban Indians.

''(2) EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an Urban Indian Organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the Urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) For the development of prevention, training, and education programs for Urban Indians, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection.

''(C) To provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to Urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to Urban Indian perpetrators of child abuse (including sexual abuse).

''(4) CONSIDERATIONS WHEN MAKING GRANTS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

''(A) the support for the Urban Indian Organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child

Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

''(B) the capability and expertise demonstrated by the Urban Indian Organization to address the complex problem of child sexual abuse in the community; and

''(C) the assessment required under paragraph (2).

''(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an Urban Indian Organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

**''SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.**

''(a) GRANTS AND CONTRACTS AUTHORIZED.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, may enter into contracts with or make grants to Urban Indian Organizations situated in Urban Centers for which contracts have not been entered into or grants have not been made under section 503.

''(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (c)(1) in order to assist the Secretary in assessing the health status and health care needs of Urban Indians in the Urban Center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the Urban Indian Organization which the Secretary has entered into a contract with, or made a grant to, under this section.

''(c) GRANT AND CONTRACT REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

''(1) the Urban Indian Organization successfully undertakes to—

''(A) document the health care status and unmet health care needs of Urban Indians in the Urban Center involved; and

''(B) with respect to Urban Indians in the Urban Center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

''(2) the Urban Indian Organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date

on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

''(d) NO RENEWALS.—The Secretary may not renew any contract entered into or grant made under this section.

**''SEC. 505. EVALUATIONS; RENEWALS.**

''(a) PROCEDURES FOR EVALUATIONS.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements and compliance with and performance of contracts entered into by Urban Indian Organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

''(b) EVALUATIONS.—The Secretary, acting through the Service, shall evaluate the compliance of each Urban Indian Organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of this evaluation, in determining the capacity of an Urban Indian Organization to deliver quality patient care the Secretary shall, at the option of the organization—

''(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

''(2) accept in lieu of such onsite evaluation evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

''(c) NONCOMPLIANCE; UNSATISFACTORY PERFORMANCE.—If, as a result of the evaluations conducted under this section, the Secretary determines that an Urban Indian Organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with the organization the areas of noncompliance or unsatisfactory performance and modify the contract or grant to prevent future occurrences of noncompliance or unsatisfactory performance. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew the contract or grant with the organization and is authorized to enter into a contract or make a grant under section 503 with another Urban Indian Organization which is situated in the same Urban Center as the Urban Indian Organization whose contract or grant is not renewed under this section.

''(d) CONSIDERATIONS FOR RENEWALS.—In determining whether to renew a contract or grant with an Urban Indian Organization under section 503 which has completed performance of a contract or grant under section 504, the Secretary shall review the records of the Urban Indian Organization, the reports submitted under section 507, and shall consider the results of the onsite evaluations or accreditations under subsection (b).

**''SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.**

''(a) PROCUREMENT.—Contracts with Urban Indian Organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of sections 1304 and 3131 through 3133 of title 40, United States Code.

''(b) PAYMENTS UNDER CONTRACTS OR GRANTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

''(1) be made in their entirety by the Secretary to the Urban Indian Organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the

Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

''(2) if any portion thereof is unexpended by the Urban Indian Organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the availability for expenditure of such funds.

''(c) REVISION OR AMENDMENT OF CONTRACTS.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request and consent of an Urban Indian Organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

''(d) FAIR AND UNIFORM SERVICES AND ASSISTANCE.—Contracts with or grants to Urban Indian Organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to Urban Indians of services and assistance under such contracts or grants by such organizations.

**"SEC. 507. REPORTS AND RECORDS.**

''(a) REPORTS.—For each fiscal year during which an Urban Indian Organization receives or expends funds pursuant to a contract entered into or a grant received pursuant to this title, such Urban Indian Organization shall submit to the Secretary not more frequently than every 6 months, a report that includes the following:

''(1) In the case of a contract or grant under section 503, recommendations pursuant to section 503(a)(5).

''(2) Information on activities conducted by the organization pursuant to the contract or grant.

''(3) An accounting of the amounts and purpose for which Federal funds were expended.

''(4) A minimum set of data, using uniformly defined elements, as specified by the Secretary after consultation with Urban Indian Organizations.

''(b) AUDIT.—The reports and records of the Urban Indian Organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

''(c) COSTS OF AUDITS.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

''(1) a certified public accountant; or

''(2) a certified public accounting firm qualified to conduct Federal compliance audits.

**''SEC. 508. LIMITATION ON CONTRACT AUTHORITY.**

''The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

**''SEC. 509. FACILITIES.**

''(a) GRANTS.—The Secretary, acting through the Service, may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

''(b) LOAN FUND STUDY.—The Secretary, acting through the Services, may carry out a study to determine the feasibility of establishing a loan fund to provide to Urban Indian Organizations direct loans or guarantees for loans for the construction of health care facilities in a manner consistent with section 309.

**''SEC. 510. OFFICE OF URBAN INDIAN HEALTH.**

''There is established within the Service an Office of Urban Indian Health, which shall be responsible for—

''(1) carrying out the provisions of this title;

''(2) providing central oversight of the programs and services authorized under this title; and

''(3) providing technical assistance to Urban Indian Organizations.

**''SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.**

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based education regarding, alcohol and substance abuse in Urban Centers to those Urban Indian Organizations with which the Secretary has entered into a contract under this title or under section 201.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

''(1) The size of the Urban Indian population.

''(2) Capability of the organization to adequately perform the activities required under the grant.

''(3) Satisfactory performance standards for the organization in meeting the goals set forth in such grant. The standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis.

''(4) Identification of the need for services.

''(d) ALLOCATION OF GRANTS.—The Secretary shall develop a methodology for allocating grants made pursuant to this section based on the criteria established pursuant to subsection (c).

''(e) GRANTS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

**''SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.**

''Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

''(1) be permanent programs within the Service's direct care program;

''(2) continue to be treated as Service Units in the allocation of resources and coordination of care; and

''(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

**''SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.**

''(a) GRANTS AND CONTRACTS.—The Secretary, through the Office of Urban Indian Health, shall make grants or enter into contracts with Urban Indian Organizations for the administration of Urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (hereafter in this section referred to as 'NIAAA') and transferred to the Service. Such grants and contracts shall become effective no later than September 30, 2008.

''(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for Urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

''(c) ELIGIBILITY.—Urban Indian Organizations that operate Indian alcohol programs originally funded under the NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) REPORT.—The Secretary shall evaluate and report to Congress on the activities of programs funded under this section not less than every 5 years.

**''SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.**

''(a) IN GENERAL.—The Secretary shall ensure that the Service consults, to the greatest extent practicable, with Urban Indian Organizations.

''(b) DEFINITION OF CONSULTATION.—For purposes of subsection (a), consultation is the open and free exchange of information and opinions which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

**''SEC. 515. FEDERAL TORT CLAIM ACT COVERAGE.**

''(a) IN GENERAL.—With respect to claims resulting from the performance of functions during fiscal year 2005 and thereafter, or claims asserted after September 30, 2004, but resulting from the performance of functions prior to fiscal year 2005, under a contract, grant agreement, or any other agreement authorized under this title, an Urban Indian Organization is deemed hereafter to be part of the Service in the Department of Health and Human Services while carrying out any such contract or agreement and its employees are deemed employees of the Service while acting within the scope of their employment

in carrying out the contract or agreement. After September 30, 2003, any civil action or proceeding involving such claims brought hereafter against any Urban Indian Organization or any employee of such Urban Indian Organization covered by this provision shall be deemed to be an action against the United States and will be defended by the Attorney General and be afforded the full protection and coverage of the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.). Future coverage under that Act shall be contingent on cooperation of the Urban Indian Organization with the Attorney General in prosecuting past claims.

''(b) CLAIMS RESULTING FROM PERFORMANCE OF CONTRACT OR GRANT.—Beginning for fiscal year 2005 and thereafter, the Secretary shall request through annual appropriations funds sufficient to reimburse the Treasury for any claims paid in the prior fiscal year pursuant to the foregoing provisions.

**''SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.**

''(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, through grant or contract, is authorized to fund the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision

of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

''(b) DEFINITION OF STATE.—A State described in this subsection is a State in which—

''(1) there resides Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting; and

''(2) there is a significant shortage of culturally competent residential treatment services for Urban Indian youth.

**''SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.**

''(a) AUTHORIZATION FOR USE.—The Secretary, acting through the Service, shall allow an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

''(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an Urban Indian Organization that has entered into a contract or received a grant pursu-

ant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

''(c) ACQUISITION OF PROPERTY FOR DONATION.—The Secretary may acquire excess or surplus government personal or real property for donation (subject to subsection (d)), to an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the Urban Indian Organization for a purpose for which a contract or grant is authorized under this title.

''(d) PRIORITY.—In the event that the Secretary receives a request for donation of a specific item of personal or real property described in subsection (b) or (c) from both an Urban Indian Organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation of the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the Secretary transfers the property physically to the Urban Indian Organization.

''(e) URBAN INDIAN ORGANIZATIONS DEEMED EXECUTIVE AGENCY FOR CERTAIN PURPOSES.—For purposes of section 501 of title 40, United States Code, (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant.

**''SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.**

''(a) GRANTS AUTHORIZED.—The Secretary may make grants to those Urban Indian Organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

''(1) the size and location of the Urban Indian population to be served;

''(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among the Urban Indian population to be served;

''(3) performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

''(4) the capability of the organization to adequately perform the activities required under the grant; and

''(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the Area Office of the Service in which the organization is located.

''(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for the prevention, treatment, and control of diabetes among Urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

**''SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.**

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, Urban In-

dian Organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to Urban Indians.

**''SEC. 520. REGULATIONS.**

''(a) REQUIREMENTS FOR REGULATIONS.—The Secretary may promulgate regulations to implement the provisions of this title in accordance with the following:

''(1) Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 9 months after the date of enactment of this Act and shall have no less than a 4-month comment period.

''(2) The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

''(b) EFFECTIVE DATE OF TITLE.—The amendments to this title made by the Indian Health Care Improvement Act Amendments of 2005 shall be effective on the date of enactment of such amendments, regardless of whether the Secretary has promulgated regulations implementing such amendments have been promulgated.

**''SEC. 521. ELIGIBILITY FOR SERVICES.**

''Urban Indians shall be eligible and the ultimate beneficiaries for health care or referral services provided pursuant to this title.

**''SEC. 522. AUTHORIZATION OF APPROPRIATIONS.**

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

# ''TITLE VI—ORGANIZATIONAL IMPROVEMENTS

**''SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.**

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian Tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistant Secretary of Indian Health, who shall be appointed by the President, by and with the advice

and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2005, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

''(3) INCUMBENT.—The individual serving in the position of Director of the Indian Health Service on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2005 shall serve as Assistant Secretary.

''(4) ADVOCACY AND CONSULTATION.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

''(A) facilitate advocacy for the development of appropriate Indian health policy; and

''(B) promote consultation on matters relating to Indian health.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) DUTIES.—The Assistant Secretary of Indian Health shall—

''(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, carried out by or under the direction of the individual serving as Director of the Service on that day;

''(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

''(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(4) administer all scholarship and loan functions carried out under title I;

''(5) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

''(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

''(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

''(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

''(9) coordinate the activities of the Department concerning matters of Indian health; and

''(10) perform such other functions as the Secretary may designate.

''(d) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

''(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

''(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

''(C) to manage, expend, and obligate all funds appropriated for the Service.

''(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

''(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or in any document of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

**"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.**

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary shall establish an automated management information system for the Service.

"(2) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

"(A) a financial management system;

"(B) a patient care information system for each area served by the Service;

"(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service;

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each Area office of the Service;

"(E) an interface mechanism for patient billing and accounts receivable system; and

"(F) a training component.

"(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Tribal

Health Program automated management information systems which—

''(1) meet the management information needs of such Tribal Health Program with respect to the treatment by the Tribal Health Program of patients of the Service; and

''(2) meet the management information needs of the Service.

''(c) ACCESS TO RECORDS.—Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

''(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities.

**''SEC. 603. AUTHORIZATION OF APPROPRIATIONS.**

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

# "TITLE VII—BEHAVIORAL HEALTH PROGRAMS

**"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.**

''(a) PURPOSES.—The purposes of this section are as follows:

''(1) To authorize and direct the Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

''(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

''(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

''(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

''(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

''(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

''(b) PLANS.—

''(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and Urban Indian Organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

''(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and

dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

''(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

''(ii) an estimate of the financial and human cost attributable to such illness or behavior.

''(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

''(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, Urban Indian Organizations, and Service Areas relating to behavioral health. The

Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, Urban Indian Organization, or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

''(c) PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, to the extent feasible and if funding is available, programs including the following:

''(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

''(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient/day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

''(G) emergency shelter;

''(H) intensive case management;

''(I) Traditional Health Care Practices; and

''(J) diagnostic services.

''(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

''(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

''(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

''(C) identification and treatment of co-occurring disorders and comorbidity;

''(D) prevention of alcohol, drug, inhalant, and tobacco use;

''(E) early intervention, treatment, and aftercare;

''(F) promotion of healthy approaches to risk and safety issues; and

''(G) identification and treatment of neglect and physical, mental, and sexual abuse.

''(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches for risk-related behavior;

''(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder; and

''(F) sex specific treatment for sexual assault and domestic violence.

''(4) FAMILY CARE.—Behavioral health services for families, including—

''(A) early intervention, treatment, and aftercare for affected families;

''(B) treatment for sexual assault and domestic violence; and

''(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

''(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and co-morbidity;

''(D) promotion of healthy approaches to managing conditions related to aging;

''(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

''(F) identification and treatment of dementias regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization may adopt a resolution for the establishment of a community behavioral health plan

providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

''(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization in the development and implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organiza-

tions, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

''(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

**''SEC. 702. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.**

''(a) CONTENTS.—Not later than 12 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

''(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

''(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

''(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

''(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

''(B) The right of Indians to participate in, and receive the benefit of, such services.

''(C) The actions necessary to protect the exercise of such right.

''(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service Unit, Service Area, and

headquarters levels to address the problems identified in paragraph (1).

''(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

''(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

''(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

''(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly

at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

''(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

''(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) CONSULTATION.—The Secretary, acting through the Service, and the Secretary of the Interior shall, in developing the memoranda of agreement under subsection (a), consult with and solicit the comments from—

''(1) Indian Tribes and Tribal Organizations;

''(2) Indians;

''(3) Urban Indian Organizations and other Indian organizations; and

''(4) behavioral health service providers.

''(d) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and Urban Indian Organization.

**''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.**

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including Traditional Health Care Practices, which shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

''(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

''(F) diagnostic services.

''(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian Tribes. Efforts to train and educate key members of

the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

''(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian Tribes and Tribal Organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

**''SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.**

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

''(1) provides for the training of Indians as mental health technicians; and

''(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

''(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall supervise and evaluate the mental health technicians in the training program.

''(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes to be served.

**"SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.**

"Subject to the provisions of section 221, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a clinical psychologist, social worker, or marriage and family therapist, respectively, or working under the direct supervision of a licensed clinical psychologist, social worker, or marriage and family therapist, respectively.

**"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.**

"(a) FUNDING.—The Secretary, consistent with section 701, shall make funds available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

"(b) USE OF FUNDS.—Funds made available pursuant to this section may be used to—

"(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

''(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) develop prevention and intervention models for Indian women which incorporate Traditional Health Care Practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations.

**''SEC. 707. INDIAN YOUTH PROGRAM.**

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 701, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian

Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an Area Office.

''(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the Area Office in California shall be considered to be 2 Area Offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

''(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

''(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian Tribes to be served by such center.

''(4) SPECIFIC PROVISION OF FUNDS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

''(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

''(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section

4(*l*) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(*l*)).

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services, which may incorporate Traditional Health Care Practices, to Indian children and adolescents, including—

''(A) pretreatment assistance;

''(B) inpatient, outpatient, and aftercare services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) for intensive home- and community-based services.

''(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the

review and approval of applications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall—

''(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

''(B) establish guidelines, in consultation with Indian Tribes and Tribal Organizations, for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian Tribe or Tribal Organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, Indian Tribes, or Tribal Organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service Unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide for the inclusion of family mem-

bers of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

**''SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.**

''Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral

health problems. For the purposes of this subsection, California shall be considered to be 2 Area Offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

**"SEC. 709. TRAINING AND COMMUNITY EDUCATION.**

''(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or provide funding for Indian Tribes and Tribal Organizations to develop and implement, within each Service Unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, Tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Community-based training (oriented toward local capacity development) shall also include tribal community provider training (designed for adult

learners from the communities receiving services for prevention, intervention, treatment, and aftercare).

''(b) INSTRUCTION.—The Secretary, acting through the Service, shall, either directly or through Indian Tribes and Tribal Organizations, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian Tribes, Tribal Organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

**''SEC. 710. BEHAVIORAL HEALTH PROGRAM.**

''(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

''(b) FUNDING; CRITERIA.—The Secretary may award such funding for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

''(1) The project will address significant unmet behavioral health needs among Indians.

''(2) The project will serve a significant number of Indians.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(5) The project may deliver services in a manner consistent with Traditional Health Care Practices.

''(6) The project is coordinated with, and avoids duplication of, existing services.

''(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

**''SEC. 711. FETAL ALCOHOL DISORDER FUNDING.**

''(a) PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary, consistent with section 701, acting through the Service, Indian Tribes, and Tribal Organizations, is authorized to establish and operate fetal alcohol disorder programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

''(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(A) To develop and provide for Indians community and in school training, education, and prevention programs relating to fetal alcohol disorders.

"(B) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

"(C) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected Indians and their families or caretakers.

"(D) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

"(E) To develop prevention and intervention models which incorporate practitioners of Traditional Health Care Practices, cultural and spiritual values, and community involvement.

"(F) To develop, print, and disseminate education and prevention materials on fetal alcohol disorder.

"(G) To develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.

''(H) To develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorder among Indians.

''(I) To develop and fund community-based adult fetal alcohol disorder housing and support services for Indians and for women pregnant with an Indian's child.

''(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) SERVICES.—The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in Indian communities; and

''(2) provide supportive services, directly or through an Indian Tribe, Tribal Organization, or Urban Indian Organization, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorder.

''(c) TASK FORCE.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorder Task Force to advise the Secretary in carrying out subsection (b). Such task force shall be composed of representatives from the following:

''(1) The National Institute on Drug Abuse.

''(2) The National Institute on Alcohol and Alcoholism.

''(3) The Office of Substance Abuse Prevention.

''(4) The National Institute of Mental Health.

''(5) The Service.

''(6) The Office of Minority Health of the Department of Health and Human Services.

''(7) The Administration for Native Americans.

''(8) The National Institute of Child Health and Human Development (NICHD).

''(9) The Centers for Disease Control and Prevention.

''(10) The Bureau of Indian Affairs.

''(11) Indian Tribes.

''(12) Tribal Organizations.

''(13) Urban Indian Organizations.

''(14) Indian fetal alcohol disorder experts.

''(d) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental

Health Services Administration, shall make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and Urban Indians affected by fetal alcohol disorder.

''(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations funded under title V.

**''SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.**

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, and the Secretary of the Interior, Indian Tribes, and Tribal Organizations shall establish, consistent with section 701, in every Service Area, programs involving treatment for—

''(1) victims of sexual abuse who are Indian children or children in an Indian household; and

''(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

''(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

''(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

''(3) To develop prevention and intervention models which incorporate Traditional Health Care Practices, cultural and spiritual values, and community involvement.

''(4) To develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

''(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

''(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and

''(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

**''SEC. 713. BEHAVIORAL HEALTH RESEARCH.**

''The Secretary, in consultation with appropriate Federal agencies, shall provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(2) the development of models of prevention techniques.

The effect of the interrelationships and interdependencies referred to in paragraph (1) on children, and the development of prevention techniques under paragraph (2) applicable to children, shall be emphasized.

**"SEC. 714. DEFINITIONS.**

"For the purpose of this title, the following definitions shall apply:

"(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

"(2) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities. Behaviorally, there can be problems with irritability, and failure to thrive as infants. As children become older there will likely be hyperactivity, attention deficit, language dysfunction, and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or

patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources a as community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers (mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, ministers, etc.)

''(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

''(5) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome and alcohol related neurodevelopmental disorder (ARND).

''(6) FETAL ALCOHOL SYNDROME OR FAS.—The term 'fetal alcohol syndrome' or 'FAS' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

''(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

''(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

''(C) Prenatal or postnatal growth delay.

''(7) PARTIAL FAS.—The term 'partial FAS' means, with a history of maternal alcohol consumption during pregnancy, having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

''(8) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to engage in usual and customary life activities through education and therapy.

''(9) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

**''SEC. 715. AUTHORIZATION OF APPROPRIATIONS.**

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out the provisions of this title.

# ''TITLE VIII—MISCELLANEOUS

**''SEC. 801. REPORTS.**

''The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to Congress a report containing the following:

''(1) A report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians and ensure a health status for Indians, which are at a parity with the health services available to and the health status of the general population, including specific comparisons of appropriations provided and those required for such parity.

''(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian Tribes,

Tribal Organizations, and Urban Indian Organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 808.

''(3) A report on the use of health services by Indians—

''(A) on a national and area or other relevant geographical basis;

''(B) by gender and age;

''(C) by source of payment and type of service;

''(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

''(E) provided under contracts.

''(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

''(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(n).

''(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 125(f).

''(7) A separate statement which specifies the amount of funds requested to carry out the provisions of section 201.

''(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

''(9) A biennial report to Congress on infectious diseases as required by section 212.

''(10) A report on environmental and nuclear health hazards as required by section 215.

''(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2) and 301(d).

''(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(h).

''(13) An annual report on the expenditure of nonservice funds for renovation as required by sections 304(b)(2).

''(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

''(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

''(16) A report on any arrangements for the sharing of medical facilities or services, as authorized by section 406.

''(17) A report on evaluation and renewal of Urban Indian programs under section 505.

''(18) A report on the evaluation of programs as required by section 513(d).

''(19) A report on alcohol and substance abuse as required by section 701(f).

**''SEC. 802. REGULATIONS.**

''(a) DEADLINES.—

''(1) PROCEDURES.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out titles I (except sections 105, 115, and 117), II, III, and VII. The Secretary may promulgate regulations to carry out sections 105, 115, 117, and titles IV and V, using the procedures required by chapter V of title 5, United States Code (commonly known as the 'Administrative Procedure Act'). The Secretary

shall issue no regulations to carry out titles VI and VIII.

''(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005 and shall have no less than a 120-day comment period.

''(3) EXPIRATION OF AUTHORITY.—Except as otherwise provided herein, the authority to promulgate regulations under this Act shall expire 24 months from the date of enactment of this Act.

''(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes and Tribal Organizations, a majority of whom shall be nominated by and be representatives of Indian Tribes, Tribal Organizations, and Urban Indian Organizations from each Service Area. The representative of the Urban Indian Organization shall be deemed to be an elected officer of a tribal government for purposes of applying section 204(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1534(b)).

''(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

''(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

''(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law) in effect on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

**''SEC. 803. PLAN OF IMPLEMENTATION.**

''Not later than 9 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall submit to Congress a plan explaining the manner and schedule (including a schedule of appropriation requests), by title and section, by which the Secretary will implement the provisions of this Act.

**''SEC. 804. AVAILABILITY OF FUNDS.**

''The funds appropriated pursuant to this Act shall remain available until expended.

**"SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.**

"Any limitation on the use of funds contained in an Act providing appropriations for the Department for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

**"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.**

"(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

"(1) Any member of a federally recognized Indian Tribe.

"(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

"(A) is a member of the Indian community served by a local program of the Service; and

"(B) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

"(4) Any Indian in California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of Califor-

nia under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

**''SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

''(a) CHILDREN.—Any individual who—

''(1) has not attained 19 years of age;

''(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

''(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain

eligible for such services until 1 year after the date of a determination of competency.

''(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian Tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribal Organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(c) PROVISION OF SERVICES TO OTHER INDIVIDUALS.—

''(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service Unit and who are not otherwise eligible for such health services if—

''(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

"(B) the Secretary and the served Indian Tribes have jointly determined that—

"(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

"(ii) there is no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health needs of such individuals.

"(2) ISDEAA PROGRAMS.—In the case of health programs and facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian Tribe or Tribal Organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact to individuals who are not otherwise eligible for such services under any other subsection of this section or under any other provision of law. In making such determination, the governing body of the Indian Tribe or Tribal organization shall take into account the con-

siderations described in clauses (i) and (ii) of paragraph (1)(B).

''(3) PAYMENT FOR SERVICES.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service under of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 404 of this Act or any other provision of law, amounts collected under this subsection, including medicare, medicaid, or SCHIP reimbursements under titles XVIII, XIX, and XXI of the Social Security Act, shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

''(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for

such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individual.

''(4) REVOCATION OF CONSENT FOR SERVICES.—

''(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian Tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian Tribe revokes its concurrence to the provision of such health services.

''(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian Tribes in the Service Area revoke their

concurrence to the provisions of such health services.

''(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or

''(4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

''(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of privileging process, be designated as employees of the Federal Government for purposes of section

1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

''(f) ELIGIBLE INDIAN.—For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

**''SEC. 808. REALLOCATION OF BASE RESOURCES.**

''(a) REPORT REQUIRED.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a Service Unit may be implemented only after the Secretary has submitted to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) EXCEPTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is at least 5 percent less than the amount appropriated to the Service for the previous fiscal year.

**''SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.**

''The Secretary shall provide for the dissemination to Indian Tribes, Tribal Organizations, and Urban Indian Organizations of the findings and results of demonstration projects conducted under this Act.

**''SEC. 810. PROVISION OF SERVICES IN MONTANA.**

''(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

''(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

**''SEC. 811. MORATORIUM.**

''During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration of the Public Health Service, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for

such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

**''SEC. 812. TRIBAL EMPLOYMENT.**

''For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372), an Indian Tribe or Tribal Organization carrying out a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall not be considered an 'employer'.

**''SEC. 813. SEVERABILITY PROVISIONS.**

''If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

**''SEC. 814. ESTABLISHMENT OF NATIONAL BIPARTISAN COMMISSION ON INDIAN HEALTH CARE.**

''(a) ESTABLISHMENT.—There is established the National Bipartisan Indian Health Care Commission (the 'Commission').

''(b) DUTIES OF COMMISSION.—The duties of the Commission are the following:

''(1) To establish a study committee composed of those members of the Commission appointed by the Director and at least 4 members of Congress from among the members of the Commission, the duties of which shall be the following:

''(A) To the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, which may include authorizing and making funds available for feasibility studies of various models for providing and funding health services for all Indian beneficiaries, including those who live outside of a reservation, temporarily or permanently.

''(B) To make legislative recommendations to the Commission regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of serv-

ice providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

''(C) To determine the effect of the enactment of such recommendations on (i) the existing system of delivery of health services for Indians, and (ii) the sovereign status of Indian Tribes.

''(D) Not later than 12 months after the appointment of all members of the Commission, to submit a written report of its findings and recommendations to the full Commission. The report shall include a statement of the minority and majority position of the Committee and shall be disseminated, at a minimum, to every Indian Tribe, Tribal Organization, and Urban Indian Organization for comment to the Commission.

''(E) To report regularly to the full Commission regarding the findings and recommendations developed by the study committee in the course of carrying out its duties under this section.

''(2) To review and analyze the recommendations of the report of the study committee.

''(3) To make legislative recommendations to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

''(4) Not later than 18 months following the date of appointment of all members of the Commission, submit a written report to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

''(c) MEMBERS.—

''(1) APPOINTMENT.—The Commission shall be composed of 25 members, appointed as follows:

''(A) Ten members of Congress, including 3 from the House of Representatives and 2 from the Senate, appointed by their respective majority leaders, and 3 from the House of Representatives and 2 from the Senate, appointed by their respective minority leaders, and who

shall be members of the standing committees of Congress that consider legislation affecting health care to Indians.

''(B) Twelve persons chosen by the congressional members of the Commission, 1 from each Service Area as currently designated by the Director to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

''(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.

''(D) All those persons chosen by the congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.

''(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the congressional members of the Commission.

''(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

''(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, and the remaining members of the Commission shall be appointed not later than 60 days following the appointment of the congressional members.

''(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(d) COMPENSATION.—

''(1) CONGRESSIONAL MEMBERS.—Each congressional member of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive

travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(2) OTHER MEMBERS.—Remaining members of the Commission, while serving on the business of the Commission (including travel time), shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. For purpose of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(e) MEETINGS.—The Commission shall meet at the call of the Chair.

''(f) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, provided that no less than 6 of the members of Congress who are Commission members are present and no less than 9 of the members who are Indians are present.

''(g) EXECUTIVE DIRECTOR; STAFF; FACILITIES.—

''(1) APPOINTMENT; PAY.—The Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

''(2) STAFF APPOINTMENT.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

''(3) STAFF PAY.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

''(4) TEMPORARY SERVICES.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

''(5) FACILITIES.—The Administrator of General Services shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals

required for the proper functioning of the Commission.

''(h) HEARINGS.—(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established in this section may count toward the number of regional hearings required by this subsection.

''(2) Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

''(3)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost esti-

mates as the Commission determines to be necessary to carry out its duties.

''(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

''(4) Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

''(5) Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

''(6) The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(7) The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

''(8) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

''(9) For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out the provisions of this section, which sum shall not be deducted from or affect any other appropriation for health care for Indian persons.

''(j) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

**''SEC. 815. APPROPRIATIONS; AVAILABILITY.**

''Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall

be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

**''SEC. 816. AUTHORIZATION OF APPROPRIATIONS.**

''(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.''.

(b) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (6).'' and inserting ''Assistant Secretaries of Health and Human Services (7)''.

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking ''Director, Indian Health Service, Department of Health and Human Services''.

(c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

(1) Section 3307(b)(1)(C) of the Children's Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

(A) in section 3 (25 U.S.C. 3902)—

(i) by striking paragraph (2);

(ii) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

(iii) by inserting before paragraph (4) (as redesignated by subclause (II)) the following:

''(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.'';

(B) in section 5 (25 U.S.C. 3904), by striking the section heading and inserting the following:

**''SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH.'';**

(C) in section 6(a) (25 U.S.C. 3905(a)), in the subsection heading, by striking ''DIRECTOR'' and inserting ''ASSISTANT SECRETARY'';

(D) in section 9(a) (25 U.S.C. 3908(a)), in the subsection heading, by striking ''DIRECTOR'' and inserting ''ASSISTANT SECRETARY''; and

(E) by striking ''Director'' each place it appears and inserting ''Assistant Secretary''.

(3) Section 5504(d)(2) of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(4) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(5) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377) are amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(6) Section 317M(b) of the Public Health Service Act (42 U.S.C. 247b–14(b)) is amended—

(A) by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''; and

(B) in paragraph (2)(A), by striking ''the Directors referred to in such paragraph'' and inserting ''the Director of the Centers for Disease Control and Prevention and the Assistant Secretary for Indian Health''.

(7) Section 417C(b) of the Public Health Service Act (42 U.S.C. 285–9(b)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(8) Section 1452(i) of the Safe Drinking Water Act (42 U.S.C. 300j–12(i)) is amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(9) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)) is amended in the last sentence by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(10) Section 203(b) of the Michigan Indian Land Claims Settlement Act (Public Law 105–143; 111 Stat. 2666) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

**SEC. 3. SOBOBA SANITATION FACILITIES.**

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following new section:

''SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).''.

**SEC. 4. AMENDMENTS TO THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.**

(a) EXPANSION OF MEDICAID PAYMENT FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended—

(A) by amending the heading to read as follows:

''INDIAN HEALTH PROGRAMS''; and

(B) by amending subsection (a) to read as follows:

''(a) ELIGIBILITY FOR REIMBURSEMENT FOR MEDICAL ASSISTANCE.—The Indian Health Service and an Indian Tribe, Tribal Organization, or an urban Indian Organization (as such terms are defined in section 4 of the

Indian Health Care Improvement Act) shall be eligible for reimbursement for medical assistance provided under a State plan or under waiver authority with respect to items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title and under such plan or waiver authority.''.

(2) ELIMINATION OF TEMPORARY DEEMING PROVISION.—Such section is amended by striking subsection (b).

(3) REVISION OF AUTHORITY TO ENTER INTO AGREEMENTS.—Subsection (c) of such section is redesignated as subsection (b) and is amended to read as follows:

''(b) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance provided by the Indian Health Service, an Indian Tribe, Tribal Organizations, or an Urban Indian Organization (as so defined), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization and another health care

provider to Indians who are eligible for medical assistance under the State plan or under waiver authority.''.

(4) REFERENCE CORRECTION.—Subsection (d) of such section is redesignated as subsection (c) and is amended—

(A) by striking ''For'' and inserting ''DIRECT BILLING.—For''; and

(B) by striking ''section 405'' and inserting ''section 401(d)''.

(b) SPECIAL RULES FOR INDIANS, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

(1) IN GENERAL.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

''(h) SPECIAL RULES FOR INDIANS, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—A State shall comply with the provisions of section 413 of the Indian Health Care Improvement Act (relating to the treatment of Indians, Indian health care providers, and Indian managed care entities under a medicaid managed care program).''.

(2) APPLICATION TO SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C.

1397gg(1)) is amended by adding at the end the following:

"(E) Subsections (a)(2)(C) and (h) of section 1932.".

(c) SCHIP TREATMENT OF INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended—

(1) in paragraph (2), by adding at the end the following:

"(C) INDIAN HEALTH PROGRAM PAYMENTS.—For provisions relating to authorizing use of allotments under this title for payments to Indian Health Programs and Urban Indian Organizations, see section 410 of the Indian Health Care Improvement Act."; and

(2) in paragraph (6)(B), by inserting "or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)" after "Service".

**SEC. 5. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.**

(a) IN GENERAL.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:

# "TITLE VIII—NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

**"SEC. 801. DEFINITIONS.**

''In this title:

''(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

''(2) COMMITTEE.—The term 'Committee' means the Committee for the Establishment of Native American Health and Wellness Foundation established under section 802(f).

''(3) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

''(4) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(5) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

**"SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.**

''(a) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District of Columbia and in accordance with this title, the Native American Health and Wellness Foundation.

''(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

''(c) NATURE OF CORPORATION.—The Foundation—

''(1) shall be a charitable and nonprofit federally chartered corporation; and

''(2) shall not be an agency or instrumentality of the United States.

''(d) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

''(e) DUTIES.—The Foundation shall—

''(1) encourage, accept, and administer private gifts of real and personal property, and any income from or interest in such gifts, for the benefit of, or in support of, the mission of the Service;

''(2) undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and

''(3) participate with and assist Federal, State, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

''(f) COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.—

''(1) IN GENERAL.—The Secretary shall establish the Committee for the Establishment of Native American Health and Wellness Foundation to assist the Secretary in establishing the Foundation.

''(2) DUTIES.—Not later than 180 days after the date of enactment of this section, the Committee shall—

''(A) carry out such activities as are necessary to incorporate the Foundation under the laws of the District of Columbia, including acting as incorporators of the Foundation;

''(B) ensure that the Foundation qualifies for and maintains the status required to carry out this section, until the Board is established;

''(C) establish the constitution and initial bylaws of the Foundation;

''(D) provide for the initial operation of the Foundation, including providing for temporary or interim quarters, equipment, and staff; and

''(E) appoint the initial members of the Board in accordance with the constitution and initial bylaws of the Foundation.

''(g) BOARD OF DIRECTORS.—

''(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

''(2) POWERS.—The Board may exercise, or provide for the exercise of, the powers of the Foundation.

''(3) SELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the number of members of the Board, the manner of selection of the members (including the filling of vacancies), and the terms of office of the members shall be as provided in the constitution and bylaws of the Foundation.

''(B) REQUIREMENTS.—

''(i) NUMBER OF MEMBERS.—The Board shall have at least 11 members, who shall have staggered terms.

''(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board—

''(I) shall be appointed by the Committee not later than 180 days after the date on which the Foundation is established; and

''(II) shall have staggered terms.

''(iii) QUALIFICATION.—The members of the Board shall be United States citizens who are knowledgeable or experienced in Native American health care and related matters.

''(C) COMPENSATION.—A member of the Board shall not receive compensation for service as a member, but shall be reimbursed for actual and necessary travel and subsistence expenses incurred in the performance of the duties of the Foundation.

''(h) OFFICERS.—

''(1) IN GENERAL.—The officers of the Foundation shall be—

''(A) a secretary, elected from among the members of the Board; and

''(B) any other officers provided for in the constitution and bylaws of the Foundation.

''(2) SECRETARY.—The secretary of the Foundation shall serve, at the direction of the Board, as the chief operating officer of the Foundation.

''(3) ELECTION.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

''(i) POWERS.—The Foundation—

''(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

''(2) may adopt and alter a corporate seal;

''(3) may enter into contracts;

''(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or convenient to carry out the purposes of the Foundation;

''(5) may sue and be sued; and

''(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

''(j) PRINCIPAL OFFICE.—

''(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

''(2) ACTIVITIES; OFFICES.—The activities of the Foundation may be conducted, and offices may

be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

''(k) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

''(l) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

''(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

''(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of the duties of the member.

''(m) RESTRICTIONS.—

''(1) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed 10 percent of the sum of—

''(A) the amounts transferred to the Foundation under subsection (o) during the preceding fiscal year; and

''(B) donations received from private sources during the preceding fiscal year.

''(2) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funds.

''(3) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not by reason of association with the Foundation be considered to be an officer, employee, or agent of the United States.

''(n) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

''(o) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (e)(1) $500,000 for each fiscal year, as adjusted to reflect changes in the Consumer Price Index for all-urban consumers published by the Department of Labor.

''(2) TRANSFER OF DONATED FUNDS.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

**''SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.**

''(a) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

''(1) may provide personnel, facilities, and other administrative support services to the Foundation;

''(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board; and

''(3) shall require and accept reimbursements from the Foundation for—

''(A) services provided under paragraph (1); and

''(B) funds provided under paragraph (2).

''(b) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3)—

''(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

''(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

''(c) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the facilities and services—

''(1) are available; and

''(2) are provided on reimbursable cost basis.''.

(b) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act is amended—

(1) by redesignating title V (as added by section 1302 of the American Indian Education Foundation Act of 2000) (25 U.S.C. 458bbb et seq.)) as title VII;

(2) by redesignating sections 501, 502, and 503 (as added by section 1302 of the American Indian Education Foundation Act of 2000) as sections 701, 702, and 703, respectively; and

(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by

paragraph (2)), by striking ''section 501'' and inserting ''section 701''.

○

Senator ENZI. Chairman McCain, welcome to our home.

**STATEMENT OF HON. JOHN MCCAIN, U.S. SENATOR FROM ARIZONA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS**

Senator MCCAIN. Thank you very much, Mr. Chairman. I will make my statement part of the record and ask unanimous consent to do so.

I would just like to comment that this act is long overdue. It is important. I think you, in your opening statement, articulated the importance of this legislation very well. I am very pleased for Senator Dorgan and I to have the opportunity to work with you and Senator Kennedy and get this bill done. It is long overdue.

Thank you, Mr. Chairman.

Senator ENZI. Thank you.

[Prepared statement of Senator McCain appears in appendix.]

Senator Dorgan.

**STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS**

Senator DORGAN. Mr. Chairman, let me just add my thank you, and ask that my statement be made a part of the record. I have said often I think we have a bona fide emergency in health care on Indian reservations, the first Americans. I hope very much that this hearing is one more stimulus towards finally passing this legislation. We should have done it in the last session of Congress, but we were unable to get there.

So my hope is, and I believe Senator McCain and I have worked very hard and appreciate your cooperation to do this. My hope is that we will get a bill to the President for signature that advances health care on Indian reservations and with Native Americans.

Thank you very much.

Senator ENZI. Thank you.

Senator Kennedy.

**STATEMENT OF HON. EDWARD M. KENNEDY, U.S. SENATOR FROM MASSACHUSETTS**

Senator KENNEDY. Mr. Chairman, I want to first of all join you in thanking Senator McCain and Senator Dorgan for inviting us to participate in this program. As we know, they have the primary jurisdiction in terms of where Native Americans are living, and the enormous health disparities that exist for Native Americans in Indian country.

We know that also there are a number of Native Americans who are in urban areas. We want to try and make sure, to the extent that we can, is harmonize whatever we are doing here and in your committee so it ties on into the excellent legislation which they have introduced.

I just want to commend them. It has been far too long since the Senate addressed this issue. We have many health challenges in this Nation, but the disparity issue is such a compelling one. We will hear time after time of what is happening out there in Indian country this afternoon. And that is absolutely intolerable in our country and in our society.

Once in a while we get disparities in urban areas among different kinds of groups, but if we look at the total range of health disparities, it does not exist in any place in our Nation as it exists with Native Americans. This cries out for action. It cries out for response.

I just want to thank Senator McCain and Senator Dorgan for their leadership. This legislation is way, way overdue. I thank you for having the hearing and giving the spotlight on this. I pledge to work with you and our colleagues to do what we can so we have a seamless web in trying to make sure that those whose tradition comes from Indian land are going to have the kind of health care needs that they are entitled to in our Nation.

I thank you, and I would like to ask that my full statement be put in the record.

[Prepared statement of Senator Kennedy appears in appendix.]

Senator ENZI. Without objection, all statements will be in the record.

I think you can tell from the opening statements that there is a lot of passion behind this, so let's get on to the witnesses. Our first witness is Dr. Charles Grim. Dr. Grim is the director of Indian Health Service. He is the Assistant Surgeon General and holds the rank of Rear Admiral in the Commissioned Corps of the Public Health Service. We thank you for being here, Dr. Grim.

**STATEMENT OF DR. CHARLES GRIM, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT G. MCSWAIN, DEPUTY DIRECTOR; GARY HARTZ, DIRECTOR, OFFICE OF ENVIRONMENT HEALTH AND ENGINEERING; AND CRAIG VANDERWAGEN, M.D., ACTING CHIEF MEDICAL OFFICER**

Mr. GRIM. Thank you, Chairman Enzi.

Mr. Chairman and members of the committee, we are very appreciative of this joint hearing that you agreed to hold and we are very honored to be able to testify before you here today on the important issue of the reauthorization of the Indian Health Care Improvement Act.

My name is Dr. Charles Grim. I am accompanied today by Robert McSwain, my deputy director; Craig Vanderwagen, our acting chief medical officer; and Gary Hartz, our director for the Office of Environmental Health and Engineering. I will be giving the opening comments for the Department, but my colleagues are with me today so that we can respond to your questions.

This month, July 2005, marks the 50th anniversary of the Transfer Act, Public Law 83–568, which officially transferred the Indian health programs from the Bureau of Indian Affairs [BIA] to the U.S. Public Health Service, effectively establishing the Indian Health Service. The Transfer Act provided that all functions, responsibilities, authorities and duties relating to the maintenance and operation of hospitals and health facilities for Indians and the conservation of Indian health shall be administered by the Surgeon General of the United States Public Health Service.

This transfer was significant in that our program was moved to an executive branch department, then the Department of Health, Education and Welfare, and now the Department of Health and

Human Service. This transfer was more appropriate to the role of the Federal Government in addressing the health care needs of American Indians and Alaska Natives. Since the Transfer Act, the health status of Indians have improved significantly.

Today, we are here to discuss another significant milestone in the evolution of our Federal Government's responsibility for the provision of health services to American Indians and Alaska Natives, the Indian Health Care Improvement Act which was first authorized in 1976. It forms the backbone of the system through which the Federal health programs serve American Indians and Alaska Natives and encourage their participation in these and other programs.

IHS has the responsibility for the delivery of health services to more than 1.8 million federally recognized American Indians and Alaska Natives through a system of IHS, tribal and urban Indian-operated facilities in programs based on treaties and judicial decisions and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of the American Indian and Alaska Natives to the highest level in partnership with the population we serve. Our goal is to assure that comprehensive, culturally appropriate, acceptable personal and public health services are available and accessible.

Our foundation is to uphold the Federal Government's responsibility to promote healthy American Indian and Alaska Native people, communities and cultures, and to honor and protect the inherent sovereign rights of tribes.

The Indian Health Care Improvement Act builds upon the Snyder Act of 1921, which authorized regular appropriations for the relief and distress and conservation of health of American Indians and Alaska Natives. Like the Snyder Act, the Indian Health Care Improvement Act authorizes programs that deliver health services to Indian people, as well as providing additional directives and guidance.

For example, the Indian Health Care Improvement Act contains specific authorities addressing recruitment and retention of health professionals serving Indian communities, the provision of health services, the construction, replacement and repair of health care facilities, access to health services, and the provision of health services to urban Indian people.

We are here today to discuss the reauthorization of the Indian Health Care Improvement Act and its impact on programs and services provided for in current law. S. 1057 proposes to amend current program authority to assure the highest possible health status for Indians. Improving access for health care for all eligible American Indians and Alaska Natives is critical to achieving this goal and a priority for all those involved in the administration of this important program.

S. 1057, however, also provides expansions which may negatively impact access by requiring the secretary to consult, negotiate, develop reports and establish programs and activities beyond the reasonable scope necessary to effectively implement the Indian Health Care Improvement Act. In S. 1057, between desire to improve access and provisions that potentially compromise access, we hope to find a means for achieving our common goal.

Since enactment of the Indian Health Care Act in 1976, statutory authority has substantially expanded programs and activities to keep pace with advances in health care delivery and administration. Federal funding for the Indian Health Care Improvement Act has contributed billions of dollars to improve the health status of American Indians and Alaska Natives. Much progress has been made, particularly in the areas of infant and maternal mortality.

The Department has also reactivated the Intra-departmental Council on Native American Affairs to provide a consistent HHS policy when working with more than 560 federally recognized tribes. This council, which was authorized in the Native American Programs Act of 1974, gives the IHS Director a highly visible role within the Department on Indian policy. I serve as the vice chair of that council.

The Department has also revised our consultation policy recently through a process which involved tribal leaders. The policy emphasizes the unique government-to-government relationship between Indian tribes and the Federal Government and assists in improving services through better communications. Consultation is conducted at different levels and includes annual budget consultations with tribes to ensure their participation in this important process. The annual budget meetings provide tribes with an opportunity to meet directly with all department agencies and identify their priorities for upcoming years.

In addition, the Centers for Medicare and Medicaid Services has established a technical tribal advisory group which was established to provide tribes a vehicle to communicate concerns and comments to CMS on Medicare, Medicaid and SCHIP policies impacting their members. IHS has been vigilant about improving outcomes for Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible or struggling with this potentially disabling disease.

The Department has not been a passive observer of the health needs of eligible American Indians and Alaska Natives, yet we recognize the health disparities among this population do exist and are among some of the highest in the Nation for certain diseases, as you pointed out. We know that improvements in access to IHS and other Federal programs and private sector programs will result in improved health status for Indian people.

We support the provisions that increase the flexibility of the Department to work with tribes and urban Indian programs to increase the availability of health care, including new approaches to delivering care and to expand the scope of health services available to American Indians and Alaska Natives. I commend Congress for including in S. 1057 various changes that respond to the concerns raised in previous proposals. Some of the changes improve the ability of the Secretary to effectively manage the program.

In the area of behavioral health, title VII of S. 1057, it provides for the needs of Indian women and youth and expands behavioral health service to include a much-needed child sexual abuse and prevention treatment program. The Department supports this effort, but opposes specific requirements in certain sections of this title, specifically 704, 706 and 711. Essentially, it is a "shall" ver-

sus "may" issue that diminishes the flexibility of the secretary in providing for these important programs in a manner that supports the local control and priorities of tribes and be able to address their specific needs.

The Department also opposes a new section 104(a)(2) which proposes to allocate the Indian Health Profession Scholarship Program funding by formula to the 12 IHS areas. If allocation by formula is authorized, students will not be given an opportunity to apply for a scholarships if their area does not receive an adequate allocation and if their desired profession is not considered a priority in their area, even though there may be great needs nationally for such professions. We would recommend that this program remain a national program.

My written testimony includes other specific areas of concern. In addition, the Department continues to carefully analyze all provisions contained in S. 1057. The department would like to continue to work with your committees to discuss our concerns with the bill as drafted.

Based on the work that has occurred between the Department and congressional committees in the 108th Congress on the predecessor proposal, S. 556, to this current bill S. 1057, I am confident that we can reach a mutual agreement on a bill that can be acceptable to our parties, including tribes and urban Indians, and raise their health status in the years to come.

I would be pleased to answer any questions that you may have, and thank your for having us today.

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

Senator ENZI. Thank you very much for being here. I will mention that we are going to have some confusion with votes that are starting at 3 p.m. today, but one of the things that we do by having people serve on panels, we are hoping that they are also open to written questions. A lot of times we have written questions anyway that go into much more detail than would be possible for us to be able to do in a forum like this.

So we hope that all witnesses will be open to answering written questions, from all committee members. Our purpose is to build a record so that we have the capability to write the best bill. I appreciate the testimony you have given.

As you might be aware, I am very interested in expanding health information technology to all health care providers. We have done some legislation on that. Could you briefly tell me what kinds of information technology activities are occurring in the Indian Health Service? More importantly, are there any barriers to broader implementation of those programs?

Mr. GRIM. The Indian Health Service has had electronic health records for many, many years. Just this year, we started the implementation of a fully electronic graphical user interface health record. It has now been rolled out in 24 of our sites. We are in hopes that by the year fiscal year 2008 or 2009, we will have a fully electronic health record in all of our programs. We are making use of the latest technology that there is. We have tele-health programs that are excellent that are in the State of Alaska that tie all of the community health clinics into some of the regional hub hospitals. We are looking at the expansion of tele-medicine across

our agency in the years ahead. We have it in various sites, but not others.

So I would say, Senator, that we are I think right on the cutting edge. We are working with the President's Health Information Technology Program. We have representatives that are sitting on that. I would be happy to answer anything further or more details that you might about that for the record.

Senator ENZI. I will do some followup questions in writing.

Senator McCain.

Senator MCCAIN. Thank you very much, Dr. Grim.

For the record, you might mention who is accompanying you at the table.

Mr. GRIM. Okay. I have my deputy director, Robert McSwain; Gary Hartz, our director for the Office of Environmental Health and Engineering; and Craig Vanderwagen, our chief medical officer.

Senator MCCAIN. Welcome.

Doctor, we have been around this track a few times before, as you know.

Mr. GRIM. Yes, sir.

Senator MCCAIN. Last year, you raised several objections. We tried to accommodate them. A lot of those objections have to do with flexibility. You want maximum flexibility for the Department to work on meeting the health care needs of Indian people. I understand that. Most bureaucracies do. But some of the objections you raised last year and this year seem to reflect an unwillingness to accord the same flexibility to Indian tribes. We find that not proportional. What is your response?

Mr. GRIM. I would just say that we would continue to work with the committee if there are specific provisions in the bill where you think that we are giving up the tribes' flexibility I would be more than happy to discuss it.

As I mentioned earlier, we have a very robust consultation policy within both the Department and the Indian Health Service, and do not make any major policy or budgeting decisions without consulting tribes. So we would be more than happy to work with the committees on those specific issues.

Senator MCCAIN. One specific issue, you raise objection to the GAO preparing a comprehensive baseline report on Indian health facilities that is presently in the bill.

Mr. GRIM. Yes, sir.

Senator MCCAIN. Yet your department has never been able to provide the tribes or Congress any total information on the number, size or status of the Indian health facilities. If the GAO does not prepare a comprehensive baseline report, then who does?

Mr. GRIM. The reason that we made those comments, Senator McCain, is that the agency has been in the process over the course of the last 1½ years in consulting with tribes on a new priority system for the agency. It will be a more expansive type of priority system than our current one. We are in the final process of that. We had a tribally driven work group called the Facilities Appropriation Advisory Board, made up of tribal members across the Nation that developed a priority system recommendation with waiting and criteria.

We sent that out to tribal leaders all across the Nation. We received over 800 comments on that. The group incorporated those and they are very close to making a recommendation to me. That will be a much more comprehensive listing than we currently have. That was the reason we asked that reference to GAO doing that report be removed. We feel that we are very, very close to implementing that. It has been through tribal consultation.

Senator MCCAIN. How does a GAO baseline report interfere with any of the things you just said? Are you concerned about needless expenditure of taxpayer dollars? I do not see how a GAO report would interfere with any of the good things that you just described.

Mr. GRIM. Our concern, I think, is that it would take additional time of agency staff. We are almost there. We almost have the data. We would have to work with GAO I think rather extensively to get the data transferred over to them into a report, but if that is the committee's wish.

Senator MCCAIN. Mr. Chairman, I have several questions I would like to submit for the record. I thank you, Mr. Chairman.

I thank the witnesses.

Mr. GRIM. Certainly, Senator.

Senator ENZI. Senator Dorgan.

Senator DORGAN. Mr. Chairman, thank you very much.

Dr. Grim, you and I have had plenty of opportunity across the dais to talk about these issues. I will not ask you again the question, what was your recommendation to the Office of Management and Budget for funding for the Indian Health Service. Was it substantially different than that which was expressed in the President's budget to the Congress? I have asked you that a couple of times and I think you have felt like you have been unable to answer it or unwilling to answer it and would probably get in trouble if you answered it. Do you still feel that way?

Mr. GRIM. Yes, sir. [Laughter.]

Senator DORGAN. Why don't we get you in trouble today? [Laughter.]

Let me ask you, at a recent hearing one of the witnesses who testified after you and Dr. Carmona spoke mentioned that the Indian Health Service is funded at about 40 percent or 45 percent of the level of need. What is your assessment of that? Almost all of us would agree that there are in many cases a bona fide emergency with respect to health care on reservations, so it is funded at something below the level of need. What is your assessment of the statement that it is only at 40 percent or 45 percent?

Mr. GRIM. We have some data on that and we can provide that for the record, Senator Dorgan.

Senator DORGAN. But do you think it is 50 percent of the level of need or 75 percent of the level of need? Any notion?

Mr. GRIM. We have data that we update annually on that and I cannot recall what the exact numbers are right now, but we will provide that.

Senator DORGAN. Do any of your staff know the answer to that? It just seems to me like that is a pretty fundamental question. What is the need out there and how close are we to meeting the need? I have said before in other venues that we have a trust responsibility for health care for American Indians. We also have re-

sponsibility for health care of Federal prisoners, and we spend about twice as much per capita for Federal prisoners' health care as we do for Native Americans'.

So it seems to me just by observation we are something substantially below the level of need. I am trying to determine whether we have any notion of what that is.

Mr. GRIM. We do have a notion of what that is. I do not know if it has been updated for the current fiscal year, Senator Dorgan, but it is somewhere in the nature of 60 percent.

Senator DORGAN. At 60 percent? All right. That would suggest we are about 40 percent short of fulfilling the need, which is really a serious, serious omission.

My colleague, Senator McCain, asked the question about the health care facilities. I believe this year the recommendation is a cut in health care facilities. I think it is around $70 million, $75 million. I would share his question about why would anybody object to a GAO baseline report. I understand that you are working on a priorities list. I also understand from an inquiry I made yesterday that that is about 6 months or 9 months away.

Mr. GRIM. We have done the master health services planning for that whole process across our regions, but you are probably accurate in an about 6-month timeframe before a final report would be done. What we still have yet to do is we have told the tribes that if the recommendations that all came in resulted in a significant change to either the criteria that we were suggested or the weighting of the criteria, that we would come back to tribal leadership one more time, show them the formula, talk to them about the changes that had been made and why those had been made based on the recommendations from around the Nation. And then if there was not significant disagreement, we would implement that new priority system, run all of our health services master plans through that, and then come up with a comprehensive list.

Senator DORGAN. Yes; there is an urgency to do that and get that done as quickly as possible. I hope you would not object to the requirement in the bill with respect to the GAO. If it is duplicative, so be it. Although perhaps by the time that would be implemented, you would have finished your report.

I think certainly on behalf of those of us who serve on the Committee on Indian Affairs, there is an urgency here to find a way for us to move this legislation forward. We are very frustrated. We could not do it last year. We should do it now. I hope that you and others will play a constructive role in letting us, not letting us, in cooperating with us to move this legislation sooner rather than later.

Mr. GRIM. Yes, sir; Senator Dorgan.

Senator DORGAN. Thank you, Mr. Chairman.

Senator ENZI. Thank you.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Welcome, Dr. Grim. I always appreciate your being here and hearing from you. Your statement this afternoon does not make any reference to the Dental Health Aide Therapist Program. We are going to be hearing a little bit more on the third panel this

afternoon. As a dentist and as a public health professional, can you give your opinion regarding this program?

Mr. GRIM. I have traveled to Alaska numerous times, as you know.

Senator MURKOWSKI. And we like that.

Mr. GRIM. I am looking forward to coming again sometime soon. I have traveled with our former secretary to that region. We did have an opportunity to talk with the tribes about that particular program the last time we were up there last summer. We felt that the program had merit, and since then additional views have been coming forward and additional concerns.

We are continuing to meet with all the parties that are concerned. We have met with the Alaska tribes. We have met with the American Dental Association. We continue to try to look for a solution to the problems of the high levels of unmet dental care that occur in the bush in the very rural parts of Alaska. We are committed to working with you and with the tribes there to try to resolve that issue.

Senator MURKOWSKI. Some of us feel that one way to resolve it is through this Dental Health Aide Therapist Program. Can you kind of speak to some of the challenges that IHS has in recruiting dentists for rural Alaska and to these villages?

Mr. GRIM. Yes; I can, Senator. We currently have about a 24 percent vacancy rate for dentists nationally, IHS-wide. The last statistics that I had seen from the tribes in Alaska showed that in the outer-lying parts of Alaska that number is getting close to about 50 percent. We are having trouble nationally recruiting dentists into many of our programs.

So we continue to work with organizations like the American Dental Association. We work with the U.S. Association of Colleges of Dentistry to try to do what we can to recruit at locations like that, but currently we are simply lacking the ability to fill those.

Senator MURKOWSKI. Are you having any success with that recruitment then?

Mr. GRIM. We are able to fill our positions to this level, but we seem to be at about this level and cannot seem to quite get over to filling greater than about 75 percent of our dental positions right now. It has been hovering around that for a couple of years.

Senator MURKOWSKI. So as we look into the future, then, with meeting the dental health care needs of our Alaska Natives in our villages, do you see a way that we are going to be able to get enough dentists out there in rural Alaska to meet the need?

Mr. GRIM. I think it is going to require a long-term concerted effort, but I am always hopeful that we are going to be able to do that. We continue to have moneys in our scholarship and loan repayment programs that we use to try to train new native students, and I think we need to continue to try to be very aggressive at recruiting current Alaska Natives who want to get into dental school and try to encourage them to do that; get them into our scholarship program and hopefully have them go back home and serve their obligations in their communities, and then continue to stay with their tribal programs and serve out their professional career.

I do think it is going to be a long-term effort. We are working with all sorts of individuals, as I said, universities and the Amer-

ican Dental Association, among others, to try to jointly work on that issue for the Indian Health Service.

Senator MURKOWSKI. You have kind of ducked the specific question of how you feel about the Dental Health Aide Therapist Program. What I am hearing you say is you recognize the need. We have to do something. We must do something and that you are going to be working with us on that.

Mr. GRIM. Yes; Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Senator ENZI. Thank you.

Senator Reed.

Senator REED. Thank you, Mr. Chairman.

Thank you, Dr. Grim.

Let me follow on with Senator Murkowski's question and broaden it to recruiting other health care professionals. It is not just dentists you have a problem recruiting. Could you lay out the shortcomings for recruiting as you see them today?

Mr. GRIM. I can give you some specifics on percentages of where we are right now in many of the professions. I can supply that for the record. Really, a lot of what we deal with tracks with what the Nation as a whole is. There is a nursing shortage, and so we are facing difficulty recruiting nurses as well. Pharmacy and dentistry continue to be areas where we have high vacancy rates, too, and it seems to track with some of the needs in the Nation as a whole.

So not only are we facing the private sector economy trying to recruit the same types of people. Many times our locations are rural and isolated and so we have the difficulty of that as well on top of it. But we do have, as I said, scholarships and loan repayment programs. We have very active recruitment programs for nursing, medicine, dental, pharmacy, and we are doing the best we can.

I know the professions themselves are looking at those issues, too, as they see the numbers of certain types of professions, you know, more people retiring than are graduating and what it is going to mean for the country.

Senator REED. Is there more that we can do to assist you in terms of legislation or appropriations? Is this simply a social problem that is beyond any additional help from us?

Mr. GRIM. I guess if I knew the answer, we might already be here. Yet we would welcome any help that the committee might be able to provide us. We are still studying the issues, too, and working with the various professional organizations. We have a large group of professional organizations we work with on a regular basis. They are all very, very supportive of our program and try to help us within their own ranks of their professions, but we still face those difficulties. Thank you for your support.

Senator REED. Doctor, Senator Dorgan alluded to the budget shortfalls which your rough estimate is about 40 percent gap between the need and the resources. In high-cost parts of the country like Rhode Island, where we have the Narragansett Tribe, not only is this funding insufficient, but the costs are significantly higher. Is there any attention to these areas? Where there are high costs, housing costs in the area where the tribe has their tribal lands

growing at 100 percent, I am not exaggerating, in the last five years. It is incredible.

Mr. GRIM. I believe you.

Senator REED. It is hard to just maintain the staff. They have not had a raise in 5 years. Is there any attention to these specifically high-cost areas?

Mr. GRIM. Well, there are some pay adjustments that staff can get for living in higher cost areas, but one of the things that we are trying to do is to recognize it on a formula allocation basis. As I said, whenever we get any new additional program increases, we consult with tribes on how that is distributed across the Nation. As they have joined us in the process and the agency not making those decisions alone, our formulas for distributing money have become more and more complex, but more sensitive to issues like that. We have certain formulas now for types of funds that we give out that a portion of the funds are given out based on the nearest metropolitan area and the costs in that area. So we are trying to take some of that into account now as we allocate funds. We will divide a formula into three parts and maybe one-third is devoted to the costs in an area. So if you live in a higher-cost area, you get more funds in that component of the formula. So we are trying to do that to try to address it within the funds that we have.

Senator REED. Thank you very much, Doctor.

Thank you, Mr. Chairman.

Senator ENZI. Thank you.

I would mention that Senator Inouye could just be here briefly between committee meetings and the vote. He does have a statement to submit and questions that he will want to have submitted, too. And that is open to members of both committees, as well.

Senator Coburn.

Senator COBURN. Thank you, Senator.

Welcome from one Oklahoman to another. Glad to see you again, Dr. Grim.

Mr. GRIM. Thank you, Senator. Good to see you.

Senator COBURN. Would you like to have an irreversible dental procedure done on you by a dental health aide? Would you want your family to have an irreversible dental procedure done by a dental health aide that has a high school graduation and some foreign training?

Mr. GRIM. I think if I was in a situation where I was in pain with a lack of adequately trained dentists, I would be able to do that.

Senator COBURN. That is my whole point. We are going to give less quality because we are not meeting our need. I just came through a campaign and one of the things I was critical of, and I am critical of, is health care to Native Americans, with six times the rate for dialysis for Native Americans, six times the rate, which says we are not doing diabetes right. The question is, the ADA opposes this, but why can't you work out a deal where they have locum tenens up there? If they really do not want this to happen, why won't they volunteer for service up there? Let's work a deal. Let's have them do the right thing.

You create an environment where we can have dentists who will volunteer their services for Native Alaskans and solve this problem

while we are in a shortfall. I think you will find that they will be agreeable to that. I think that would solve the problem. But this idea of not meeting our obligation, meeting it by name, but not in quality, I think is one of the most critical things we have to do at the Indian Health Service. That is by no means a reflection on the people who work there. You have a burden and you do not have the resources with which to carry out the completion and attack that burden.

With your electronic medical record, have you instituted best practices, especially for diabetes?

Mr. GRIM. Yes, sir; we have.

Senator COBURN. And that is being followed? Are you tracking that to see the better outcomes and lower hemoglobin and A(1)(c)s and better compliance?

Mr. GRIM. Yes, sir; we have. We have seen a downward trend in the hemoglobin A(1)(c)s. We are seeing better blood pressure control; better us of the ACE inhibitors. We have an extensive database of almost our entire diabetic patient population, tracking both clinical indicators. We also with the special diabetes program funds for Indians that Congress made available for us, we have just recently released the report to Congress that shows a huge increase in the number of both primary and secondary prevention programs in Indian Country that were present now, prior to the funds were not available to the population.

So we are seeing a very positive trend in the care of diabetes. We have been in the diabetes care business for many years. In fact, the diabetes grant funds, one of the things we did was put together with professional experts in the agency and the American Diabetes Association a series of 11 or 12 best practices that tribes could use in their grants, depending on what were the particular problems in their communities, and suggested ways they might assess which of those they wanted to do. So I think we have done an outstanding job with the use of the funds that Congress given. Tribes deserve a lot of credit for that because the vast majority of those funds went directly to tribes. They have implemented a lot of great programs.

Senator COBURN. I would just note that the Congress refused to support recently with an amendment that I offered for additional funding for diabetes prevention. We are going to buy more land, rather than take care of the Native American obligation that we have. It was pretty disappointing to me. I think we got 17 votes in the Senate to fund prevention activities for diabetes, so it might reflect on the Senate where our priorities are.

Do you ongoing tracking on prevention across the board within Indian Health Service?

Mr. GRIM. Yes, sir; we do. We have long been an agency and a health care system that focuses on prevention, not just in the clinic, but also in environmental health arenas as well, and safe water and sanitation facilities, to make huge improvements.

Senator COBURN. So can you give me a time at which we are going to see the same type of diabetic control in the Indian population, Native American population, that we see in the rest of the population in this country?

Mr. VANDERWAGEN. Dr. Coburn, I would say right now we are probably leading the Nation in diabetic treatment, not necessarily primary prevention, but in secondary prevention through effective treatment with evidence-based best practices. I would say we have evidence to support the assertion that we are probably leading the country right now.

Senator COBURN. So we are going to see a decline in complications, amputations, dialysis?

Mr. VANDERWAGEN. In fact, we have had a 50-percent decline over the last 5 years in amputations. We are the only sub-population where deaths due to ESRD have declined between 2000 and 2002. I think the Senate, the Congress invested well in putting that money into that diabetes effort. Now, can we extend it to heart disease, cancer and other chronic diseases is the real challenge that I think we are facing in Indian country.

Senator COBURN. Well, best practices is going to help you do that. This is a great example to help us know how we solve the rest of the health care problem in this country. It is called prevention. It is not treatment after the fact. It is prevention. And you all are to be complimented on the institution of best practices because it is what it is going to take for us to get out of the health care crisis that we are in in this country. My hat is off to you. I just want to see the results coming forward, and then work on the prevention in terms of diet because that is just as important for not only the Native American community, but the entire American community.

Mr. GRIM. Our three primary focus areas that we have been working with tribes around the country on are health promotion, disease prevention, behavioral health issues, both alcohol, substance abuse and mental health, as well as those behavioral issues with the lifestyle diseases like diabetes and chronic disease management. We are looking at better models with now that we might put in place in many of our programs because we do have a huge burden right now of patients that already have these diseases, but we are focusing on all three of those areas. Again, we are looking at some best practice models in chronic disease management that we will start using in some other disease areas.

Senator COBURN. I can ask this later and ask it formally as part of the record, do you have tracking on malpractice claims within the Indian Health Service as relative to outside of the Indian Health Service? Can you give that data to the Committee so that we can look at it?

Mr. GRIM. Yes, sir; I believe we can.

Mr. VANDERWAGEN. In brief, it is about 100 cases per year that come to torts. That rate really is about 50 percent compared to the private sector.

Senator COBURN. Come to trial or that are filed?

Mr. VANDERWAGEN. That are filed and deemed worthy and are carried forward. That has been a pretty steady state for about the last 10 or 15 years, some slight trending up. Most of that is associated with our larger, more complex hospitals, but we would be happy to give you the full picture.

Senator COBURN. Thank you very much.

Let me just thank you again for your service, and I am proud you are an Oklahoman.

Mr. GRIM. Thank you.
Senator ENZI. Senator Murray.

**STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Mr. Chairman, I know that we have a series of votes on and another panel to come before us. I will be very brief.

I just want to really thank you and Senator Enzi for having this joint hearing. I hope that this allows the members of our Health Committee to really begin to understand this legislation so we can move it forward. I think we all understand the severe crisis facing our tribal communities today and the responsibility that we have to make sure that we address some of the tremendous disparities that are out there.

I am very pleased that my friend Ralph Forquera, who is from the Seattle Indian Health Board, is part of the second panel. I think he is going to provide us with some really excellent information concerning Native Americans who live in urban areas. I am pleased that he is here. I am sorry that we are going to be having votes and I will be missing much of his testimony, but it is very important for our committee to hear that.

I think when we hear the statistics about the fact that Native Americans are much more likely to die from specific diseases, 420 percent more likely to die from diabetes, 52 percent more for pneumonia and influenza. It goes on and on. I think we have a responsibility, really, to address that.

So Mr. Chairman, I will not ask a question at this time. I will submit them for the record. Dr. Grim, if you could respond because I do know we have a series of votes. I am really pleased that we are having this hearing and allowing our Committee to begin to understand this problem and help move it forward.

Thank you very much.

Mr. GRIM. Thank you for your interest.

Senator MCCAIN. Thank you very much, Dr. Grim. You got off easy today. We had a series of vote. [Laughter.]

Mr. GRIM. Thank you for that, Senator McCain.

Senator MCCAIN. Thank you. We would really like to get down to some serious negotiations so we can get this thing done as quickly as possible. That is going to require, and I know some of this is not totally up to you, but some of it going to require some concessions on both sides. We do have another body that has to consider it as well, who we have been in constant communication with, but this is almost an abrogation of our responsibilities when we do not address this much-needed legislation.

So thank you, and thank your colleagues for all you do.

Our next panel is Rachel Joseph. She is the chairperson of the Lone Pine Paiute Shoshone Reservation in Lone Pine, CA. She is also the cochair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act.

Mr. Don Kashevaroff is the president of the Seldovia Village Tribe in Alaska. He is also the president and chairman of the Alaska Native Health Tribal Consortium. We are glad you could travel this long distance to be with us today.

I would also like to send a special welcome to Richard Brannan, the chairman of the Northern Arapaho Business Council from Fort Washakie, WY. Thank you very much from Fort Washakie, WY. I thank you for being here today. I have appreciated all the expertise on tribal issues that you have provided to us over the years. I know the committee will appreciate your testimony.

I would also like to introduce Ralph Forquera, the executive director of the Seattle Indian Health Board in Seattle, WA.

Ms. Joseph, it is nice to see you. Please begin.

Ms. JOSEPH. Thank you, Mr. Chairman.

Senator MCCAIN. By the way, my colleagues are voting and they will be coming back and forth. I want to extend my apologies for the interference of our parliamentary procedures. Welcome, Ms. Joseph.

**STATEMENT OF RACHEL A. JOSEPH, CHAIRPERSON, LONE PINE PAIUTE SHOSHONE RESERVATION**

Ms. JOSEPH. Thank you, Mr. Chairman.

I am here today to present testimony on behalf of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act, the National Indian Health Board and the National Congress of American Indians. Thank you for this joint hearing and providing me the opportunity to testify in support of S. 1057.

The message of Indian nations across the country is please reauthorize the Indian Health Care Improvement Act this year. This act enacted in 1976 declared this Nation's policy to elevate the health status of our population to the highest possible level. We believe this should be at parity with the general U.S. population. Nearly 30 years later, we are no where near achieving this goal. However, S. 1057 would facilitate forward movement.

Health care reality in Indian country compared to the general population is our people still die due to accidents 204 percent greater than rest of the population; 650 percent more likely to die from tuberculosis, a preventable disease; 318 percent more likely to die from diabetes. The epidemiology center in the Northern Plains has recently reported that the Northern Plains Indians have the highest SIDS rate in the world. The Surgeon General reports that Indian youth are dying at 3.1 times greater than the general population.

Our challenges are escalating, and like so many other programs in the country we are seeing employee take-backs, reduced hours of operation, staff reduction and burnout. Resources are limited and our estimates indicate that the Indian health budget has lost over $2.46 billion in purchasing power over the last 14 years.

I have testified to this before. Medical inflation has increased over 200 percent since 1984. Unfortunately for the IHS, the OMB inflation rate ranges from 1.9 percent to 4 percent a year, when medical costs inflation is between 6.2 and 18 percent.

Like the private sector, we face ever-increasing costs for pharmaceuticals, equipment and other costs. As raised earlier by the Senator, the per capita expenditures for our patients is approximately one-half of the per capita expenditures for Medicaid beneficiaries,

and the expenditures for a prisoner's health care is almost double what is spent on a patient in the IHS system.

In 1999, a national steering committee for the reauthorization was formed. Consultation was held extensively across the country to develop consensus recommendations to address our current needs. Included among those recommendations was the authorization for a comprehensive behavioral health program which reflects tribal values and emphasizes collaboration among alcohol and substance abuse social services and mental health programs, which was reflected in title VII of S. 1057. I was quite taken aback when I heard Dr. Grim express objection to section 11(2)(b). In fact, that has been a challenge for us in dealing with reauthorization. We have never seen a finite list of what the objections are.

But if I might briefly talk about what our intent was when we developed language with 711(2)(b). This is a section dealing with fetal alcohol disorders. We feel strongly that we need to do everything we can to change the behavior of pregnant women, high-risk pregnant women, and women that are pregnant with Indian babies, to encourage them not to indulge in alcohol and substance abuse. That was our intent. We think this is a priority and we think that the program should do this. We are surprised that there is an objection to that provision.

Another recommendation is authorizing the elevation of the Assistant Secretary, elevation of the Indian Health Service Director to an Assistant Secretary appointed by the President with the advice and consent of the Senate.

The deplorable disparities in our health indicators compared to the general population require us to assert that we need to approach our responsibilities differently. Status quo is not acceptable. We believe that elevation would be comparable to the administration of the BIA programs by an Assistant Secretary in the Department of the Interior and the Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development.

We also recommend authorizing the Entitlement Commission to study the optimal way that health care should be provided to our people. Indian tribes strongly believe that through the cession of 400 million acres of land to the United States in exchange for promises for health care and other services often reflected in treaties, that we secured a de facto contract which entitles us to health care in perpetuity, based on the moral, legal and historic obligations of the United States. We also believe that we need to be able to address the long-term health care for the elderly as an option, rather than more expensive, costly or clinical care.

We believe that these recommendations, many of which are included in S. 1057, are essential to help us modernize our health care delivery.

In closing, I want you to know that in spite of our deplorable health conditions, we remain optimistic because our tribal governments and programs are having successes and do so much with so little. We hope for reauthorization this year. We hope that one day our young people no longer commit suicide because they will have hope. We hope that one day we will no longer have to deal with meth problems and other substance abuse in our communities. We

hope that our grandchildren will be healthy. We hope that we can provide long-term quality health care to elders in the waning years of their lives.

We hope for all these things because we know that the Creator has put us here for a purpose and we need your help.

Thank you for this time.

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

Senator ENZI. Thank you.

Mr. Kashevaroff?

**STATEMENT OF DON KASHEVAROFF, PRESIDENT, SELDOVIA VILLAGE TRIBE, AND PRESIDENT, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM**

Mr. KASHEVAROFF. Thank you, Mr. Chairman.

My name is Don Kashevaroff. I am appearing here as the chair of the Tribal Self-Governance Advisory Committee, which has appointed me to the National Steering Committee for the Indian Health Care Improvement Act. I am from Alaska. I am the president of my very small tribe of 400. I am also the president and chair of the Alaska Native Tribal Health Consortium, which through Anchorage and the Alaska Native Medical Center, we comanage that and we serve 130,000 Alaska Natives through the hospital and water and sewer projects in various other programs that we have.

Both my small tribe and my very large company practice self-determination and self-governance by assessing the health needs of our people and redesigning and expanding our programs to improve the available care.

I have a couple of issues that I want to address with you today. The first one is home health care. I also have submitted written testimony. Hopefully, that can be in the record, sir. What we found at ANMC, we have 150 beds. About one-quarter of the beds we have are taken up by folks that might or should not be there. If we were a private sector hospital, they would discharge the people. We continue to serve them because we have no place to send them. Many of them need step-down units and various other care that we do not have in existence.

Home health care is in S. 1057, and we are very supportive of that staying in there. What we found out, as I have stated already, Indian Health Service does not have the money we need to provide the services to Indians. What we have been doing over the past few years is relying more and more on third party payers. We bill insurance companies, if the Indian happens to have insurance, we bill the insurance company. Those insurance companies actually say, well, you only can have a stay in the hospital for a couple of days and then we will not pay anymore, because they know that there are cheaper ways of providing health care to people than staying in a hospital bed. So we are kind of stuck with the hospitals and we do not have all the home health care provisions that we are looking for. So we are very supportive of that in the bill that we can expand those services.

We have also found out that our elders, the best care we can give our elders are close to home. When we make our elders travel, they come in and they actually encounter a foreign language, they en-

counter English, and they have to be with us. They have unknown areas that they have to live in. They lose track of their families. They are removed from their family. Many of them just refuse to come in for care. So by having a home health care-based system where we are able to get out there and provide the services to them like the rest of the country has realized, will modernize IHS and bring us up into where we should be, and be able to provide better health care at a lower price. So we are very supportive of the home health care provisions in there, Senator.

I would also like to touch on the Federal Tort Claims Act coverage. I noticed in Dr. Grim's written testimony that they thought that there might have been an expansion of FTCA coverage. To the best of my knowledge looking at the Act, there is no change in FTCA services to ineligible non-beneficiaries. The language does not increase any change in it.

What we are faced with with Federal tort claims coverage is that we provide a service, and if we do not have Federal tort claims coverage, we have to take money out of our contracts support costs or a direct-service budget to pay for insurance that the government or IHS did not have to pay for before. So when our tribes take over programs, we have to have coverage. If we do not have coverage, we have to pay an insurance provider. The amount is staggering that we have to take out of our direct services budget.

In ANTHC alone, if we had to provide insurance for everybody, we would lose about four or five specialty providers. We have very many specialty docs, and we would have to basically let them go and take the money and buy insurance. We do not want to be in a situation where we end up doing that. So I am actually puzzled a bit by Dr. Grim's written testimony that the Administration has these concerns that we are expanding coverage because we just do not see it, and maybe they can tell us later on where they see those concerns at.

Real quick, also negotiated rulemaking is in the S. 1057. The Tribal Self-Government Advisory Committee is very supportive of negotiated rulemaking. We have found in the past that when we implemented title V of the ISDEAA that it worked extremely well. They even gave us awards for how well it worked, that we were able to get IHS in the room, and the tribes in the room. The tribes are delivering the health care out there and we are encountering a lot of things that IHS does not have to encounter. We have the understanding of how to provide health care out in the country. By working together, we are both able to understand the rules and put the rules down on paper so we can work better in the future. It has helped tremendously, us both having the same common understanding.

I also wanted to mention about the dental health aide therapists. I know we are going to have a panel on that pretty quick. Alaska Native Medical Center, which is managed by the Alaska Native Tribal Health Consortium and by South Central Foundation, we strongly support dental health aide therapists. Without question, that is our answer to our crisis that we are having in Alaska. I grew up in a village that luckily had a dentist come every 6 months from Anchorage. And it was the same dentist, so he knew me, and I got decent care.

People are concerned that there will not be good care. Well, these dental health aide therapists are sent out to school on it, and for 2 years they are down getting trained to do what they are going to do. I personally have had times when dentists maybe did not do as good a job on me as I wished they would have, and I had to go in for follow-up care. So I think it really comes down to the individual person whether you are going to get a quality dentist or quality care or not. We have a huge crisis in bush Alaska. If you go to a village of 100 or 200 people, you are not going to have a dentist wanting to live there. Even if you have a volunteer come in once a year, it is not going to provide the services the folks need.

I personally would love to have a DHAT work on my teeth, just as I go to a nurse practitioner and a physicians assistant for care. I have no problem doing that.

Finally, I wanted to mention that the tribes want to have, fundamentally we want to look at S. 1057 and make sure that it does not regress from anything in current law. There was one instance that we found in section 403, which is the current law section 206, where Indian health programs may only bill third-party payers for reasonable charges as determined by the Secretary. This is a change. Our concern is by making the Secretary figure out what the reasonable charges are is going to increase the bureaucracy extensively, as opposed to current practice where we bill under current practice methods.

So I do want to thank you for holding this hearing, Mr. Chairman, and hopefully trying to move this legislation forward. I am here to answer any questions.

Thank you.

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

Senator ENZI. Thank you.

Chairman Brannan.

**STATEMENT OF RICHARD BRANNAN, CHAIRMAN, NORTHERN ARAPAHO BUSINESS COUNCIL**

Mr. BRANNAN. Good afternoon, Senator Enzi. Thank you for asking me to come and testify.

I come from the Wind River Reservation, carrying a very heavy heart because of the suffering, the pain, that children and older people are going through on our reservation. I want to thank you personally for asking me to come here, and giving us a voice.

There are many statistics that justify the need for improving health care on the Wind River Reservation and Indian country in general. I have listed a number of them in my written statement and I know you hear them from many others. But what I would like to do is spend my time here today to try to put a face on the problem that we are faced with every day on the reservation.

My testimony here today is in honor of Francis Brown, a respected elder and ceremonial leader of the Northern Arapaho Tribe, and Marcella Hope Yellow Bear, a baby, both of whom died needlessly because of lack of funding. Both of them suffered terribly before their untimely deaths. Francis had four brain tumors. He went to IHS for assistance. He was told there was no funding to help him to get the care he needed. He went home, suffered and died. Marcella Hope Yellow Bear was 18 months old when she died.

Her entire short life was one of torture and pain. According to the newspaper accounts, she had an open hole through her chin, numerous broken bones, and burns on her body and the bottoms of her feet. She was found hanging from a coat hook in a closet. The police found her that way. Physically abused and tortured, her whole life was nothing but pain.

When I did hear, it was like somebody shooting my heart with an arrow, and part of my soul died when I heard that. Both of these could have been prevented. The system and all of us failed them because of lack of adequate funding. For his entire life, Francis Brown was one of the cultural and ceremonial leaders and elders of our tribe. Among his many contributions, he helped preserve the medicine wheel up in the Big Horn National Forest and other sacred sites. His early loss robbed not only his family, but our tribe of his culture and ceremonial knowledge.

Marcella was a beautiful and innocent little baby, just so beautiful I cannot describe how pretty she was. She was also the hope of our future. That is our future, our children. In our tribe, we believe children are sacred and we hold onto them because they are not tainted by the world and they are a blessing from God. Yet she was killed by her own parents, both members of our tribe, because of their addiction to methamphetamine. Those drugs and others, including alcohol, are the scourge of our reservation in Indian country.

As you can see from these two painful examples, we need funding for both prevention and treatment. I am here today to give my support to S. 1057, but also to remind you of the need to fully fund it and to remind you of the trust responsibilities of the United States to American Indian tribes.

Also, the Almighty gave me a vision where I saw this beautiful, wonderful white house with a bright picket fence, immaculately maintained yard, with a swing, a play area full of children. I am sure people have experienced children full of joy, full of happiness, smiling, seen them dressed in their Sunday best on Easter Sunday with their little beautiful socks and dresses and healthy and smiling, and just shrilling with happiness. That is the vision the Almighty gave me of the Northern Arapaho children and our people.

I do know that this committee has the ability to make that vision come true for the Arapaho people, and I ask for your help. I thank you for allowing me to testify here today.

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

Senator ENZI. Thank you.

Mr. Forquera.

## STATEMENT OF RALPH FORQUERA, EXECUTIVE DIRECTOR, SEATTLE INDIAN HEALTH BOARD

Mr. FORQUERA. Thank you, Mr. Chairman.

My name is Ralph Forquera. I am the executive director for the Seattle Indian Health Board. I am also the director for the Urban Indian Health Institute, which is a division of the Seattle Indian Health Board we created in 2000 to conduct research and perform epidemiologic studies on the health of urban American Indians.

I am an enrolled member of the Juaneno Band of California Indians, which is a State-recognized tribe from the San Juan Capistrano region of Southern California.

The Seattle Indian Health Board is a private nonprofit community health center established in 1970 as a free clinic in what was then an old U.S. Public Health Service hospital, so we are celebrating our 35th anniversary this year. We are currently under a contract and hold several grants from the Indian Health Service under title V of the Indian Health Care Improvement Act. We are one of 34 such nonprofit Indian-controlled corporations located in 41 cities and 19 States around the country that contract with the Indian Health Service under title V.

About 20 of the 34 existing programs provide some level of direct care. The remaining 14 programs provide health education, information, referral assistance and other services designed to improve access to health care. In addition, urban Indian health organizations play an important cultural role in many cities by offering programs and services that are culturally appropriate and socially acceptable to the wide array of Indian people living in cities. For example in Seattle we serve Indian people from over 150 American Indian tribes and Alaska Native villages each year.

The role of providing an identifiable and culturally acceptable place in American cities for Indian people is an often overlooked effect of these programs that in many ways has become an essential part of the healing process for Indian people who often feel abandoned and isolated in American cities. According to the 2000 census, the majority of Indian people are now living in American cities. Over 70 percent of Americans who self-identify as American Indian alone or mixed race on the census are living in American cities.

The trend toward urbanization has been steady since the 1950's when the policy of this Nation was to relocate Indian into cities in an ill-fated attempt at assimilation. Over 160,000 people were directly affected by the relocation and termination policies. There remains a sizeable number of urban Indians who carry an emotional scar of this experience with them. As a result, that experience greatly influences their behaviors and their ability to trust government institutions, including oftentimes our own.

Little is known about the overall health status of urban Indians across the Nation. While the Urban Indian Health Program has been a part of the Indian Health Service for nearly 30 years, only recently have formal efforts to document the health of urban Indians been attempted.

The lack of available data has made it difficult for us to defend the need for help in addressing the growing health crisis among urban Indians. However, in March of 2004, the Urban Indian Health Institute released a first report documenting for the public the severe health disparities among urban Indians. Using data from the National Centers for Health Statistics and the 1990 and 2000 U.S. census data, that we know is woefully inadequate for urban areas, the report still found significantly higher rates of illness and identified multiple known risk factors that likely contributed to these findings.

The report brought greater attention to the plight of urban Indians and helped us to begin to build interest in looking at the health of this population. The report documented for the first time our anecdotal assertion that urban Indians were experiencing ill-health in disproportionate numbers. Our principal partner in this work to date is the Indian Health Service, which has now included us as one of the 10 Indian Health Service-funded regional tribal epidemiology centers, ours being the only one that focuses specifically on urban Indians and is on a nationwide basis.

Title V, the urban Indian health section of the Indian Health Care Improvement Act, provides the critical link in recognizing that Indian country encompasses both reservation and urban communities. The 34 urban Indian health organizations reflect the nature of their local communities. They offer not only services, but a place of Indian identity that is frequently lacking for Indian people in American cities. In the broadest sense of healing, finding a place of belonging and acceptance can have a powerful and positive effect on the health of Indian people.

Our ability to focus on Indian people and not be encumbered by the restrictive nature of limiting services to federally recognized tribal members adds to our capacity to heal wounds also. Title V is the only authority that specifically defines the health care role for the Indian Health Service in addressing the needs of urban Indians. For this reason, title V is an essential tool in assuring that urban Indians are not forgotten as a group of Americans in need of health improvement.

In the request for my participation in the hearing today, two specific questions were posed to me. The first deals with the extension of Federal tort claims protection for urban Indian programs. The second concerns an issue that periodically has been brought to our attention by the Department of Justice regarding equal protections provisions of the Constitution and the fact that urban Indians are not subject to tribal governments with self-governance authority.

With regard to the Federal Tort Claims Act issue, similar protections have been extended to community health centers through the Public Health Services Act. Those of us who receive funding through the Bureau of Primary Health Care are already eligible for FTCA protection. It would seem to me that extending this protection to urban Indian health programs would add minimal risk to the government. Inclusion could save considerable expense for those programs who are now purchasing private liability insurance for support for their work. The resulting savings could be used to provide needed services.

It should also be noted that the title V program is truly crafted using the community health centers as a model. So therefore the extension of the privilege of FTCA for another group of federally sponsored safety net providers seems a fair and equitable action.

With regard to the Department of Justice's concern about equal protection matters, I first need to state that I am not an attorney nor am I professionally trained in this area. However, it seems to me that the enactment of title V defined a special class of health care provider similar to various arrangements made through other Federal programs like the Federally Qualified Health Center Pro-

gram under the Bureau of Primary Health Care and disproportionate share hospital payment structure under CMS and others.

Clearly, the Federal Government has a rational basis for providing funding, tax breaks and other benefits it deems to be in the interest of the Government or society in general. That rational basis should not allow such distinctions to withstand an equal protections challenge.

In the case of urban Indian health programs, the Congress has a clear and rational basis for its decision to provide programs, services and funding to urban Indians. After all, it was the ill-conceived policies of relocation and termination that led to the removal of large numbers of Indian people from reservations to cities. Congress dealt with Indians as a special class of citizens then, and it clearly can and should so do as it tries to rationally address the consequences of those policies.

The structure of the title V program, that of using a nonprofit Indian-controlled corporate structure, offers the full benefits of the self-determination principles called for in President Nixon's special message to Congress in July 1970 that forms the foundation for today's Federal Indian policy. Successful urban Indian health organizations in some respects embody the spirit of self-determination. Our use of IHS funds to leverage our other public-private resources to extend our capacity to serve urban Indians is exactly what I believe the authors of title V intended.

It is clear that the Congress has the authority and the will to direct programs to address identified and documented health disparities affecting American Indians and Alaska Natives. In these times of rapid change in the health care system in America, and the sharp escalation in the cost of health care, the importance of having organizations devoted to assuring access and quality health care for Indian people makes good public policy. It is fitting, then, that the Congress continue this policy by reauthorizing Title V.

Thank you for offering me this opportunity to testify. I would be happy to answer questions.

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

Senator MCCAIN. Thank you very much.

Ms. Joseph, what is your response to the Department's view that the Intra-departmental Council consultation and Tribal Technical Advisory Groups are sufficient for Indian policy so that the elevation of the director to an assistant secretary is not necessary?

Ms. JOSEPH. Thank you for the question, Mr. Chairman.

The request or the advocacy for the elevation is not a new issue for tribes, for one thing. It has been around long before this effort to reauthorize. We feel the deplorable health conditions of our people warrant us to carry out our responsibilities in a different way, and maybe elevating the issues to a higher level would be a better approach. We know that status quo is not acceptable.

We think that it is also consistent with the government-to-government relationship in that it is comparable to the assistant secretary that has oversight of the BIA programs in the Department of the Interior. There is an assistant secretary for Public and Indian Housing in the Department of Housing and Urban Development.

We think an agency that has such large responsibilities for Indian people should be at a level where they can collaborate at a higher level in the Department; be a member at the table when priorities and policies are addressed; be a player in the decisions that are made when the Department's priorities are established; and be at a level that ensures that other agencies in the Department are also considering the needs of American Indians and Alaska Natives.

Senator MCCAIN. What is your response to the Department's view that we should mandate positions such as the diabetes coordinators within IHS?

Ms. JOSEPH. Mr. Chairman, I thought that was real interesting a request, to require a mandate when earlier in the testimony there was an objection to mandates. In particular, that is related to mandating diabetes coordinators. For the record, I believe all areas have diabetes coordinators. The one we have in California, she is wonderful and we like her and she is doing a lot to inspire us, to prevent and to educate.

But the tribal leaders during this discussion weighed this and did discuss it. They said, say for instance in five years we have a major epidemic in our area, and we might want a cardiovascular disease prevention coordinator or a tuberculosis prevention coordinator. With limited resources, the tribes locally may need to move resources and have another priority in five years. That was the wish to have some flexibility for local decisions.

Senator MCCAIN. Thank you.

Mr. Kashevaroff, how would you respond to the views of the American Dental Association that there is a "false concern" that in Alaska that is only a choice between no dental care and some dental care, so that dental health aides are necessary?

Mr. KASHEVAROFF. I believe that anybody that wants to come up to Alaska and go out to the bush, which we call it, will see that there is basically no access to dental care out there. Village folks that live there, if they have a toothache, they have a choice of either waiting six months to a year for a dentist from a regional hub to arrive, or to get on an expensive plane and fly in. That is what we are faced with.

We do have some dental care. Dr. Grim mentioned that we have a 50 percent vacancy rate out in the bush in Alaska. That means we only have one-half the dentists. If Washington, DC only had one-half the dentists, you would have a lot of lines around here of people wanting dental care.

So it is compounded in the fact that you live in a village and there is no way to access dental care than hop on a plane, which you cannot always do because we get snowed in for weeks at a time sometimes. And you only have one-half the dentists out there in the first place. So we have a very big problem, Mr. Chairman.

Senator MCCAIN. You mention in your statement that negotiated rulemaking was used in the self-governance regulations. What benefits have you seen in the implementation of the regulations? What is your response to the Department's concerns that negotiated rulemaking is costly and time-consuming? Were your negotiations costly and time-consuming?

Mr. KASHEVAROFF. Mr. Chairman, I was not privy to the budget of the negotiations. I do not think they are that time-consuming because we actually had a deadline imposed. I know S. 1057 has a longer deadline imposed. But the little bit of time put up front saves a lot of time in the end.

By us coming together and working out the issues with the IHS, the tribes and IHS working out the issues, getting on the same foothold, understanding the same things, has saved us immensely right now years later from having tons of lawsuits back and forth because we cannot agree on what we said. When we are both in the same room, we negotiated it out and you had negotiations go where there is give and take, and everybody is satisfied somewhat, and we were able to achieve that.

As I said earlier, they gave us some kind of awards because we were so efficient at doing it. I cannot imagine why the Administration is against having negotiated rulemaking after we have been so successful in the past.

Senator MCCAIN. As has self-governance.

Mr. KASHEVAROFF. Yes.

Senator MCCAIN. Chairman Brannan, in your testimony you state that addiction to methamphetamine and alcohol are epidemic on your reservation. What is currently being done to combat the problem and, in your opinion, will the new comprehensive care behavioral health programs provided in the Act be helpful in any way?

Mr. BRANNAN. Yes, Chairman; they would be.

Senator MCCAIN. It is epidemic on your reservation?

Mr. BRANNAN. Yes; it is.

Senator MCCAIN. Would you give me a few statistics to describe that situation?

Mr. BRANNAN. I guess throughout Wyoming it is considered epidemic, even in the State of Wyoming. I do not have the specifics.

Senator MCCAIN. For example, most of your teenagers?

Mr. BRANNAN. What you see is an underlying culture of people, and we have a number of tribal members coming up and saying, can you please do something for my family member; they are going to die, because all they are doing is ingesting poison into their system. There is no place for us to send them. There is no treatment dollars available for methamphetamine whatsoever. Alcohol is a significant problem, but methamphetamine is 50 times worse.

Probably their life expectancy is less than 5 years once they take it for the first time. Typically, they are addicted for life once they do it, just the first time. There is a significant backlog of patients that need alcohol treatment alone. In some instances, it takes them 6 months to 9 months just to go to treatment. With an alcoholic, if they finally identify or I guess understand that they do have a problem, they confess it, you need to get them to treatment as soon as possible. It is a constant theme. People are dying from cirrhosis.

Senator MCCAIN. You have a lot of dental problems, I would think.

Mr. BRANNAN. Oh, yes.

Senator MCCAIN. Because of methamphetamines.

Mr. BRANNAN. Yes, yes. Even without the methamphetamines, we can only serve 25 percent of our actual need. Our service unit

is funded at 51 percent of the level of need funding. Our denial rate is about three times more than what they approve under a contract health service budget. We are sending people home that have cancer, saying there is no money for chemotherapy, therefore you have to die. That is the reality of it.

Senator MCCAIN. Then you must have a problem with teen suicide as well.

Mr. BRANNAN. Yes; we did in the 1980's, there were over 20-some young people that killed themselves, one right after another. It is consistent.

Senator MCCAIN. Is that associated quite often with the use of meth?

Mr. BRANNAN. No; it is mainly associated with the lack of hope on the reservation, lack of opportunity. What we are doing right now is we are trying to develop a boys and girls club to give them some type of outlet. But the main thing is prevention on the reservation. Right now, the lack of funding within IHS is so significant we cannot even do prevention. We have to wait until somebody is sick or almost dying because the funding is so inadequate. What we need is preventive health dollars. We can work with our children. We can get them to exercise. We can get them to have a vision for their future, hope. But right now, we do not have that resource available.

Senator MCCAIN. Mr. Forquera, is your clinic the only urban clinic doing epidemiologic studies on urban Indians?

Mr. FORQUERA. It is currently, Senator. We actually established the Urban Indian Health Institute out of frustration on my part. Nobody was doing work to directly address the issue of urban Indians. Shortly after we established the organization, Dr. Trujillo, who was then the director of the Indian Health Service, who had had some experience working in the urban Indian community, helped to find some resources to help us set up the epidemiology side of the research element of the program.

We have been struggling since we have had no directed resource in order to be able to track the health of urban Indians, and the fact that a lot of our data has to come from local municipalities or from other institutions that sometimes do and sometimes do not collect information that is Indian-specific. We have been having to go and develop those databases in order to be able to do the work that we are doing. We are in the process of doing that now, and I think are making progress, but we are also finding tremendous obstacles because of resource and other problems.

Senator MCCAIN. Many of your patients are in Seattle due to the policies of relocation and termination. Do you maintain contacts with the tribes in which these individuals may be members?

Mr. FORQUERA. A large number of our clients are in fact enrolled members of their tribes. We also see a number of Indian people who are members of terminated tribes. We see a few Canadian Indians who come down. And then we are also identifying an awful lot of Indians who were adoptees or children of adoptees or people that had been displaced from their nativeness not only in the 1950's, but prior to that.

One of the great advantages of the work that we do and one of the fun things that we do is helping people re-link themselves up

to their nativeness. It is amazing the power of that experience for the individual and how good that makes us as an institution feel that we can help people reconnect with their roots and help them. They then become great supporters of the organization. They get services from us. They help the community by using their skills as part of the community. It is a wonderful thing.

Senator MCCAIN. Chairman Brannan, where is the nearest city or metropolitan area to your tribal lands?

Mr. BRANNAN. Mr. Chairman, we have two cities. One is Lander, WY. That is approximately 24 miles from Fort Washakie. The other town is called Riverton, WY.

Senator MCCAIN. Are there problems with drugs and teen suicide in those non-Indian areas?

Mr. BRANNAN. It is not as prevalent, but the meth problem is throughout the State, especially within Fremont County where the reservation is located.

Senator MCCAIN. Are there meth labs on your reservation?

Mr. BRANNAN. Well, a lot of it I believe is foreigners from old Mexico. They did have a drug bust, and I think they had 250 pounds of methamphetamine.

Senator MCCAIN. That is a lot of doses.

Mr. BRANNAN. Yes; it is.

Senator MCCAIN. Well, it is a national problem, as you know, but it also seems to be most concentrated in lower-income areas, and naturally that means Indian country. At least we would see some benefits from passage of this act, wouldn't you think?

Mr. BRANNAN. Yes; it would help us significantly.

Senator MCCAIN. I thank the witnesses. I thank you for your patience today. I apologize for this back and forth shuttle as we try to finish up our voting on the Department of Homeland Security. I can tell you at least we passed on amendment yesterday that directs funding directly to the Indian tribes, so it does not have to go through the State and local authorities. So a small benefit.

Thank you for all you do. Thank you for your good work. We look forward to seeing you again.

This panel is adjourned.

Now, our last panel is Mary Williard, DDS, deputy director of the Yukon Kuskokwim Health Corporation in Bethel, AK; and Robert M. Brandjord, DDS, who is the president-elect of the American Dental Association in Washington, DC.

Dr. Williard, welcome. Maybe out of pure curiosity, where is Bethel, AK located, in relation to, say, Anchorage?

Ms. WILLIARD. We are about 450 air miles west of Anchorage.

Senator MCCAIN. And the population is?

Ms. WILLIARD. In Bethel itself, about 6,000 to 7,000, depending on the time of year.

Senator MCCAIN. What is it in January? [Laughter.]

Ms. WILLIARD. Probably around 6,000.

Senator MCCAIN. And in August?

Ms. WILLIARD. More like 7,000.

Senator MCCAIN. Some come to the great State of Arizona in the wintertime, and we are always glad to have them.

I thank the Chairman.

Dr. Williard, who is that with you?

Ms. WILLIARD. This is my daughter. Her name is Suskwok or Shauna Williard.

Senator MCCAIN. You are welcome to be here. Do you have written testimony? [Laughter.]

Thank you. She is welcome here, Dr. Williard.

Ms. WILLIARD. Thank you.

**STATEMENT OF MARY WILLIARD, DDS, YUKON KUSKOKWIM HEALTH CORPORATION DENTAL CLINIC**

Ms. WILLIARD. Mr. Chairman and members of the committee, as you know, my name is Dr. Mary Williard. I have been practicing public health dentistry for my entire career. About 9 years of that has been in the Public Health Service through the IHS. I completed a 2-year dental residency in general practice at a hospital in North Carolina. I have practiced both in the Navajo area as well as in the Bethel, AK area.

I have been in Alaska for 7 years working for the Yukon Kuskokwim Health Corporation [YKHC]. I have also chaired the Academic Review Committee for the Dental Health Aide Program since its inception.

On behalf of the Alaska Native Health Board and YKHC, I would like to say it is an honor to be here and have the opportunity to testify, and to bring my daughter to see how this great country runs.

I really think this is a very important hearing for the future of the people in my area and especially for the children. I learned this morning that the ADA has started a campaign in our village newspapers that states that we are providing substandard care, second-tier of care to our village people through the Dental Health Air Program, specifically dental therapists; that we are experimenting on the people of the villages. I am here to say very strongly and clearly that that is not true.

I personally have a vested interest to make sure that that is not happening. I believe that what we are doing is a good thing and it has been well thought out. I know that the tribes and the people in the area are supportive of us.

I am a little nervous so I might stutter a little. Anyway, one of the things that I have done as part of my role in the Dental Health Aide Program is help to develop the dental standards that dictate how we work with the dental health aides and specifically the dental therapists, and how they become certified to provide the care that they are allowed to do. The quality assessments that are being one on our dental therapists are taken directly from the Indian Health Service for dentists. We are not allowing them to provide a second-tier or a substandard quality of care. They are expected to provide the services that they provide at the same level of quality.

These candidates have been hand-selected from large numbers of applicants. They are very responsible, respectable members of the community. I feel like we have gotten some really wonderful people into our programs. Part of my job at YKHC is to supervise the dental therapists that we have there. We do have two dental therapists who have completed the 2-year training in New Zealand to receive their diploma of dental therapy. These two young people are

Alaska Natives and have been in our clinic for about 6 years now providing services. I have looked at every aspect of their service and their skills. I have found them to be quite skilled at what they are doing. They learned well during their schooling. They have taught our dentist, actually, some new materials and information that they learned in school.

One of the other things that I do during my time in YKHC is I have observed the new dentists coming in from dental school. I have to work with them and bring them up to par with the other dentist on our staff. What I can say is comparing dental school graduates with our dental therapists is that I have seen that the skills are equal.

Hearing Dr. Grim say, sort of hesitate whether he would let a dental therapist work on his own teeth or his own children, I am not surprised. Most dentists are very picky about where they go. I do not know that I would Dr. Grim work on my teeth. I have never seen what he can do. [Laughter.]

But I can tell you that my children and I have been treated by the therapists, and I have no problem with that because I have seen what they can do and I believe that they are very well trained. They provide a good service.

I look forward to allowing them to go out to the villages once they are certified and working in a general supervision capacity with the dentist in Bethel. One of the things that I really think is important about this is that we will have very competent dental providers in the villages with the people on a daily basis, so that not only will the people out there be able to see a dentist maybe once a year, but they will actually be able to see one when they need one, a dental provider.

They will be able to see the therapist at the school, at the basketball games, mostly, in the villages, and be able to talk to them in the grocery store and say, you know, gee, I know you told me I need to brush my teeth all the time, but what can I do when I cannot afford a toothbrush? And maybe when they are deciding what to purchase at the store, they can, you know, what were you saying about the diet soda compared to the regular soda?

Those kind of things are really important when you are talking about trying to change a community's habits about oral health. Daily presence is a much more effective way of changing habits in a population than the itinerant-type approach that has been utilized in the past. So I think that is a very strong aspect of our program.

I do not think volunteer programs will work. I am not saying that I do not want to see volunteers come. Please come. Please do as much volunteer work as you can. I think that would be great. I do think that they do not provide the continuity of care that will address the issues that we need and to help build a strong prevention program.

The drill-and-fill model is still the old volunteer model as well. When you come in and you see patients, you drill and fill and you just get back out, and you have not made that connection with the patient. It just has not worked.

One of the things that I have seen as well is that village residents have long, 30 years there have been community health aides

in the villages. And when a doctor comes out to the village and talks to the patients and tells them what they know, the patients will listen, but when the doctor leaves the room, the patient turns around and asks the community health aide, you know, is that right? What can you tell me? So the trust is there when the people are there in the communities.

One of the things about the Dental Health Aide Program is that the main focus is that we are looking at prevention. However, the dental health aide therapists are going to be there to help us deal with the problems that are already existing. You have already heard there is a very large problem with dental decay in our areas, unmet needs. Even if Dr. Grim was able to recruit dentists to our area to fill all the available positions, that is not going to meet our dental needs. A study in 1991 was done in Alaska that showed that even if the number of dentists in Alaska was doubled at that time, it would still take 10 years to meet the needs.

So recruiting dentists to fill positions is not the only answer. We need all the help we can get. That does not mean we are looking for substandard care. That means we are looking for good quality care and we have come up with a method to do that. The dental health aides or dental therapists have been working in a number of countries for years and have a very good track record. In Canada, over 30 years of practicing; in Saskatchewan, being regulated by the dental profession, there has never been any merited claim against a dental therapist, and they provide the same level of services and more than we will allow under our Dental Health Aide Program.

So in closing, well, one other thing I would like to say is that we do thank Dr. Grim for his letter of support of our program, and we will have that in our written testimony. We also have e-mails of written support from the South Central Foundation in Anchorage that states that they strongly endorse the Alaska Dental Health Aide Therapy Program.

What I would like to ask you all, Mr. Chairman and the members of these committees is to please listen to the people that live and work in these communities and refuse to take away our federally recognized right to manage our own health care. Please support S. 1057 of the Indian Health Care Improvement Act, and do not limit the scope of practice of the dental health aides.

Thank you. I am open to questions.

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

Senator ENZI. Thank you.

Dr. Brandjord.

**STATEMENT OF ROBERT BRANDJORD, DDS, PRESIDENT-ELECT, AMERICAN DENTAL ASSOCIATION**

Mr. BRANDJORD. Thank you, Mr. Chairman and members of the committee.

I am Bob Brandjord. I am president-elect of the American Dental Association and a practicing oral surgeon in Minnesota. I am here to express the American Dental Association's strong support for using dental health aides and other innovations in dental care delivery to help reduce the disproportionate burden of dental disease that many Alaska Natives suffer from today.

Equally important, I must state the American Dental Association's unequivocal opposition to experimenting on Alaska Natives by allowing non-dentists to perform irreversible dental surgical procedures. This is second-class care. It is unsafe. It is unfair. And most of all, it is unneeded. It is an admission that those who have been entrusted with the care of these people have essentially given up on them. Instead of really focusing on preventing disease, the solution is to extract it. Alaska Natives deserve better. They deserve high-quality, fully trained, licensed dentists to provide the care.

They can receive that care if we can break down the bureaucratic obstacles that are preventing it. Decades ago, Alaska Natives were almost entirely free of dental decay, but the trend has reversed. Many Alaska Natives now suffer from often severe untreated dental disease. Deterioration is due partially to the transition from the traditional subsistence diet to processed sugary foods and beverages; partly to the lack of oral health education and proper self-care; and partly to inadequate access to appropriate dental care.

Alarmed at the declining oral health of its constituents, the Alaska Native Tribal Health Consortium has resorted to the desperate measure of deploying dental therapists to extract teeth, drill out cavities, and do pulpotomies, which are like a root canal. With only 18 to 24 months of post-high school training, these well-intended, hard-working people do not know what they do not know. They are not prepared to routinely perform these procedures safely. Dentists perform thousands of procedures every day with such expertise that the public views them as routine or simple. But there is no simple surgical procedure. I know this. I spend a great deal of every working day removing teeth.

For example, extracting a tooth can lead to serious and in some cases life-threatening complications. It can lead to chronic and acute infection, injury to adjacent teeth, gums, and bone, including fractured or broken jaws, displacement of teeth, parts of teeth, or foreign objects into the airway, gastrointestinal tract, and sinuses; even severe life-threatening breathing or airway problems.

Proponents of the dental therapist plan argue that there are only two choices: Second-class care or no care. This is not true. Our written testimony includes an alternative model that builds on the current dental delivery system by making it more efficient. The authors include the dental director of the Alaska Native Medical Center in Anchorage. Central to this plan is the creation of the new mid-level aide called a community oral health provider. They can be trained in Alaska and not in New Zealand. These community-based dental aides could provide the patient education and preventive services that ultimately are the best and perhaps the only way to end the epidemic of dental disease that plagues Alaska Natives.

Despite our attempts to help, we have continually run into a bureaucratic brick wall of opposition by those who, by their own admission, are so vested in the therapist position that they will not consider any alternative.

Mr. Chairman, the public health agencies who took responsibility for providing care for Alaska Natives have been unable to meet their own goals. Dentistry did not create this situation, but we are willing to help remedy it. But therapists are a big step in the

wrong direction. Rather, we need a dental health aide to provide education, prevention and appropriate services in every village. We need a more efficient system to provide the needed care safely and effectively. We need less redtape.

We urge the Senate to adopt the language offered on the House side by Chairman Young which supports dental aides, but precludes the use of therapists to perform irreversible dental surgical procedures.

I want to thank you for your time and attention, and I would be happy to answer any questions.

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

Senator ENZI. Thank you.

I thank both of the people who testified. The one who is probably the leading expert among Senators among this would be Senator Murkowski from Alaska. I will defer to her for questions.

Senator MURKOWSKI. Thank you, Mr. Chairman. I appreciate the opportunity to lead off with the questions. I unfortunately will have to be excusing myself after this because I have to get over to the energy conference, so I am splitting my time.

I do not know. I am not the resident Senate expert because I spend a lot of time in the dental chair, but I do spend a lot of time traveling around my State and do know that in terms of health care issues and the area where we are so lacking is in dental health care. Dr. Williard, I appreciate your bringing your daughter here. As a mom with kids that are spending a lot of time in the dental chair nowadays, it is at this age where we are able to make a difference with our kids.

Unfortunately, our Native children out in the villages are the ones that are suffering most. They are suffering because of the change in diet, as you have indicated Dr. Brandjord, and because of other changes as we are evolving as a new State, as a society that is moving from a subsistence lifestyle to a cash economy. It is hurting out kids' teeth. As a consequence, it is hurting us as adult. It is putting a stress and a strain on the whole health care system.

What is the answer? The answers are very, very difficult. I, for one, I have a real hardship when people say that we are experimenting on Alaska Natives by providing them with something. We are not experimenting. We are trying to do something to take that first step to give the care that is so necessary and is so needed. I appreciate your testimony, Dr. Williard. I could tell that it was coming from the heart and very unscripted. You are living there. You are talking with the people and you know that when you have a doctor come to town who just blasts in and blasts out, the information that was left with you while you were sitting in that dentist chair goes out the window with that dentist.

I know because I was raised in a tiny community where the doctor came to town every other week. It was good news for my family that my mother was not pregnant that year because she did not have to worry about whether or not she was going to deliver the baby by herself or whether the doctor was going to be in town. So we know what happens when we do not have that continuity of care. There are lapse. There are gaps.

So we have to do something. We have to do something. The program that we are talking about here today is novel. It is new and as a consequence it is raising concerns.

I guess I would like to primarily direct my questions to you, Dr. Brandjord. When the first class of dental health aide therapists graduated from the University of Otago in New Zealand, the Associate Dean Tom Kardos, who himself is a dentist, said the following. He said:

> The dental therapist will be able to provide oral health care, including undertaking procedures such as fillings and extractions, along with educating their communities in good oral health care and habits in accordance with the course they have taken.

He has been obviously an advocate for the program. He believes that the dental health aide therapists can safely do the work for which they have trained.

So I guess my question to you is, what kind of reach-out or conversation or dialogue has the American Dental Association had? Have you sent any kind of a delegation to New Zealand to meet with Dr. Kardos, with his colleagues, to observe the level of training that goes on; to attempt to work out some of the differences that you have indicated that we have with this program?

Mr. BRANDJORD. Thank you, Senator. No, we have not sent anybody to New Zealand, but last year we sent six volunteers from our government affairs committee up to Alaska to work in the villages. They went through their normal credentialing process which was somehow expedited thanks to Indian Health Service. They worked side by side with Indian Health Service dentists. They were extremely productive and they worked with Alaska Native dental assistants and dental health aides that were there.

Those dental health aides and dental assistants helped them with the cultural sensitivity and with continuity of care issues that are brought up. Even in the Indian Health Service, there is a problem with continuity of care with the low number of dentists and the rapid turnover.

So the dependence on continuity of care comes exactly from the dental health aides and dental assistants in the area. Dental health aide therapists doing the procedures are not the answer. When we looked at the different things, the level of care that had to be provided, it was very extensive care. If we could look at the screen up there, you can see one of the patients that was treated by one of our volunteers. That is not simple work. That is something that is more complex.

If we are going to take care of these individuals, we need fully trained, licensed dentists to provide that level of care. So that is what we are talking about. We agree almost completely with everything Dr. Williard was talking about in regards to prevention. Absolutely, prevention is the foundation of all health care. We know that. Dentistry has done a good job with prevention. We have to do a good job in Alaska, and that is why we believe that there should be dental health aides in every Alaskan village to help provide dental preventive services, doing services such as providing fluorides, sealants, cleanings, and also placing temporary restorations.

So we really think that is a very valuable resource and we agree on all of those things. In fact, when you look at our proposal, that is exactly what it is about. Then we add the community oral health care provider who coordinates all these efforts among a number of villages and a population base so that when the dentist comes to that community, villagers will have continuity of care through the dental health aide that is there, and dentists can be more efficient by providing care that is a broad spectrum of care at that time. In fact our program, when you look at it, uses the Anchorage Hospital model, and with this efficient system to provide the care, their productivity increased many-fold. In fact, in the last year of implementation, their production increased over 100 percent, and over a 3-year period of time, over 300 percent.

So we believe that there are four things that we have to do. First of all, we have to fill up our quotas of Indian Health Care dentists. The American Dental Association has been to Congress and we have supported increasing the loan forgiveness payments, which seems to be a big advantage for getting students out of dental school going into the Indian Health Service. In fact, when we met Dr. Grim and one of his assistants, Chris Halliday from Indian Health Service, he said he believed if he had loan forgiveness for every slot in the Indian Health Service for dental positions, he could fill them. So he would need the funding for that. That is one thing that we want to do.

Second is prevention. I talked about that. Prevention is the foundation for dental care.

Third, are the volunteers. We want to get the volunteers back up into Alaska.

Senator MURKOWSKI. How do we get them there? We have the greatest State on Earth and we cannot get professionals to come out to our villages. We might get them to come out and give us 1 week or 2 weeks on either side of a fishing trip, but we need care and the care is not just when the fish are running. We have to figure out a way.

Mr. BRANDJORD. It is interesting you say that because our volunteers went up there in the dead of winter. They were not there during fishing season. They understand they are not going up there on a vacation. They are going to work. We are putting together, and are now in the process right now of hiring a full-time individual at the American Dental Association to work with finding volunteers and setting up the coordination of getting these volunteers into Indian villages and into Alaskan villages. We are trying to get the care where it is needed.

In fact, when we were putting this together, it is interesting that we talked to other different health care providers who have volunteer programs. The great State of Alaska is a little different than some other States because when we talked to the American College of Obstetricians and Gynecologists, they have a volunteer program and their members sign up to participate in these programs to go out specifically through the Indian Health Service. They have given up on going to Alaska because of the credentialing problems. They are different than anyplace else.

So one thing that this Committee could do is to bring about a central certification process that could be used for volunteers to go

into these areas to help. Our volunteers that went, it has been a year and a half now, those that went then have to reapply and get recredentialed now. If they went to one village for one week and another village for another week, they would have to be recredentialed. That is inappropriate.

Senator MURKOWSKI. It is.

Mr. BRANDJORD. When we talked to the Joint Commission on Accreditation, of Healthcare Organizations those people say we could work with a much simpler form where there would be temporary privileges less paperwork.

Senator MURKOWSKI. We want to work with you on that credentialing.

Mr. BRANDJORD. We would love to work with you.

Senator MURKOWSKI. From what I understand, we have extended that offer to kind of work through some of these issues on the credentialing. To the best of my knowledge, you have not taken us up on the offer, so we would hope that we would be able to. That seems like one that we ought to be able to figure through.

Mr. BRANDJORD. I would totally agree with you. It is interesting that I have a letter here from a dentist in Alaska. If I may read it, it is very short. It is dated May 25:

> On or about February 11 of this year, I submitted an application to participate in dental project backlog. During the first week of April of this year, I was fingerprinted as part of the application process. It is now almost June. I understand there are building transition issues on your part, but what is the status and fate of my efforts to help alleviate the access issues in the villages?

So yes, we have made that effort, but we are not getting a response on the other side. I do not know how we do that. But if there is some way to aid us, and when we went out there, we did not just go out on our own. We went with the Indian Health Service dentists and we worked with them. We believe that that is not a solution that is going to last forever, but if we can get them over this backlog of dental disease, we believe we can make a difference.

Senator MURKOWSKI. How many dentists do you think you are going to be able to or would have to recruit to be able to assist in this effort, full-time dentists?

Mr. BRANDJORD. For full-time dentists, I do not know. That would have to be through the Indian Health Service. I am not sure. But last year at our House of Delegates, which has 360 members, on 1 day, we handed out a paper, just asking how many would volunteer for a minimum of 2 weeks to go to Alaska. We had 140 volunteers.

Senator MURKOWSKI. Well, I am not meaning to be the negative nabob here, but one of our big problems is that most of these villages, there is no hotel. There is no bed and breakfast. You are there and you might sleep at the home of the community health practitioner or maybe in the gym. It makes it tough on people. So we have some issues that just make this tough. We need to know that we have a realistic timeframe that we are dealing with, and that we are dealing with enough numbers that we can actually make a difference.

We need to get through this backlog, but we recognize that kids are born every day, and they are going to have the next generation

of dental problems. So this is not just something that we can get on top of the wave now and be clear with.

Mr. Chairman, I am going to have to submit the rest of my questions for the record. I really apologize because this is extremely important. I think you can tell that I want to do something. I hear that you want to do something. We certainly know that from the Alaska perspective, those professionals who are giving so much every day want to make something work.

I do not want to get in a situation where I feel it is the Dental Association saying this is our turf and nobody else can come onto it. This is not about turf. This should be about the health and well-being of Alaska Native people. If we can put together a program that provides for continuity of care, that is good and safe and works, we have the benefits of telemedicine where you can be talking to your real-live doctor in Boston and working on a procedure. We have made incredible advancements in the State with telemedicine.

I would like to think that we can work through some of these issues so that we do not have dentists saying there is no other way except for us to come up, and as Alaskans knowing that Shauna here is going to be able to see a dentist two weeks out of every year, and hope that her toothache is during that 2-week time period. So work with us.

Mr. BRANDJORD. We will work with you. We realize the epidemic of dental disease that is there. We want to do nothing more than help to resolve that issue. But to resolve that issue, to keep doing fillings and extractions will not resolve it. What will resolve it is to have good preventive care. We can accomplish that with the dental health aides.

In regards to your statement about the facilities and the bed and breakfasts up there, yes, the bed and breakfast for every one of our volunteers up there was bringing their own sleeping bag and sleeping on the floor of the clinic. So yes, we are familiar with that, but they are still willing to go back. They are that dedicated. I think that is something that is hard for people to perceive.

I thank you for your concern.

Senator MURKOWSKI. It is also hard for them to give more than 2 weeks, and that is one of our biggest problems. That dedication, that passion is there and they will come up and they will give, and it is extremely generous. We do not want to denigrate that generosity, but there is a recognition that there are 50 other weeks of the year that are without any kind of care. So we will work on filling those gaps.

Mr. Chairman, thank you very much.

Senator ENZI. Thank you.

Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman.

Yesterday, I had one of those irreversible dental procedures known as a root canal, so I am having a tough time talking about this subject. [Laughter.]

Senator ISAKSON. I am honored to be here and appreciate both your testimonies. I am sorry I was late for the other panels.

Dr. Williard, you are a dentist and I take it you oversee a regional plan. Do you manage the dental health aides?

Ms. WILLIARD. Yes; I do.

Senator ISAKSON. I do not want to cut you off, but I want to get to the end question.

Ms. WILLIARD. Okay.

Senator ISAKSON. And that is a full-time program for the Native Alaskans.

Ms. WILLIARD. Yes.

Senator ISAKSON. How many dentists and how many dental health aides are in that program?

Ms. WILLIARD. We have nine dentists in the Bethel area. We have two dental therapists, and we have nine primary dental health aides.

Senator ISAKSON. Okay. Here is my question, and I did not get a chance to read. I take it this S. 1057 has a scope of practice component to it. What new scope of practice are these therapists or aides going to be allowed to do under this bill that they cannot do now?

Dr. WILLIARD. There is no new scope of practice that they would be able to do under S. 1057. What the American Dental Association would like to see done is to have this bill modified so that it takes away the rights that we have to practice as we are doing right now.

Senator ISAKSON. Okay. Now, Dr. Brandjord just referred to the program they had recommended. They have suggested a program which I take it drew the line on scope of practice for the therapist and the aides. Is that correct?

Dr. WILLIARD. Yes.

Senator ISAKSON. You said you have nine dentists there in your program now?

Ms. WILLIARD. Yes.

Senator ISAKSON. Then that is not enough dentists to do the irreversible dental procedures?

Ms. WILLIARD. We have 15 dental positions in our area, so we have 6 that are vacant right now. As I have said before, filling those vacancies does not actually provide enough treatment ability to meet the needs. So even if we were to get 100 percent filling of those positions, it still would not meet the needs that are out there. That would just meet the criteria that have been set by what is able to be funded by the IHS and by our corporation.

Senator ISAKSON. One of the issues that comes up in many health professions in scope of practice is a shortage of trained people being the justification to allow a scope of practice possibly beyond the training of others. Are we in that position in Alaska now where we in effect have people who are trying to do the best they can, but are not sufficiently trained to do, say, root canals, which I think take a lot of training after yesterday's experience? I hope so.

Dr. WILLIARD. You are talking about the dental therapists not having the training to do that?

Senator ISAKSON. Yes. I am saying, in Alaska are we having to resort to asking people, with the best of intention, to do procedures they are not trained for?

Ms. WILLIARD. No; we are not asking them to do procedures they are not trained for. The dental therapists that we have sent to training and are training further in our own facilities have a spe-

cific scope of practice which limits what they can do in a patient care setting. That limit will keep them in a practice setting that utilizes only what their skills are. If a patient's care needs get beyond the limits that a dental therapist has been trained to provide, then they are trained to recognize those limits and refer to a dentist.

The picture that you saw earlier from the ADA, definitely I agree with them. That is beyond the scope of practice of a dental therapist. That patient would be referred to the hub clinics for treatment. But fortunately, that is not the only kind of patient we see. We do have a lot of patients that need a little less than that severe care, and can be seen by the therapists and the procedures that they are capable and competent of performing.

Senator ISAKSON. Okay. Dr. Williard, in the proposal that the ADA made, what is it that you do not like about their proposal?

Ms. WILLIARD. They have excluded the use of the therapists.

Senator ISAKSON. Totally? Or just for these irreversible procedures?

Ms. WILLIARD. The therapists are distinguished by the fact that they can do irreversible procedures. What their suggestion would do for a therapist is strip them of their ability to provide those services. They would become basically a primary dental health aide, which is a health aide that we already have and who we can train for about a month in Bethel to provide the preventive services and the fluoride treatments that they are providing already.

So basically, it would be the equivalent of tying a dentist's hand or arm behind their back and asking them to treat a patient. That is what their proposal would do. We do not say that their proposal is not okay, for lack of a better word. I think it is a good proposal in some settings. I think it would be fine to do that Community Oral Health Practitioner Program in parallel with the Dental Health Aide Program. Anything that people are willing to do to try and help provide more services to our area is a good thing as long as it is well thought out and supported with data.

What I do not agree with is that the American Dental Association is not willing to allow that to happen at the same time as our Dental Health Aide Program is running. They want us to drop the program and then pick up this other program. That will not work. We have seen and looked at all of the studies that show that the dental therapist is a safe, quality provider. You can look at Gordon Trueblood from Canada who has done extensive studies on the quality of care provided by a dental therapist.

In those studies, he has shown that the quality is equal, if not better, than a dentist in the procedures that a therapist is allowed to perform. A therapist does not do a whole scope of dental procedures that a dentist would do. Their training is very heavily geared towards teaching them what their limits are. This is very different from what you might learn in dental school, where you are taught all eight different specialties in the dental field. Nobody tells you that you cannot do something.

Senator ISAKSON. Mr. Chairman, could I have the liberty of asking two more questions?

Senator ENZI. Certainly.

Senator ISAKSON. I know I have gone beyond my time.

I have said this before, and am not taking sides here even though it is going to sound like I am. The dental profession, of all the health professions, seems to me to have done a remarkable job of lessening the volume of work because of what they did in preventive health care, fluoridation of the water, and good health practices. You, Doctor, and the association are to be credited for that.

It sounds to me like the exacerbation of the problem in Alaska over the last 10 years is a whole absence of that, or at least a significant one. Otherwise, it may be the change in eating habits, you referred to people fluoridating and things like that.

If it has been done once in the continental United States, understanding there is a world of difference in Atlanta, Georgia and Alaska, and where Native villages might be. I know accessibility is a problem and everything else. I guess I ought to ask the Doctor a question for a minute, because I have been directing everything to you.

Is your proposal designed with that goal in mind? If it is, can the number of trained professionals be available to meet the demand that exists today, and even would exist if there were some lessening of those problems?

Mr. BRANDJORD. Thank you for your question. First of all, with the proposal that has been made, using the community oral health provider, that particular program, and it has been looked at by these three people in education and then one who is the director up at the Anchorage dental facility, they estimate that using that particular program, 85 percent of the individuals within that village could be seen and taken care of in any year. Now, that is in the paper that has been submitted along with our written testimony.

One other thing in regard to your comments about the scope of practice of individuals, part of the issue is that the expanded function dental assistants can help do some of the reversible procedures and that is why they become more efficient. They will have one dentist per three or four auxiliaries in the Anchorage facility working in up to three chairs at one time so that they can be more efficient and produce more care, and then deliver also more preventive services.

So yes, there is an expanded scope that is there that can be done, and yes they can reach more people.

If I can just add one thing. You mentioned fluoridation. There are fluoridation units in the villages, but they are not activated right now. Some of it is the CDC's requirements for maintenance. From our understanding now, we have some new technology that CDC has and that has been implemented in the tribal villages in South Dakota where they have remote control of the fluoridation of the water system that can work.

Senator ISAKSON. Well, I have abused my time. CDC is in my home State and if you all have any problem with them, you let me know because you need all the help you can get out there.

Your daughter is beautiful, Dr. Williard.

Ms. WILLIARD. Thank you.

Senator ISAKSON. Thank you for the time, Mr. Chairman.

Senator ENZI. Thank you.

Ms. WILLIARD. Could I make one comment about the program, the community oral health aide program?

Senator ENZI. Certainly.

Ms. WILLIARD. Thank you, sir.

The program, it was written by a panel of people who did include one of the chiefs from the Anchorage area, Tom Kovalesky. In teleconferences and meetings with the authors of that proposal, and the dental chiefs of Alaska throughout the State, Dr. Kovalesky and the other officers did concede that this proposal was probably not as effective in the rural areas and that it would be more effective in an urban setting.

The situation that we find in our individual villages, having to fly in by airplane and being spread out with such small populations in some of these communities, the models that are used in that program do not apply. That is something that the dental directors outside of Anchorage unanimously agree with.

Senator ENZI. Thank you.

I want to thank both of you and all of the other people that have testified. I apologize for the interruptions. We are still doing votes. Senator McCain and I have been shifting off and on here so that we would have somebody chairing and could continue to gather the information. All of this, of course, builds some testimony that will be used in furthering the legislation, correcting the legislation, drafting additional legislation.

There will be more statements submitted by other members of both committees, and questions that I hope all panelists will take time to answer. You will not all receive questions because we will be searching for things that are in your area of expertise or clarifications on what you said in your statement or things that you may have said today.

Also, members of the panel, if you have some comments in regard to other questions that were not asked, or if you want to expand on the comments that were made, you are perfectly able to do that, too. The record will remain open for another 10 days to complete that process.

So I appreciate everyone who has helped out here today and the hearing is adjourned.

[Whereupon, at 4:55 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MARIA CANTWELL, U.S. SENATOR FROM WASHINGTON

Thank you, Mr. Chairman. I appreciate your continued leadership on these issues which we have been working on for a number of years.

I'd also like to thank you for opening this hearing up to our HELP Committee colleagues. Their expertise in healthcare delivery, will be extremely valuable as we work together to improve the health and well-being of Native Americans.

I believe reauthorizing the Indian Health Care Improvement Act will help us begin to close the disturbing health disparity in Indian country and allow us to fulfill the United States' obligation for Indian health.

According to the U.S. Commission on Civil Rights, between 1998 and 2003, industry experts estimate that medical costs grew approximately 10–12 percent, while the IHS funding increases are less than 5 percent annually. When compared to other Federal health expenditures, it's clear that IHS is grossly under funded. We have a responsibility to take a close look at the healthcare services we're providing to this population and make sure that they're equitable and adequate.

This issue is particularly important to Washington State. Between 1990–2000, the Indian population grew almost by almost 28 percent—7.5 percent faster than the rest of our population. The life expectancy for Indians living in Washington is approximately 4 years shorter than that of the rest of the population, due to factors that we can impact—chronic under funding of the Indian Health Service, the lack of geographically available health services and the lack of trained providers that are available to serve the Indian population. We can address these issues for Washington and the rest of Indian country by moving forward with the reauthorization of this critical legislation.

To give you an idea of how badly this legislation needs to be updated, I'll use the example of behavioral health services. The current law limits behavioral health services to those dealing with substance abuse. While substance abuse is a critical health issue, mental health disorders are not addressed. This is particularly alarming when one looks at the suicide rate of the Indian population—91 percent higher than the rest of the United States. Clearly there is a need for increased attention to the behavioral health needs of the Indian population.

I'm pleased to see the increased focus on preventative health in this bill. While Indian country is still experiencing a shorter life expectancy than other American populations, the causes of death have shifted. Today the leading causes of death among Indian populations are chronic disease rather than infectious disease, communicable diseases. The health disparities that exist among the Indian population are numerous and unacceptable. They have higher rates of almost every disease and adverse health condition:

- Alcoholism—777 percent higher.
- TB—650 percent higher.
- Diabetes—450 percent higher.
- Accidents—208 percent higher.

- Pneumonia/influenza—52 percent higher.
- Suicide rate—91 percent higher.

Although the health disparities still exist in Washington and across the country, we have made progress. I am aware, for example, of our success in the Northwest in reducing the rate of Sudden Infant Death Syndrome, diabetes, HIV/AIDS, cancer and tobacco use through the use of health promotion and disease prevention programs. Reauthorization would allow for the expansion of facilities construction options, enhance tribal decisionmaking and enhance the ability to recruit, train and retain health professionals.

The last time this bill was reauthorized was in 1992 and it expired in 2000. Since then, bills have been proposed every year to no avail. This is a very complicated issue, it's a huge bill but the time has come to fully address the health needs of the Indian population.

We have a legal and ethical responsibility to provide healthcare to Indians and this is the perfect opportunity to begin to address ways in which we can improve the way we do so.

One area of great concern to me is the impact of the Medicare Prescription Drug Benefit implementation on Indian country. The Tribal Technical Advisory Group was formed to consult with the Center for Medicare & Medicaid Studies (CMS) on reimbursement rates and policies. Under the roll-out of the transitional assistance or, the drug discount card, under the Medicare Modernization Act earlier this year, we saw many problems in the implementation of this program. Beneficiaries were often confused about their choices and many didn't know they even had a choice to make. Like other low-income elders across the country, low-income Indian elders will experience a gap in prescription drug coverage when their costs exceed the initial $1,500 coverage limit. Most Indians will expect their HIS and Tribal Clinics to pay for their pharmaceuticals after they fully utilize their prescription drug coverage. However, IHS expenditures will not be counted toward the threshold to qualify for the catastrophic coverage under the drug plan. IHS will have to absorb all pharmacy costs for Indian elders up to the $3,600 annual limit. I am hopeful that in consultation with my colleagues on the Senate Finance Committee, we will resolve this inequity.

Another area of grave concern to me is the lack of attention that behavioral health services in our healthcare delivery system. According to the Indian Health Service, 13 percent of Indian deaths occur in those younger than 25 years of age—three times that of other populations and the U.S. Commission on Civil Rights points out that American Indian youth are twice as likely to commit suicide.

Reauthorization is especially important as it provides an opportunity to address the need for mental health coverage within the IHS. Title VII proposes a comprehensive approach for behavioral health assessment, treatment and prevention.

Under current law, behavioral health provisions are largely limited to substance abuse treatment and prevention and the issue of mental health is largely unaddressed.

The current Indian health bill is a product of much collaboration between tribal leaders, IHS officials and program personnel and it's imperative that we look to these experts during this process.

I'd also like to thank Ralph Forquera, the executive director of the Seattle Indian Health Board, for joining us here today. Each year, the Seattle Indian Health Board serves over 6,000 individual patients and provides approximately 30,000 patient encounters. While the Seattle Indian Health Board has become quite skilled at providing high quality services with limited funding, they're currently facing a budget shortfall of $200,000 for clinic services. We must work to make sure that our providers have the resources they need to provide high quality health care to the Indian populations all over the country and especially here in Washington.

I'm looking forward to hearing of the Seattle Indian Health Board's many accomplishments, especially as they relate to the health needs of urban Indians.

Once again, thank you Mr. Chairman for beginning the reauthorization of the Indian Health Care Improvement Act and for holding this hearing. The time has come for this bill to finally be reauthorized and I look forward to working with my colleagues in the Senate to make this a reality year.

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PREPARED STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

I thank Chairman McCain for his leadership.

I thank my colleagues on the HELP Committee for joining with us in considering today the Indian Health Care Improvement Act Amendments of 2005. I am particu-

larly pleased to note that two of our colleagues from the HELP Committee Senator Kennedy and Senator Bingaman—have asked to be added as cosponsors of S. 1057.

It is my earnest hope that, by working together—together as authorizing committees, and together with the Administration and representatives of Indian country—the Indian Health Care Improvement Act will be reauthorized this year.

I know our witnesses today will provide additional statistics regarding health needs in Indian country. We cannot, in good conscience, be satisfied with the status quo like this:

- Native American youth are more than twice as likely to commit suicide; in the Great Plains area the likelihood is as high as 10times.
- American Indians and Alaska Natives are 517 percent more likely to die from alcoholism.
- 650 percent more likely to die from tuberculosis.
- 318 percent more likely to die from diabetes.
- 204 percent more likely to suffer accidental death.

Over the past few months, my colleagues have heard me speak on the Senate floor about Indian health care in connection with amendments I have offered to the fiscal year 2006 budget resolution and the fiscal year 2006 Interior appropriations bill. My amendments proposed to provide an additional $1 billion for programs not only in the IHS, but also BIA, tribal colleges, water infrastructure.

I have talked on the Senate floor about people in tribal communities who are hurting and in desperate need of services. Many of these people I know or have known, or, in the tragic case of Indian youth suicide, whose surviving family members I have met with.

I know this is true, too, for Dr. Grim and the other witnesses who will testify today—you all see and hear and experience, every day, the very real need for the kinds of services and programs and facilities, the kinds of best practices, collaborations and innovations that S. 1057 would authorize for American Indian and Alaska Native communities. I want to thank each of you who has stuck with this reauthorization process since 1999 and earlier for your persistence and continuing vision.

I want to say that I am particularly pleased with and supportive of the provisions of title VII of the Indian Health Care Improvement Act Amendments of 2005. This section of the bill would authorize the Secretary of Health and Human Services—through the Indian Health Service, the tribal health programs and the urban Indian organizations—to develop a comprehensive behavioral health prevention and treatment program. Such a program would emphasize collaboration among alcohol and substance abuse, social services and mental health programs and would benefit all age groups.

Since the Committee on Indian Affairs' hearing on June 15 on teen suicide prevention, several more youth suicides have occurred on the Standing Rock Reservation in North and South Dakota. The services and programs for Indian youth, in particular, the training of paraprofessionals, the education of community leaders, the construction and staffing of new facilities and research that would be authorized by title VII will make a very real difference in the lives of men and women who live at Standing Rock, and all Native Americans.

I look forward to the comments today of the Indian Health Service, the tribes and urban Indian organizations, and others and appreciate your help in improving this legislation that will provide creative and effective solutions to address the health needs of Indian people.

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PREPARED STATEMENT OF HON. MICHAEL B. ENZI, U.S. SENATOR FROM WYOMING, CHAIRMAN, COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Good afternoon. Thank you for coming to today's joint hearing on the Indian Health Care Improvement Act.

There is no greater challenge before us in the Congress than the work we must do to continue to improve the quality of the health care that is available to those living on reservations. Unfortunately, it seems that no matter how much progress we make, there is always more to do. Today's hearing will enable us to chart our current progress and discuss what we can do to increase the services that are available to address the physical and emotional problems that continue to plague American Indians and Alaska Natives.

When the Indian Health Care Improvement Act was first signed into law in 1976, it was written to address the findings of surveys and studies that indicated that the health status of American Indians and Alaska Natives was far below that of the general population. It continues to be a matter of serious concern that, as the health

status of most Americans continues to rise, the status of American Indians and Alaska Natives has not kept pace with the general population.

Studies show that American Indians and Alaska Natives die at a higher rate than other Americans from alcoholism, tuberculosis, auto accidents, diabetes, homicide, and suicide.

In addition, a safe and adequate water supply and waste disposal facilities, something we all take for granted, isn't available in 12 percent of American Indian and Alaska Native homes—as opposed to 1 percent of the general population. Several years ago, residents on the Wind River Reservation in Central Wyoming faced a drinking water shortage that threatened the health and safety of everybody in the area. Canned drinking water had to be donated to tribal members and local residents. The lack of these basic services makes life even more harsh for these people and contributes to those already high rates of death.

Coming from Wyoming, I know full well the problems we encounter in the effort to provide quality health care to all the people of my home State. That is why I have always made it one of my goals to help bring that perspective to the hearings and floor debates we have on the issues that affect the people of my State.

When I was first elected to the Senate in 1996 I knew that quality of life issues on the reservations in Wyoming and throughout the country would continue to be a top priority of mine. I also knew that, in order to make life better for those living on the Wind River Indian Reservation specifically, and other reservations nationwide, my staff and I would need to be intensely committed to taking the issues head-on and looking for creative ways to solve complicated problems.

That is why I put someone on my staff who already had a great deal of experience with these issues and shared my commitment to act on them. His name is Scotty Ratliff and he served with me in the Wyoming legislature. I tasked him with the challenge of helping me to find solutions to the problems on our reservations that would be both progressive and culturally sensitive.

Tribal leaders are already committed to making things better on their reservations and I congratulate them on their vision and the hard work they have put into making it a reality. My only question continues to be, "How can I help?" In the years since I have been in the Senate I have made numerous trips to the Wind River Reservation in Wyoming and met and spoke with the residents and tribal leaders. We all want the same goal—a better life for those who live there. I am confident that working together we will continue to make the kind of progress we must make if we are going to find effective and efficient ways to address the problems that continue to plague those living on our reservations across the country.

As I noted during my visits to the Wind River Reservation, their problems are not unique to them. To have an impact on all those who live on reservations from coast to coast, we will need to take a varied approach to address each of these problems separately. Clearly, people of different ages have different problems. A multifaceted approach to solving each of their problems will require a systemic, as well as a financial approach.

Local, State, and national governments and agencies must work together with tribal leaders to focus our resources where they will do the most good. That kind of approach has the greatest chance of being successful.

Earlier this year the HELP Committee held hearings on the nomination of Michael Leavitt to serve as Secretary of Health and Human Services. I believe we are fortunate to have Michael Leavitt at the helm of an agency that oversees the health care needs of the people of reservations all across the country. I am also pleased Dr. Charles Grim is here with us today. Dr. Grim has an important job to do as the Director of Indian Health Services and he knows firsthand the level of dedication it will take to steadily improve health care for all American Indians. Dr. Grim has an unmatched understanding of the needs of Native Americans that you can't get from reading reports and memos from people out in the field. I have every confidence in his willingness and his ability to be an important part of the solution to the health care needs of those on our reservations and beyond.

Again—the good news is—we're making progress. As we do, we continue to find so much more that needs to be done. How do we best provide the assistance that is needed effectively and efficiently? That is the challenge that lies before us.

As we begin to hear from our witnesses, I would like to acknowledge and thank them all for their willingness to share their experiences with us so that we might craft a more effective bill to address the health care needs of our American Indian and Alaskan Native population.

I would also like to welcome Richard Brannan, the chairman of the Northern Arapaho Business Council of Fort Washakie, WY. No one knows better than he does the problems faced by those living on reservations and by those who rely on the Indian Health Service for their healthcare needs. No one understands better than he

does the necessity of making progress in addressing the health disparities experienced by American Indians. Most important of all, no one is more committed than he is to making a difference in the lives of all those who live on the reservation.

I know he has an important message to share with us based on his experience and background with all those who live on the Wind River Reservation. I look forward to his comments and those of our entire list of witnesses. Each of you has a perspective and a point of view to share that only you can provide. I look forward to hearing a summary of your prepared remarks so we can address the underlying issues during our question and answer session.

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PREPARED STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII

Thank you Mr. Chairman. I commend the committees for holding this hearing today.

The status of Indian Health Care has significantly improved over the years and Indian mortality rates have declined. However when compared to the United States general population Indians have a higher likelihood of dying from diseases such as alcoholism [770 percent], tuberculosis [650 percent], AND DIABETES [420 percent]. Life expectancy is also 5 years less than the general population. Preventive health services are needed more than ever as is increased funding for those programs and services.

In 1976 the Indian Health Care Improvement Act was enacted into law for the specific purpose of increasing the health status of native peoples. Since then bills were introduced in the 106th, 107th, 108th, and 109th congresses. Although these efforts were disappointing, I commend Congress for continuing to work on these crucial issues.

This bill is critical to Indian country. It authorizes behavioral programs, provides alternatives for rural dental care, and authorizes the Indian Health Service to provide long-term care, are among the many positive changes that I have seen in this bill. I believe it is congress' obligation to ensure that Native Americans have full and timely access to health care.

There is some language in the bill that I am concerned about because it may be detrimental to tribal sovereignty. However I will continue to work closely with my colleagues.

I commend my colleagues Senators Dorgan and McCain for drafting this legislation. Once again, thank you for holding this hearing.

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PREPARED STATEMENT OF HON. EDWARD M. KENNEDY, U.S. SENATOR FROM MASSACHUSETTS

I commend Senator McCain, and Senator Enzi for convening this joint hearing on the Indian Health Care Improvement Reauthorization Act. The Nation has a legal and moral commitment to provide Native Americans—the Nation's first Americans—with the best possible health care, and I'm pleased to be a cosponsor of this important bill.

From the earliest days of colonization that brought infectious diseases to Native Americans, to the 18th century military conflicts that sought to destroy Native peoples, to the 19th century treaties that sought to confiscate Native lands, to the 20th century boarding schools that sought to undermine, tribal culture and language, the history of Native America has often been a shameful part of the history of America.

The Federal Government has long promised better health care to Native Americans in exchange for land. Since at least 1926, the Government has been looking into the adequacy of such health care, but sadly, many of the inadequacies identified in the 1920's still exist today.

Decade after decade, Congress refused to give tribes the resources to develop and operate their own communities. Too often, it was said that Indian peoples did not have the expertise to invest such resources wisely to conduct their own governments, operate their own businesses, educate their children, or provide health care to their people. For generations, this reactionary national mentality poisoned the relationships between tribes and the Federal, State, and local governments.

Native Americans are eager to improve the health status of their people. They deserve control of their own destiny, but they require Congressional action to make their vision a reality, and it is time for us to honor the commitments we made long ago.

Chronic underfunding of American Indian and Alaska Native health care by the Federal Government has weakened the capacity of the Indian Health Service, tribal governments, and the urban Indian health delivery system to meet the health care

needs of the American Indian and Alaskan Native population. The Indian Health Service per capita expenditures for American Indians and Alaskan Natives are one-half of what is spent for Medicaid beneficiaries, one- third of that spent by the Veterans Administration, and one-half of what the Federal Government spends on Federal prisoners' health care.

As a result of inadequate funding, American Indians endure health conditions most Americans would not tolerate.

Native Americans are 8 times more likely to die from alcoholism, 7 times more likely to die from tuberculosis, 5 times more likely to die from diabetes, and 50 percent more likely to die from pneumonia or influenza than the rest of the United States, including white and minority populations.

Native American infants die at a rate 2½ times greater than the rate for white infants.

Native Americans are at a higher risk for mental health disorders than other racial and ethnic groups in the United States.

Their cardiovascular disease rate is twice that of the general population.

Their life expectancy is 71 years—nearly 5 years less than the rest of the population.

These statistics represent real people who deserve more from the U.S. Government.

The Indian Health Care Improvement Act has been amended many times, but it was only extended through 2001. It is long past time to reauthorize this act.

Congress has been working to do so for the past 5 years. The current legislation reflects years of consultation with the Tribal National Steering Committee and holds great promise for improving the lives of Native Americans through comprehensive public health efforts. Despite widespread support, the bill has not been brought to the Senate floor for a vote.

A better future is well within our grasp. We have a unique opportunity to make much more rapid progress on the long journey toward respect for our First Americans. We must bring the Indian Health Care Improvement Reauthorization Act to the floor. We must pass this legislation. Until every American Indian and Alaskan Native receives first class health care, we will never give up the fight. I look forward to this hearing and to the testimony of each of the witnesses.

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PREPARED STATEMENT OF HON. JOHN MCCAIN, U.S. SENATOR FROM ARIZONA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Good afternoon. The bill before us today, S. 1057, is the latest iteration of the reauthorization of Indian Health Care Improvement Act that has lingered in the Senate for many years. And while there was much debate about the measure at the end of the last Congress, the need to improve the provision of health care services for Native Americans is undebatable. I am very heartened that our colleagues from the HELP Committee under the leadership of Chairman Enzi and Ranking Member Kennedy have so actively engaged in advancing the legislative process. I appreciate not only their support, but the expertise and insight that the HELP Committee brings to the effort.

Nearly 30 years ago, Congress enacted the Indian Health Care Improvement Act to meet the fundamental trust obligation of the United States in providing comprehensive health care to American Indians and Alaska Natives. It was last reauthorized in 1992—13 years ago.

This act is the statutory framework for the Indian health system and covers just about every aspect of Indian healthcare. S. 1057 builds on that framework by providing significant advancements in health care delivery and by promoting local decisionmaking, tribal self-determination and cooperation with the Indian Health Service.

Those critical improvements include increased access to care, especially for Indian children and low-income Indians, programs designed to recruit and retain healthcare professionals on Indian reservations, and alternative financing for healthcare facilities and other services.

Reauthorization of this Act is a high legislative priority. It has been 6 years in the making—far too long for the much needed improvements. Substantial work was completed last year and we have but a few remaining issues that I hope we can resolve quickly so that the bill can be enacted soon. I welcome the witnesses and look forward to the testimony.

PREPARED STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Thank you Mr. Chairman.

I want to thank Chairman Enzi for holding this joint hearing. I'm happy that my colleagues on the HELP committee have this opportunity to learn more about the crisis facing tribal communities today and why this bill is so critically important.

Mr. Chairman, I believe improving the quality and access of health care in tribal communities is one of the Federal Government's greatest treaty obligations. But when it comes to providing that care——

- the Federal Government has fallen short of its moral and legal obligation.

Chairman Enzi, I'd ask for your commitment to continue to work together on this important issue so that we can help the Committee Indian Affairs move this bill forward.

I know you have some concerns about the bill and I'd like to work with you to address them. As you may know, this legislation has been through an exhaustive review by tribal leaders and health professionals, the Committee on Indian Affairs and the Administration.

And in light of two reports by the U.S. Commission on Civil Rights documenting the health care disparities facing Native Americans living on reservations and in urban areas it is time for the Congress to reauthorize this law.

Finally, I'd like to join with my colleagues in welcoming Ralph Forquera to the committee. Ralph is a national leader on issues affecting Native Americans living in urban areas and I'm pleased to see he's here today representing the Seattle Indian Health Board.

Thank you.

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PREPARED STATEMENT OF MARK KELSO, DDS, NORTON SOUND DENTAL DIRECTOR
NOME, AK

As a dentist with 19 years of direct patient care experience in Western Alaska, I believe that I can speak with great credibility regarding the dental needs of the indigenous people of the region. I have observed the cycle of destructive dental disease repeated from one generation to the next. The current method of itinerating dentists to rural communities for several weeks annually does little to elevate the public's aptitude toward the importance of good oral health. The dentists' role is viewed as one of simply alleviating pain and infection or repairing decayed teeth. While this service is important, it ultimately shifts the burden of one's own responsibility in the maintenance of their oral health to that of the provider.

The dentists being of different ethnicity and cultural upbringing are not easily viewed as a role model for children and young adults to emulate. The dentists' short duration in the village also hampers their ability to bring about long-term patient motivation. Patients respect the dentists' advice while they are there, but their enthusiasm to better clean their teeth and limit the intake of sugary foods soon fades upon the dentists' departure. Established poor dental habits re-emerge.

A dental chart review demonstrates that patients receive the care that is warranted. An ongoing trend of preschool children being afflicted with rampant dental decay in the baby teeth and subsequent restoration of these teeth either by multiple sedation appointments locally or by operating room procedures in Anchorage is a frequent occurrence. The erupting adult teeth are cleaned, sealed, and fluoridated but ultimately succumb to the rigors of poor diet and hygiene. The teeth usually receive several fillings of increasing complexity. In too many cases, the teeth reach a diseased state in which extraction of all of the teeth is the only viable treatment. Full dentures are fabricated. An analysis of the cost and effort to provide all of these services with the end result of being an edentulous teenager or young adult is sobering. Thousands of dollars per patient in both dental and hospital services along with associated travel were expended.

A change in public perception regarding the importance of good oral health is needed. Native American dental providers are key in this process. Dental Therapists, residing and working in villages of a high oral disease rate, will be a constant dental presence in those communities. They will have the luxury to examine and treat patients more than once a year. More time can be spent on improving patients' oral hygiene index. Weekly fluoride rinse programs in the school will be an important job duty. But to gain the respect of the communities, the Dental Therapists must be known as the primary dental health care providers. They will obtain this status by alleviating existing need. The Dental Therapists must be able to perform routine fillings, treat infected nerves in children's teeth, and extract painful, hopeless teeth. The dentists will still itinerate through the villages to perform more com-

plex treatment, eventually providing higher level services such as root canal completions, permanent crowns and bridges, denture fabrications, and orthodontic assessments not currently available in these remote locations. As the level of dental care increased in the hub-clinic in Nome, the dental expectation of the community did too. A decrease in basic dental disease followed. Such a model could be extended to the villages through the use of Dental Therapists.

Another important aspect is the influence that the Dental Therapists will have on the school-age children and young adults. A criterion for the selection of all of the Dental Therapists in the Norton Sound region was that they all possess nice teeth, value a healthy smile, and practice good oral habits in their daily lives. Many junior and senior high school girls in the villages, the future mothers of the next generation, desire to look their best like most American girls. They may wear trendy clothes, style their hair, and apply cosmetics, but the deteriorated condition of their teeth negates these other measures. The Dental Therapists will frequently reinforce the need to alter dietary choices and practice daily oral hygiene to improve this segment of the population's oral health. Through the Dental Therapists own actions, they can inspire the youth that it is important and "cool" to have good teeth. It will not be socially acceptable any longer to brandish a smile of decay -riddled teeth or missing teeth altogether. Usually the children's teeth mirror those of the mother, either good or bad. This will be an excellent opportunity to stop the generational cycle of rampant tooth decay and premature tooth, loss. The Dental Therapists will be an ever-present, walking advertisement to the importance of good oral health.

I urge the Senate Committees on Indian Affairs and Health, Education, Labor, and Pensions to support S. 1057 as it is written. The ability of the Dental Therapists to perform the procedures of fillings, dental pulp treatments, and basic extractions is crucial to their success. The Dental Therapists' potential to bring about positive long-term change is greater than that of any number of itinerant dentists, either compensated or volunteer.

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PREPARED STATEMENT OF TOM KOVALESKI, DDS, DIRECTOR, SOUTHCENTRAL FOUNDATION, [SCF] DENTAL PROGRAM

Thank you for the opportunity to submit testimony to the SCIA and HELP Committee regarding the practice of DHATs and section 121 of S. 1057, the Indian Health Care Improvement Act Amendments of 2005. Please include my testimony in the record of the July 14, 2005 hearing regarding S. 1057.

I was honored to be one of the four authors of the paper, "Integrated Dental Health Program for Alaska Native Populations." Since the first draft was released, I have been in regular discussion with tribal dental health program directors in Alaska. I have stated to them repeatedly that in my view the COHP model should be viewed by them, by the ADA, and by Congress, not as a substitute for DHATs, but rather as a tool for achieving additional efficiencies and improvements. In my view, there is a place for implementation of COHP and DHATs as part of an integrated dental health program.

I do not endorse the conclusion of the ADA that COHP can substitute for DHATs in resolving the crisis regarding access to dental services among Alaska Natives. I would recommend both programs be implemented as pilot programs with the results evaluated closely. While I think both SCF's efficiency expertise and the full implementation of a COHP model may help the crisis, there is still a pressing need for additional practitioners that expanded function dental hygienists and DHATs could help fill. Throughout the development of the DHAT standards ultimately adopted by the Community Health Aide Program Certification Board, I actively participated with other dental providers in reviewing the Standards and the research base for mid-level dental practice and shared my concerns around the training and quality assurance components. I believe that DHATs have the potential to be high quality providers with proper training and quality assurance.

As a practicing, licensed dentist responsible for a large program serving both an underserved urban and rural populations, I do not believe the dental community can afford to reject any responsible approach to expanding access to dental services. I believe dental assistant training, increased capacity, expanded function hygienists, COHP, and DHATs, provide such a responsible options for reducing the backlog of dental disease in Alaska.

I urge Congress to not make changes in the authority of the community health aide program pursuant to section 121 of the Indian Health Care Improvement Act under which DHATs are certified so that we can evaluate their impact along with other strategies.

If I can offer additional information that will help you in your deliberations, please let me know.

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INDIAN HEALTH CARE IMPROVEMENT ACT: QUESTIONS FOR THE RECORD

(SENATOR HATCH)

JULY 15, 2005

**Panel I**
**Questions for Ms. Rachel Joseph**
**National Steering Committee**
**Chairperson, Lone-Pine Paiute Shoshone Reservation**

**No. 1.** Title VII would authorize a comprehensive behavioral health program, reflecting tribal values and collaboration among various substance abuse, social service, and mental health programs. You spoke of the need to have a "systems of care" approach to mental health in addition to this comprehensive package. Can you tell me specifically what this "systems of care" approach would add to the comprehensive program already outlined in title VII?

**No. 2.** The National Steering Committee has a long history with this legislation. Can you tell us what the major stumbling blocks have been to passing this bill in the past, and how this bill has addressed these issues?

**Panel II**

**Questions for Mr. Don Kashevaroff**
**Alaska Native Health Tribal Consortium and Tribal Self-Governance Advisory Committee**

**No. 1.** What, specifically, are the concerns on the part of the Administration with negotiated rulemaking and how does this bill address those concerns? Why is negotiated rulemaking of particular importance to tribes?

**Questions for Mr. Richard Brannan,**
**Chairman, Northern Arapaho Tribe**

**No. 1.** In your testimony, you stated that the Arapaho Tribe has a high disproportionate number of diabetics—would you please describe the current state of the dialysis program available to the Arapaho Tribe?

**No. 2.** Regarding the issue of care for the elderly, you mentioned that most Arapho elderly, choose to remain in their own homes—do you believe that they would still remain in their own homes if better facilities were available to them?

**No. 3.** I understand that family and domestic violence remains a large problem facing the American Indian population, and that expansion of related services is vital to combating that problem. What services are currently provided on the Wind River Reservation with regard to family and domestic violence; and what services do you suggest be added to enhance the current program?

**Questions for Mr. Ralph Forquera,**
**Executive Director, Seattle Indian Health Board;**
**and Director, Urban Indian Health Institute**

**No. 1.** I am concerned by your statement about the lack of available data needed to address the growing health crisis among urban Indians—it appears that this crisis may be much larger than we are even capable of gauging. What are the main reasons it is so difficult to collect data of urban Indians; and, do you have suggestions of what Congress can do to improve the data collection process?

**No. 2.** Do you consider the trend toward urbanization to be increasing?

**No. 3.** With regard to the Federal Tort Claim Act, you stated that inclusion could save considerable expense for programs that are now purchasing private liability insurance to support their work ? can you provide a hypothetical estimate of those savings?

**Panel III**

**Questions for Dr. Mary Williard, D.D.S.**
**Yukon-Kuskokwim Health Corporation, AK**

**No. 1.** You support the current program which permits Dental Health Aide Therapists (DHAT) to perform various procedures on patients in remote areas. The American Dental Association has concerns with three of these procedures (extracting teeth, drilling cavities, and pulpotomies). What programs are currently in operation that are similar to the DHAT program? Do participants in these programs perform these controversial procedures? Can you provide us information on these programs:

where they are, how long they have been in operation, what studies have been done assessing their safety and effectiveness, particularly with regard to these three procedures?

**No. 2.** You mention that the dental therapists will work under the supervision of a dentist. Who are these dentists and how can they supervise dental therapists who are in remote villages? What "back-up" exists if a procedure runs into unexpected complications?

**STATEMENT OF THE**

**AMERICAN DENTAL ASSOCIATION**

**TO THE**

**COMMITTEE ON INDIAN AFFAIRS**

**AND THE**

**COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS**

**U.S. SENATE**

**ON**

**S. 1057**
**THE INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2005**

**SUBMITTED BY**

**ROBERT M. BRANDJORD, D.D.S.**
**PRESIDENT-ELECT**

**JULY 14, 2005**

**Executive Summary**

The American Dental Association (ADA) has been concerned about access for underserved populations for many years and has been working on the development of models to respond to various access challenges. Since October 2003, when the ADA established a task force to explore the options available for delivering high quality oral health care services to Alaska Natives in the approximately 200 rural villages in Alaska, the Association has attempted to work to find solutions that would be acceptable to all stakeholders. At a November 15, 2004 meeting with tribal leaders the ADA and Alaska Dental Society (ADS) extended an invitation to work together to address the access backlog issue. This was followed-up with a letter from the ADA and ADS presidents to all tribal health directors.

The response to our backlog initiative was at first encouraging, but unfortunately, it appeared that villages that had voiced some initial interest in the program decided not to pursue it. One of the reasons given for that was the difficulty in credentialing dentists to come to Alaska. The ADA approached the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in an effort to seek a solution to the credentialing paperwork burden. The ADA also established a new full time position within the Association for an employee who would help coordinate the placement of dentists in Indian Health Service (IHS) and tribal programs.

Contrary to some misconceptions, the tribes, the IHS and the ADA all agree on most issues affecting the Dental Health Aide Program--including the concept that expanding the Community Health Aide Program (CHAP) to include dental health aides who can provide education and preventive services is a reasonable response to address the needs of Native Alaskans in rural villages.

The one concept that the dental community unequivocally opposes is allowing non-dentists, including Dental Health Aide Therapists (DHATs), who are inadequately trained and unlicensed, to perform irreversible surgical procedures--such as extracting teeth, drilling cavities or performing pulpotomies (which are similar to root canals), because doing so would risk patients' safety and health. The Alaska Board of Dental Examiners agrees with the dental community. The Board, in response to a unanimous vote, stated in a February 7, 2005 letter to the Alaska Attorney General that DHATs are practicing dentistry illegally.

Providing dental services to Alaska Natives in remote villages is complicated by many factors and the failure to properly diagnose and to take appropriate and timely actions in the event of complications has real life consequences. For example, many adult patients have other diseases—diabetes, heart problems, etc.—which add to the complexity and make treatment more dependent on comprehensive training. Also, it is not possible to predict the more routine, "simple" extractions from the complicated procedures before the process begins. The dental community's concern is that DHATs' training is not

adequate to help them recognize cases such as these—cases in which failure to do so could put the patient at great risk.

While the ADA recognizes that in any given procedure things can go wrong for either a dentist or a therapist, the difference is that a dentist can draw upon a more extensive set of knowledge, skills, and abilities to problem solve and apply a more advanced level of skills as needed. This disparity in potential problem solving and level of skills is understandable given the fact that dentists typically undergo four years of training in dental school after completing their undergraduate work (generally totaling 8 years of higher education), while DHATs are provided training only over a 2 year period after graduating from high school. To underscore the educational gap between the foreign-trained DHAT and other members of the dental team, it is important to note that the entry point for a dental hygienist, who cannot perform the irreversible procedures the DHAT may be permitted to do, is a minimum of two-years of post-secondary education. Also, unlike DHATs, both dentists and dental hygienists are licensed and must undergo independent verification of their competency by a state board, including passing a clinical examination.

The ADA believes that it is a false choice that Native Alaskans will have either no care or care provided by DHATs.

The ADA has suggested that it would be preferable to put a dental health aide in every village to provide oral health prevention and education, establish a coordinator position to work with the tribes to bring more dentists to the villages, and reduce the credentialing paperwork redundancy.

In addition, the ADA believes there is a better alternative program -- an Alaska-based solution for an Alaska access problem. Four dental experts, including the current dental director of the Alaska Native Medical Center in Anchorage, Alaska, recommended that the best way to deliver care to the Alaska Natives is to make the current delivery system more efficient by using more dental assistants and providing more dental chairs for each dentist. Also, as part of that program, the experts recommended the development of a new Community-based Oral Health Provider (COHP). COHPs, like DHATs, would be mid-level providers, but they would have an expanded management role (in addition to an expanded clinical role), which will significantly enhance the efficiency of the current delivery system. COHPs, who could be trained in Alaska in about 12 to 18 months, would coordinate care, provide preventive services and help with oral health education and nutrition so that when dentists are in the village clinics, they are much more productive and efficient. The ADA believes this promising model, many aspects of which have already proven to be successful in the Southcentral Foundation program, is a better solution for Alaska tribal programs. A paper on this model has been given to staff.

Finally, the ADA supports language passed last year in the House Resources Committee in H.R. 2440, and which we understand will be reintroduced this year, which supports the dental health aide program but prohibits non-dentists from performing irreversible procedures on patients.

My name is Robert Brandjord. I am president-elect of the American Dental Association (ADA) and a practicing oral surgeon from Minnesota. Thank you for providing the Association with the opportunity to comment on S. 1057, the Indian Health Care Improvement Act.

I am here to express the ADA's strong support for using dental health aides and other innovations in dental care delivery to help reduce the disproportionate burden of dental disease that many Alaska Natives suffer from today. At the same time, I am here to state the ADA's unequivocal opposition to experimenting on Alaska Natives by allowing non-dentists to perform irreversible dental surgical procedures.

The 152,000 members of the ADA, representing over 72 percent of the profession, believe strongly that all Americans deserve access to dental care. We are committed to working with all stakeholders to find short- and long-term solutions to providing that care, especially to low-income and geographically isolated populations for whom access to dentists is difficult and who, consequently, suffer a disproportionate degree and severity of dental disease.

Since October 2003, when the ADA established a task force to explore the options available for delivering high quality oral health care services to Alaska Natives in the approximately 200 rural villages in Alaska, the Association has attempted to work with the Indian Health Service (IHS), the Alaska Native Tribal Health Consortium (ANTHC), and the Alaska Dental Society (ADS) to try to find solutions acceptable to all.

The task force traveled to Alaska in March 2004 and met with IHS and tribal representatives, ADS leadership and Alaska dentists. Some members of the task force conducted a site visit of Hooper Bay (population about 1,200) and Chevak (about 250 people), villages within the Yukon-Kuskokwim Health Corporation (YKHC). In addition, six members of the ADA's Council on Government Affairs (CGA) spent a week in various Alaska villages providing pro bono dental services as guests of the IHS and the respective tribal health programs. The council members submitted reports to the task force.

All six council dentists (and, subsequently, the task force) agreed that a dental health aide (i.e. a Primary Dental Health Aide I or II) in every village to provide education and prevention would be of great value. Some additional observations by the six dentists: the homes in the villages do not have running water and the water is of such poor quality that soft drinks are the beverage of choice; candy and sugar drinks are ingested throughout the day and are readily available in the village store; smokeless tobacco is used by children; despite significant need for care, the adult population does not generally demand care until there is pain; the majority of dental procedures on adults are emergency based (extractions) with no recall program; and tooth decay is rampant and often visible on children's teeth.

The six ADA dentists, all experienced practitioners, agreed that the circumstances under which they had to function in the villages created significant challenges and required the

application of all of their skills and abilities to assure that good quality dentistry was delivered. Those conclusions were consistent with the IHS practice (as told to ADA personnel attending IHS site visits over the years) of not sending inexperienced dentists to remote locations to provide dental services because they might face circumstances that they were not prepared to properly handle.

The ADA has undertaken several initiatives (described below) to try to alleviate the access problems in Alaska and stands ready to work with the IHS and tribal programs to make these efforts more effective. The Association believes that the real solution lies in an enhanced delivery system that makes the current system more efficient. To this end, the Association is open to the development of a new community-based allied provider which protects patient safety. As described in greater detail below, we can offer one approach—the Community-based Oral Health Provider model (COHP)--that appears to meet these goals and was specifically designed with input from Alaskans, using people trained in Alaska, to address the needs of the Alaska Native population.

In addition to the March 2004 visit, a portion of the task force traveled to Anchorage and met with tribal leaders on two other occasions. At a November 15, 2004 meeting the ADA and ADS extended an invitation to work together to address the access backlog issues. This effort was followed-up with a letter from the presidents of the ADA and ADS to all tribal health directors, asking them to work with the ADA and ADS to bring dentists to villages in a manner that works for all.

Unfortunately, the approximately 140 ADA member dentists who expressed an interest in volunteering to serve Alaska Native patients in two- to three-week trips were rebuffed. The Norton Sound Health Corporation requested a single dentist to serve for several months. A second request, from Metlakatla, sought one full time and one part-time dentist. As we made clear when we attempted to launch this operation, the ADA volunteers' responsibilities to their own patients precluded their serving for periods longer than two or three weeks. Even within these limits, their sheer numbers could have had a significant impact on the people most in need of care. For example, the six ADA dentists who volunteered in the winter of 2004 provided services valued at approximately $20,000 each in a single week. Five of those dentists said they were ready to return this year, and yet no corporation told us that they wanted any volunteers.

One of the obstacles to more efficiently bringing dentists (and other health care professionals) to the villages is the need to submit voluminous credentialing paperwork to each facility. This requirement applies to all providers, including those hired by the IHS and tribal programs, as well as private practitioners who want to provide care in the remote villages. Even movement from one village to another requires that a practitioner undergo a separate credentials review. (Indeed, we were told by an IHS official that this was the case when the IHS tried to bring psychiatrists, psychologists and other mental health care providers to Red Lake during last year's tragic events there.) The ADA also spoke with officials of the American College of Obstetricians and Gynecologists (ACOG). ACOG currently provides volunteer physicians for many facilities in various states that serve the American Indian population; ACOG reports it experiences significant

difficulties in credentialing and licensing, and has stopped sending doctors to Alaska and some other locations as a result.

The ADA believes this redundancy results in a very confusing, excessive, and potentially inconsistent credentialing system that serves as a disincentive to health care professionals who want to provide care to this underserved population. It also makes the IHS and tribal programs less efficient and more costly to operate. While some view these credentialing barriers as a reason to throw up their hands and discount any plan that uses volunteers to treat the backlog of dental disease in tribal villages, the ADA prefers to fight for changes in a bureaucracy that keeps willing providers from patients in need.

In an effort to explore a means of alleviating the paperwork redundancy, the ADA contacted the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) with concerns that dentists who want to provide care to Alaska Natives are being unnecessarily impeded from doing so because of the lack of a uniform credentialing and privileging process. Any effort to develop a uniform credentialing process would not only help the ADA in our efforts to establish a program in Alaska and the lower 48 states, but would also help other organizations as they establish their own programs to provide care to underserved Americans.

For years, as the founding member of the "Friends of the Indian Health Service" the ADA has worked as an aggressive advocate for increased federal funding to ensure the IHS and tribal programs have the resources they need to deliver oral health care services to the

American Indian/Alaska Native (AI/AN) population. In recent months, the Association recognized it needed to do more to acquire the expertise needed to assist in the placement of dentists in IHS and tribal programs. So, the ADA established a new position within the Association – "Manager, American Indian/Alaska Native Dental Placement." We are currently recruiting for this position. The person filling this position will work with the ADS and Alaska tribes to coordinate and enhance the outreach program to get more dentists to provide oral health care in Native villages. In addition, this person will also develop a plan for a program to do outreach with tribes in the lower 48. The Association recognizes that such an effort requires a full time person who can ultimately work with the IHS and tribal programs throughout the country to help address the considerable access problems facing AI/AN populations in many parts of our country. The ADA is pursuing its commitment; to be effective, this program will need the good faith cooperation of the IHS and tribal leaders.

Contrary to some misconceptions, the ADA, the Alaska tribal leadership and IHS agree on many issues, including

- The extent and severity of oral diseases among Alaska Native children is exceptionally high.
- Access to the approximately 200 villages in rural Alaska is very difficult.
- The conditions that contribute to oral disease go beyond the delivery of oral health care services – and require behavioral changes and improved living conditions.

- An excellent means of helping to break the cycle of dental disease and provide culturally competent care is to train an individual from each village to provide dental education and prevention.
- More AI/ANs must be brought into the oral health care delivery system at all levels (including dentists) to provide culturally competent care.
- The dental vacancy rates within the IHS and among Alaska Tribal programs must be addressed.
- The expansion of the Community Health Aide Program (CHAP) to include dental health aides is a reasonable response to address the needs of those in the rural villages and, with one exception concerning DHATs performing irreversible surgical dental procedures, is enthusiastically supported by the ADA and ADS.

**Essentially, the parties disagree on one issue.**

The dental community, including the ADA, ADS, American Association of Oral and Maxillofacial Surgeons, the Academy of General Dentistry, and the American Academy of Pediatric Dentistry unequivocally oppose dental access solutions that would put patients at risk by allowing non-dentists to perform irreversible surgical procedures such as extracting teeth, drilling cavities or performing pulpotomies (which are similar to root canals).

**Patient Safety at Risk**

The Alaska Board of Dental Examiners agrees with the dental community. The Board, in response to a unanimous vote, stated in a February 7, 2005 letter to the Alaska Attorney General that DHATs are practicing dentistry illegally. The Board expressed a concern that the rural citizens of Alaska are being put at risk because the unlicensed DHATs will be performing irreversible dental procedures, such as fillings, extractions and pulpotomies, which are the "exclusive duties of a licensed dentist" pursuant to Alaska law. (See Attachment)

The above dental organizations oppose non-dentists, including Dental Health Aide Therapists (DHATs) within the CHAP program, performing irreversible surgical procedures because doing so risks patient safety and health. Proponents of DHATs doing irreversible procedures cite the number of extractions and restorations (drilling teeth) performed by the DHATs during their training as evidence that they will be well prepared to perform such procedures in remote locations on both children and adults. They also predict that DHATs will know to limit themselves to less complicated procedures, leaving the more complicated extractions, for example, to dentists.

Virtually all dentists will tell you that it is not possible to predict the more routine, "simple" extractions from the complicated procedures before treatment begins. Potential complications associated with extractions include fractures to the bones that support the teeth, aspiration of a tooth, prolonged bleeding or uncontrollable hemorrhaging, damage

to adjacent teeth and/or restorations, and expansion of an infection into the pharyngeal spaces. The dental community's concern is that DHAT training is not adequate to help them recognize cases such as these—cases which could put the patient at great risk.

Another area of enhanced risk is that many adult patients have other diseases—diabetes, heart problems—that make treatment more complex and dependent on comprehensive training. For example, the DHAT may have to assess whether there is a cardiovascular condition that might necessitate that a patient be pre-medicated with antibiotics to prevent a secondary heart infection; or assess whether a patient has hypertension and/or diabetes and whether those conditions are controlled. And, unfortunately, many adults within the Alaska Native population have one or more of these health complications. Any of the irreversible dental procedures cited above can lead to problems that can threaten not only the patients' oral health, but also their general health. In extreme cases, infections and other complications from dental procedures can be life-threatening.

High-quality dental care is much more than performing procedures — proper treatment planning calls for diagnostic skills beyond the scope of non-dentists' training. As stated by Dr. Michael Glick in his editorial in the April 2005 edition of the *Journal of the American Dental Association,* "...acquiring the clinical skills necessary to perform particular tasks is not enough to become a competent professional health care provider. To optimize the benefit of learned and acquired clinical proficiencies, these skills need to be accompanied by a comprehensive theoretical background."

The ADA recognizes that in any given procedure things can go wrong for either a dentist or a therapist. The difference is that a dentist can draw upon a more extensive set of knowledge, skills, and abilities to problem solve and apply a more advanced level of skills as needed; a DHAT cannot.

This disparity in potential problem-solving and level of skill is understandable given the fact that dentists typically undergo four years of training in dental school after completing their undergraduate work (generally totaling 8 years of higher education), while DHATs are provided only 18 months of foreign training over a 2 year period after graduating from high school. To underscore the educational gap between the DHAT and other members of the dental team, it is important to note that the entry point for a dental hygienist, who cannot perform the irreversible procedures the DHAT may be permitted to do under the CHAP program, is a minimum of two-years of post-secondary education. Also, unlike DHATs, both dentists and dental hygienists are licensed and must undergo *independent* verification of their competency by a state board, including passing a clinical examination. By contrast, DHATs are certified by the CHAP Certification Board with only one dentist member, who also serves as a DHAT supervisor. There is no independent verification of competency for DHATs.

The following is a *partial* listing of the comprehensive range of biomedical and behavioral science education, ethics and professionalism, and clinical sciences that dental schools must teach to dental students in order to be accredited. According to the Commission on Dental Accreditation (CODA), dental school graduates are expected to demonstrate:

- Knowledge of biomedical, behavioral and clinical science of sufficient depth, scope, timeliness, quality and emphasis to ensure achievement of the curriculum's defined competencies;
- An in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems, in which the mouth and face are a critical anatomical area existing in a complex biological interrelationship with the entire body;
- A high level of understanding of the development, spread, diagnosis, treatment and prognosis of oral and oral-related disease; and
- Biomedical science knowledge of sufficient depth and scope for graduates to apply advances in modern biology to clinical practice and to integrate new medical knowledge and therapies relevant to oral health care.

CODA clinical science requirements are equally rigorous, with required competencies caring for pediatric, adult and geriatric patients including, but not limited to:

- Patient assessment and diagnosis;
- Comprehensive treatment planning;
- Health promotion and disease prevention;
- Informed consent;
- Anesthesia, and pain and anxiety control;
- Fillings, using the full range of safe and effective materials;

- Replacement of teeth;
- Periodontal (gum disease) therapy;
- Pulpal (root canal) therapy;
- Hard and soft tissue surgery;
- Dental emergencies, such as those resulting from blows to the face or other traumatic injury;
- Malformed bite; and
- Evaluation of the outcomes of treatment.

In addition to this broad range of scientific knowledge and clinical skills, "Graduates must be competent in providing appropriate life support measures for medical emergencies that may be encountered in dental practice."

U.S. dental students are required to master all of the knowledge and skills above before graduation. And even after graduation, in almost all states, they must pass a comprehensive licensing exam, administered by an independent examiner, before they are entrusted with the health of a patient.

The contrast between a dentist's training and that of a DHAT is stark. Here is the entire course listing for the University of Otago (New Zealand) Diploma in Dental Therapy, a two year program:

First year:

- General Health Science
- Oral Health Science
- Clinical Dentistry

Second year:

- Society and Health
- Advanced Clinical Dentistry
- Dental Therapy Practice

The failure to properly diagnose complications and take appropriate and timely actions has real life consequences. According to the American Association of Oral and Maxillofacial Surgeons (AAOMS), potential complications from surgical and invasive procedures include conditions that require additional procedures, medication or other therapies beyond the scope of DHAT training, including:

- Acute or chronic infection;
- Injury to adjacent teeth, gums or bone;
- Bone fractures in the jaw or elsewhere in the face;
- Prolonged pain, swelling or even hemorrhage;
- Displacement of tooth, tooth fragments or foreign objects into the airway, gastrointestinal tract or sinus; and
- Breathing or heart problems.

AAOMS goes on to state, "We cannot envision a scenario where an irreversible procedure should be provided by someone who is not a dentist. A patient in need of irreversible dental care services should not be subjected to a lower standard of care just because he or she receives care in a particularly remote area of Alaska. While some may argue that care from a dental health aide is better than no care at all, the reality is that the potential for harm from an irreversible dental procedure is very real. . . . Steps should be set in motion so that patients seeking care for these irreversible procedures through the Indian Health Service receive their care from the most qualified professionals."

**The Choice Is Not Between "No Care" and "Some Care"**

A common rationale used to support the use of DHATs to perform irreversible dental procedures in remote villages is that some restorative dental care is better than none. The ADA disagrees with this false choice of either no care or care provided by a DHAT. We all agree that no care is unacceptable. The choice is between licensed dentists, who typically undergo at least eight years of higher education, and high school graduates with 18 months training over a 2 year period in New Zealand.

The ADA has suggested a better alternative -- putting a dental health aide in every village to provide oral health prevention and education, establishing an ADA coordinator position to work with the tribes to bring a great many more dentists to the villages, and reducing the credentialing paperwork redundancy. If all parties work together in good faith, these goals could be accomplished.

**An Alternative Approach – An Alaskan Solution for an Alaskan Problem**

The ADA asked an *independent* group of experts to come together to develop some alternate ideas on how to improve access to the Alaska Native population and to write a paper. As a result, in April 2005 Drs. Howard Bailit[1], Amid Ismail[2], Tryfon Beazoglou[3] and Tom Kovaleski[4] developed a paper titled the "Integrated Dental Health Program for Alaska Native Populations." (See Attachment)

What the authors of the paper determined is that the best way to deliver care to the Alaska Native population is to make the current delivery system more efficient. This will require more dental assistants, more dental chairs per dentist, and the creation and introduction of a newly designed position – the Community-based Oral Health Provider (COHP). The model described in this paper incorporates many of the efficiencies (such as recognizing the need to train more dental assistants and to increase the number of chairs available for each dentist) that have already proven successful in the Alaska Native Medical Center run by Dr. Kovaleski in the Southcentral Foundation in Anchorage. In addition to those efficiencies, the proposed model also calls for the development of a

[1] Howard L. Bailit, D.M.D., Ph.D.; Professor Emeritus & Director, Health Policy & Primary Care Research Center, University of Connecticut Health Center, University of Connecticut.

[2] Amid I. Ismail, Dr.P.H., M.P.H., M.B.A., B.D.S., Director, Program in Dental Public Health, Professor, School of Dentistry, Professor, Epidemiology, School of Dentistry, University of Michigan.

[3] Tryfon Beazoglou, Ph.D., Professor, Health Economics, University of Connecticut Health Center, University of Connecticut.

[4] Thomas Kovaleski, D.D.S., Dental Director Southcentral Foundation, Alaska Native Medical Center, Anchorage, Alaska.

COHP, essentially a prevention and community-based person who can provide preventive care, education, as well as coordination and preparatory service for the dental team when it travels to a village. COHPs, who could be trained at the University of Alaska in about 12 to 18 months, coordinate care, provide preventive services, and help with oral health education and nutrition so that dentists are much more productive and efficient in the village clinics. DHATs are not envisioned in this model, as the dentist will perform the irreversible procedures.

In summary, the panel recommended:

- With a relatively modest investment in facilities and allied dental health personnel, the current delivery system can be greatly improved, providing significantly more services to the entire population. Sustainable improvement requires the prevention of disease and efficient delivery of therapeutic services.
- COHPs are needed to improve the oral health of remote village residents. Led by a centrally-based dentist(s), COHPs should be responsible for the organization of the overall provision of community and personal level oral health services to clusters of villages. Their management role should include organizing community level health promotion and disease prevention programs, directing the activities of the dental health aides, and increasing the efficiency of visiting dentist teams to villages. Their clinical role should include providing oral health screenings, primary and secondary preventive services, gross tooth decay removal and stabilization, secondary

prevention of mild periodontal diseases, and under dentist supervision pain and infection control.

- The ANTHC, ADA, American Dental Education Association should work collaboratively to develop a national model for training these new oral health care providers in Alaska. More generally, a major effort is needed to recruit, educate, and retain a local dental workforce that is committed to working with licensed dentists in Alaska and is culturally competent to serve the needs of this population.

The ADA recognizes the potential usefulness of the "Integrated Dental Health Program for Alaska Native Populations" as a delivery system that could significantly improve oral health care access for Alaska Natives in the remote villages in Alaska. We know it will work because many of the fundamental aspects of the program have already proven successful in the Southcentral Foundation program. It is an Alaska-developed solution for an Alaska access problem and deserves to be implemented by other tribal programs interested in significantly improving access with a relatively modest increase in investment.

**Indian Health Care Improvement Act**

**S. 1057**

The Association appreciates the efforts of the committee to address the concerns raised last year about DHATs performing irreversible dental procedures by modifying section 121 of S. 1057 to provide for a study of the dental health aide program. However, this

provision continues to allow DHATs to perform irreversible dental procedures, which the ADA cannot support.

As stated above, the ADA believes very strongly that patients are unnecessarily placed at a higher risk when non-dentists are permitted to perform irreversible procedures, such as extractions, the diagnosis and treatment of caries, and pulpotomies. This is especially true when there are other models out there, such as the alternative program using Community-based Oral Health Providers. Frankly, the ADA does not understand why IHS and tribal leaders insist on supporting a delivery system that uses minimally-trained and unlicensed persons (and is acceptable no where else in the United States) when an Alaska-designed solution that will significantly enhance the efficiency of the current system, which relies on the delivery of services by skilled dentists, is available.

The ADA continues to support the approach taken in last year's House Resources Committee's version of section 121 of the Indian Health Care Improvement Act, H.R. 2440, which prohibited non-dentists from performing irreversible dental procedures. It is our understanding that this provision will be reintroduced this year and we urge the Senate to adopt similar language.

FAXED 2-7-05

STATE OF ALASKA
DEPARTMENT OF COMMERCE
COMMUNITY AND ECONOMIC DEVELOPMENT

**DIVISION OF OCCUPATIONAL LICENSING**

*Frank H. Murkowski, Governor*

February 7, 2005

Gregg D. Renkes, Attorney General
Department of Law
P.O. Box 110300
Juneau, Alaska 99811-0300

Dear Mr. Renkes:

I am writing to alert you to the fact that there are people in rural Alaska practicing dentistry illegally. They are being allowed to practice dentistry without possessing the Alaskan license to do so.

At our December 3, 2004, meeting, the Board of Dental Examiners was informed that recently trained Dental Health Aid Therapists (DHAT ) were going to begin their work in the villages of rural Alaska. At several of its meetings this past year, the Board has received formal presentations and frequently discussed the pros and cons of the work that DHAT's will be doing as they relate to the statutes and laws of our state, and the Board's mission to protect the public.

AS 08.36.360 defines the "Practice of Dentistry" as: a person engages in the practice of dentistry who

(1) performs or holds out to the public as being able to perform dental operations;
(2) diagnoses, treats, operates on, corrects, attempts to correct, or prescribes for a disease, lesion, pain, injury, deficiency, deformity, or physical condition, malocclusion or malposition of the human teeth, alveolar process, gingiva, maxilla, mandible, or adjacent tissues; * * *
(6) extracts or attempts to extract human teeth;
(7) exercises control over professional dental matters or the operation of dental equipment in a facility where the acts and things described in this section are performed or done;
(8) evaluates, diagnoses, treats, or performs preventive procedures related to diseases, disorders, or conditions of the oral cavity, maxillofacial area, or adjacent and associated structures; a dentist whose practice includes the services described in this paragraph may only perform the services if they are within the scope of the dentist's education, training, and experience and in accord with the generally recognized ethical precepts of the dental profession; nothing in this paragraph requires a person licensed under AS 08.64 to be licensed under this chapter.

As you can see from the enclosed copy of an article from Anchorage's local paper, DHAT's are and will be practicing dentistry without a license by performing "basic dental practices" and returning to Alaska to "hang a shingle." We have been advised that they will also be doing fillings, pulpotomies (root canals on baby teeth), and tooth extractions. These are all invasive and irreversible dental procedures and according to Alaska statute, the exclusive duties of a licensed dentist. Additionally, the Board has been told by Dr. Nagle, that the DHAT's will be able to provide care to anyone in the village that the village tribal elders or corporation officers authorize them to provide care for. We can only assume from this that the DHAT's care will not be limited to village native residents.

P.O. Box 110806, Juneau, Alaska 99811-0806
Telephone: (907) 465-2534 Fax: (907) 465-2974 Text Telephone: (907) 465-5437
Email license@commerce.state.ak.us Website: http://www.commerce.state.ak.us/occ/

At it's December meeting, the Board of Dental Examiners unanimously directed the Board's president to write you this letter and request that the Department of Law take appropriate action that it would normally take against a person who is practicing a profession without a license. Also, the dentists authorizing this care are in violation of AS 08.36.315(6) and (10).

AS 08.36.315. Grounds for discipline, suspension, or revocation of license. The board may revoke or suspend the license of a dentist, may reprimand, censure, or discipline a dentist, or both, if the board finds after a hearing that the dentist

(6) ... permitted the performance of patient care by persons under the dentist's supervision, that does not conform to minimum professional standards of dentistry regardless of whether actual injury to the patient occurred; ***

(10) permitted a dental hygienist or dental assistant who is employed by the dentist or working under the dentist's supervision to perform a dental procedure in violation of AS 08.32.110 or AS 08.36.070(a)(10)....

Please, kindly respond as soon as possible. The Board is concerned that we are putting our rural citizens at risk by allowing high school graduates who have attended a non-accredited dental program in a foreign country to practice dentistry in our state.

Please feel free to contact me by phone at my office in Anchorage, 274-7691.

Sincerely,

Robert E. Warren, DDS
Alaska Board of Dental Examiners
President

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**April 2005**

# Integrated Dental Health Program

# for Alaska Native Populations

**Howard Bailit, D.M.D.**

**Tryfon Beazoglou, Ph.D**

**Amid Ismail, D.D.S.**

**Thomas Kovaleski, D.D.S.**

## *Executive Summary*

During recent discussions of proposed changes in the dental care system for Alaska Natives, the American Dental Association (ADA) asked a group of dental care experts to independently study and make recommendations on the current and proposed systems. The primary problem is that the 125,000 members of the Alaska Native community, and especially those living in villages that are not accessible by roads, have a high prevalence of untreated dental diseases.

Faced with an acute problem, the Alaska Native Tribal Health Consortium (ANTHC) developed a new delivery plan for rural villages; locally recruited dental health aides and therapists will live in the rural villages and provide community and personal level preventive and treatment services. The Panel supports this general plan and suggests that with modifications it could be more effective.

The Panel offers these recommendations:

- With a relatively modest investment in facilities and allied dental health personnel, the current delivery system can be greatly improved, providing significantly more services to the entire population. Sustainable improvement requires the prevention of disease and efficient delivery of therapeutic services.
- Community-based oral health providers (COHPs) are needed to improve the oral health of remote village residents. Led by a centrally-based dentist(s), COHPs should be responsible for the organization of the overall provision of community and personal level oral health services to clusters of villages. Their management role should include organizing community level health promotion and disease prevention programs, directing the activities of the dental health aides, and increasing the efficiency of visiting dentist teams to villages. Their clinical role should include providing oral health screenings, primary and secondary preventive services, gross tooth decay removal and stabilization (ART), secondary prevention of mild periodontal diseases, and under dentist supervision pain and infection control.
- The ANTHC, ADA, American Dental Education Association should work collaboratively to develop a national model for training these new oral health care providers in Alaska. More generally, a major effort is needed to recruit, educate, and retain a local dental workforce that is committed to working in Alaska and is culturally competent to serve the needs of this population.

A financial analysis of different options proposed for improving the efficiency of the delivery system indicates that a relatively modest addition to currently planned expenditures will result in major gains in the number of patients receiving care annually. As the system becomes more efficient, the cost per patient treated or service provided are expected to decrease.

**I. Introduction**

During the past several months, the ADA, the US Indian Health Service, the Alaska Native Tribal Health Consortium, and others have been involved in discussing the proposed changes in the oral health care system for Alaska Natives. To obtain a wider view of the issue, the ADA asked four nationally recognized dental care experts to examine and make recommendations on the current and proposed oral health care systems. This report represents the group's independent views; it has not been approved or modified by the ADA. The members of the ad Hoc Panel and their contact information are seen in Attachment A.

The two primary data sources used in this report come from the Indian Health Service - the oral health of the Alaska Native populations[1] and from the Southcentral Foundation of the Alaska Native Medical Center – dental delivery system organization, staffing, utilization, and expenditures. Attachment B presents detailed information on the Southcentral Foundation system. Information provided by different informants on other Alaska Tribal dental systems varied widely. Thus, the analyses presented in this report will probably have to be adjusted as more data become available on individual Tribal programs.

**II. Problem Definition**

Epidemiological studies indicate that the 125,000 members of the Alaska Native community have a significantly higher prevalence of untreated decay,

periodontal diseases and their sequelae - pain, infection, and missing teeth - than other US populations. In the early half of the 20th century, Alaska Natives had one of the lowest dental caries experiences in North America. The incidence and severity of dental caries significantly increased as traditional lifestyles and dietary habits changed (e.g., canned drinks).

It appears that the current dental care system has not been able to effectively prevent and treat oral diseases in this population. The problems are especially acute for the approximately 50 percent of the population that lives in remote villages not accessible by roads.

There are multiple, separately organized and managed, delivery systems that provide personal dental services to the population. Overall, the system appears adequately funded and has sufficient numbers of licensed dentist positions to provide care, but operates with varying levels of effectiveness. Some important limitations in the current system include: 1) many dentists are assigned by the Indian Health Service or are contractors and do not have a long-term commitment to living and practicing in Alaska; 2) there are too few allied dental health personnel and operatories per dentist; 3) few providers are village-based staff who can provide culturally competent and continuous community and personal level services; 4) there are insufficient local training programs to prepare dental residents, hygienists, dental assistants, etc. who have a long-term commitment to serving Alaska Native populations; and 5) the productivity and efficiency of the current system is variable and can be improved substantially.

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[1] The 1999 Oral Health Survey of American Indian and Alaska Native Dental Patients: Findings, Regional Differences and National Comparisons, Indian Health Service, 2000.

**III. Alaska Native Tribal Health Consortium (ANTHC) Plan**

Faced with an acute oral health problem, the ANTHC developed a new strategy to provide preventive and therapeutic services to the significant segment of the population residing in remote villages that are only accessed by plane or boat. The plan calls for the establishment of locally recruited dental health aides to live in the villages and provide community and personal level preventive oral health services. This strategy has excellent potential to reduce the incidence and prevalence of disease and to provide the community with continuous, culturally competent care.

Another plan feature is training locally recruited dental therapists to permanently reside in the villages and provide screening, pain and infection management services, personal preventive care, and some restorative services to patients under the indirect supervision of dentists. The new system is supported with grant funds from multiple Medical Foundations and is in the process of being implemented. The effectiveness of the new system will not be known for several years.

In this proposal, COHPs replace therapists on the dental team. These new dental personnel have considerable potential, if they are integrated into an effective delivery system for villages. Specific recommendations for this new auxiliary are included in the next section of this report.

**IV. Recommendations**

The ad Hoc Panel offers several recommendations for consideration by the ANTHC leadership. In order of priority, they include:

**1. Improve the Effectiveness and Efficiency of the Delivery System**

Although the ANTHC plan has the potential to improve access to care and oral health in villages, it does not address the larger problem of the overall effectiveness of the dental delivery system for the entire Alaska Native population. In this regard, the dental care delivery system run by the different Tribal corporations can be greatly improved with a relatively modest investment in new facilities and allied dental health personnel. The basic problem faced by the ANTHC system is common to many safety net dental delivery systems. The productivity of dentists is low, because of inadequate investment in dental operatories, allied health personnel and financial incentive plans for personnel. A related issue may be the need to put more resources into the management of the delivery system. This includes experienced managers, training programs, information systems etc. Further, many operational efficiencies may be realized if the different Tribal corporations worked cooperatively in the management of the overall system. To this end, the ANTHC should consider the formation an over-sight organization to coordinate the management of the different Tribal dental care systems. In the initial phases of this effort consultants from the dental profession and industry should be used as needed. As seen in the financial analysis section, without additional dentist positions, it should be possible to provide care to 65 percent or more of the population, annually.

**2. Integrate Dental Health Aides and Community Oral Health Providers into Village Delivery System**

As previously noted, the proposed system for villages developed by the ANTHC has many advantages. The ad Hoc Panel believes that the system could be made substantially more effective with some modification and expansion of the role of COHP and with a greater focus on the integration of the dental health aides and COHPs into the village delivery system.

In terms of organizational position, the COHPs should be assigned to a cluster of villages to serve around 2,000 residents. COHPs should have a dental assistant to provide personal services efficiently and at least two dental health aides for the delivery of community and personnel level prevention programs. Two or more specific dentists should be assigned responsibility for the clinical management of each COHP village dental team and should visit the villages periodically to provide dental services. The dentists should be in frequent communications with their COHP and should have an on-call schedule to deal with emergencies. The dentists and the COHP team should be responsible for assuring that most village residents are screened, receive appropriate educational and primary and secondary preventive and treatment services annually.

In terms of clinical responsibilities, COHPs and dental health aides should screen at least 85 percent of residents twice per year, provide primary and secondary preventive treatments for caries and periodontal diseases, remove gross tooth decay where appropriate and insert temporary filling materials or sealants using the Atraumatic Restorative Treatment (ART) techniques (with or without minor removal of caries-destroyed dental tissues using hand instruments

or a small round bur in a slow speed handpiece), treat mild periodontal diseases by prophylaxes and scalings, and manage acute pain and infection under the direction of dentists. The proposed use of COHPs to restore teeth with permanent filling materials is not an appropriate use of their time and skills. Because of the severity of disease and complexity of treatment commonly seen in this population, COHPs will have insufficient skills to permanently restore a large percentage of carious teeth. They will have a greater impact on the oral health of Alaska Natives by preventing and controlling caries and periodontal diseases with the described clinical duties. This approach will also be more cost-effective, based on studies published by the World Health Organization on the use of advanced dental auxiliaries in rural areas.[2] A letter from the Pan American Health Organization supporting the use of ART and offering to collaborate in training of COHPs in this technique is seen in Attachment C. Finally, COHPs can be trained in Alaska to provide these services in approximately 12 months.

In terms of management responsibilities, COHPs should direct the activities of the dental team assigned to local communities (i.e., dental health aides and assistants), integrate dental programs with the overall plan for local medical and public health services, and organize the activities of the periodic dentist visits to villages. A more detailed description of the clinical and management roles of COHPs is presented in Attachment D.

[2] ART is successful as a long-term temporary restoration (1-2 years) for Class I and Class II restorations (Frencken JE, Holmgren CJ. ART: A minimal intervention approach to manage dental caries. Dent Update 2004;31:295-8).

In addition, an effective management structure needs to be in place to integrate these new allied dental health personnel into the overall village delivery system. Thus, the current system of dentist visits to villages needs to be modified to make better use of these resources. The changes recommended in the overall dental care system for villages, including the integration of dental health aides and COHPs, are presented in Appendix E.

**3. Establish Training Programs**

Clearly, the long-term success of the delivery system for the 125,000 Alaska Native population depends on recruiting, educating, and retaining a local workforce that is committed to working in Alaska and is culturally competent to serve the needs of this population. Although beyond the scope of this report, a major effort needs to be made to:

- Recruit Alaska Natives into the dentistry, hygiene, COHP, assisting and dental health aides.
- Establish residency training programs in Alaska Tribal hospitals for general dentistry and the recognized specialties of dentistry.
- Develop managerial training programs to prepare the personnel needed to manage the dental delivery system.

**V. Financial and Outcome Analyses**

The ad Hoc Panel presents two options for increasing the overall capacity of the dental care system to serve the needs of the Alaska Native population. There are many variations on these two options, and they are presented to provide a framework for further discussion of these issues.

Further, as already noted, estimates of the number dentists, operatories, and allied health staff in the other Alaska Tribal programs varied widely. As such, the Panel recognizes that the numbers used in the analyses may not accurately reflect the current situation. As such, additional analyses may be necessary.

Options

1. Have the other Alaska Tribal programs operate at the same level of efficiency as the Southcentral Foundation. This organization has recently made a major and successful effort to improve the efficiency and productivity of its dental delivery system. The details are provided in Attachment B.
2. Have the other Alaska Tribal programs operate at the same level of as the Southcentral Foundation (Option 1) and establish COHPs and dental health aides in villages.

Current System Configuration

Table 1 compares the delivery configuration for the Southcentral Foundation region with the other Tribal programs (combined).

**Table 1**
**Current Dental Delivery System Configuration**

| Foundation | Population | Dentists | Operatories | Assistants | Hygienists | Other Staff |
|---|---|---|---|---|---|---|
| Southcentral | 45,000 | 26 | 52 | 64 | 8 | 27 |
| Other | 80,000 | 36* | 47 | 50 | 10 | 56 |
| Total | 125,000 | 62 | 99 | 114 | 18 | 83 |

*15 positions are open and being recruited.

Compared to the other Alaska Tribal programs, the Southcentral Foundation has more dentists per eligible and more operatories, assistants, and hygienists per dentist. Under this configuration, the Southcentral Foundation treats 47.2 percent (actual) of the eligible population annually and the other Alaska Tribal programs about 33.0 percent (estimation based on 36 dentists). Compared to the national private sector dental delivery system, the current system (Southcentral Foundation and Other) for Alaska Natives has far fewer operatories and allied health staff per dentist.

Approximately 60,000 of the 125,000 eligibles live in 200 villages that cannot be accessed by road. For this population, dentists and their staff need to fly to the villages periodically to provide services. These villages will be the base of operations for the dental health aides and COHPs. It is estimated that the villages range in size from 60 to 1,400 residents and that 200 villages need to be served. The analysis assumes that one COHP team that includes at least one COHP, one dental assistant and two dental health aides will have responsibility for managing several contiguous villages, totaling an average of 2,000 people. Some unknown percentage of people living in remote villages obtain dental care when visiting central area clinics. For this analysis we assume that 25 percent of village residents will receive care in these clinics. This reduces the target population that needs therapeutic services from 60,000 to 45,000.

Increase System Capacity

**Option I - Configure other Alaska Tribal Programs Similar to Southcentral Foundation**

This will require building 25 more dental operatories and employing 40 more dental assistants and one more hygienist. The other Alaska Tribal programs appear to have adequate numbers of administrative staff.

**Option II – Add Dental Health Aides and COHPs to Option I**

Twenty three dental COHPs teams, eight in the Southcentral Foundation and 15 in other Alaska Tribal programs will be employed and assigned with dental aides and a dental assistant to serve the 200 villages. It is assumed that the COHP teams will operate (actually see patients) 200 days a year and treat at least 20 patients per day. This includes services provided by the two dental health aides and the COHP working with a dental assistant. Thus, each dental team can be expected to provide 4,000 visits per year and to serve about 1,700 patients, based on 2.32 visits per person. Thus, some 85 percent of the target population will receive screening, prevention, and therapeutic services by the COHP teams.

Impact on Utilization

Table 2 presents the expected impact of the two options on utilization rates.

**Table 2**
**Impact of Options on Utilization rates**

| Utilization | Current System | Option I | Option II |
|---|---|---|---|
| **Southcentral Foundation** | | | |
| Visits | 49,398 | 49,398 | 81,398 |
| Patients | 21,250 | 21,250 | 34,850 |
| % Utilization | 47.22 | 47.22 | 77.4 |
| **Other** | | | |
| Visits | 62,000 | 68,397 | 128,397 |
| Patients | 26,600 | 29,423 | 54,923 |
| % Utilization | 33.0 | 36.8 | 68.7 |

Compared to the current system, Options I and II lead to major gains in visits and patients treated. If the other Tribal programs filled their 15 open dentist positions, they would approximate the Southcentral Foundation utilization rates. The Southcentral Foundation dental program has made a first step in addressing the core problem of dentist productivity and has made a large investment in more operatories and allied dental health personnel that has led to major gains in utilization. Both the Southcentral Foundation and other Tribal programs could increase their efficiency substantially more with the addition of more operatories and allied dental health personnel per dentist.

Impact on Expenditures

This analysis of expenditures for the two options is based on current labor costs and does not take into account the impact of prevention programs on

reducing oral disease levels and the demand for care. This analysis also does not account for the costs of training more allied dental health personnel and administrators. The focus is on labor costs, since they account for a large percentage of clinic operating expenses. All labor costs include salary, 30 percent fringe benefits, and a 20 percent productivity bonus payment that 50 percent of clinical providers are expected to achieve.

**Table 3**
**Additional Labor Costs for Two Options to Improve Alaska Tribal Dental Delivery System**

| Personnel | Current | Option I | Option II |
|---|---|---|---|
| Dentists | $26,688,000 | $26,688,000 | $26,688,000 |
| Dental Assistants | 3,402,560 | 5,103,840 | 6,197,076 |
| Dental Hygienists | 1,630,800 | 1,721,400 | 1,721,400 |
| COHPs | - | - | 2,083,800 |
| Dental Health Aides | | | 1,736,500 |
| Totals | 31,721,360 | 33,513,240 | 38,426,776 |

## VI. Implementation

The ad Hoc Panel recommends that the ADA and other dental organization provide the ANTHC technical support in the design and implementation of a more effective oral health care system. The ADA and other dental organizations should also work with the ANTHC to gain political support in Alaska and nationally for building the training and delivery system infrastructure needed to implement this plan.

The major advantages of this proposal are:

- It addresses both the immediate and long-term needs of the Alaska Native population.

- The delivery system remains in the exclusive control of the Native Corporations and the ANTHC.
- The proposed system employs Alaska Natives in remote villages, since they are best able to understand the needs of the population and provide culturally competent, continuous care.
- It greatly improves access to care for village residents.
- It increases the effectiveness and efficiency of the overall system for all Alaska Natives.
- It is sustainable over time.
- It provides a standard of care that should be available to all Americans.

**Attachment A**
**Members of ad Hoc Panel**

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The American Dental Association provided travel support for the panel for one meeting and a small stipend, $6,000 total, for the Panel.

**Attachment B**
**Southcentral Foundation Dental Delivery System**

The Southcentral Foundation, a non-profit Native corporation, took over the management of the dental program in 1997 and mandated a new approach to meeting the needs of the Anchorage Service Unit. The first part of the solution was to become more efficient in delivering dental care. The historical typical model was one chair, one dentist, and one assistant. A dental management consultant group Accelerated Practice Concepts, Inc. was hired to evaluate the efficiency of the dental care system. Their assessment was that more efficient models needed to be developed, and additional capacity was needed to meet the needs of the population in the Anchorage area. The new more efficient models were first applied to school aged children. For example, the "school exam" model utilized three chairs, three dental assistants, one dentist, and one hygienist. The children received bitewings, a panorex radiograph, oral hygiene instruction and disclosing by the dental assistant. The hygienist provided supra and sub-gingival scaling and pre-charts with the assistant. The dentist completed the exam and helped this team provide definitive care (e.g. simple fillings, extractions, or sealants) on all three of the children appointed during that hour. The Southcentral Foundation supported enhancement of an in-house dental assistant training program. This program utilizes credentialed dental educators teaching Native students. During 2004, 36 assistants were trained to meet the needs of the program. The Southcentral Foundation agreed to build a "state of the art" paperless and digital 27 chair dental facility on the campus of the Alaska Native Medical Center, and the facility was completed July 2003. Utilizing adult models developed by Accelerated Practice Concepts and a small increase in staff, the Fireweed Dental clinic raised its productivity substantially (Table B1).

**Table B1**
**Productivity of the Southcentral Foundation Dental Program**

| | FY 00/01 | FY 01/02 | FY 02/03 | FY03/04 |
|---|---|---|---|---|
| Oct | $1,055,911 | $1092,271 | $1,324,842 | $1779,034 |
| Nov | $904,029 | $906,015 | $1,284,458 | $2,238,720 |
| Dec | $795,965 | $987,231 | $1,257,157 | $2,200,947 |
| Jan | $962,561 | $1003,009 | $1,255,611 | $2,611,374 |
| Feb | $923,067 | $1018,945 | $1,195,912 | $2,548,926 |
| March | $1,000,909 | $1,166,836 | $1,224,683 | $2,887,142 |
| April | $1,008,464 | $1,203,598 | $1,298,466 | $2,957,660 |
| May | $1,087,680 | $1,274,903 | $1,092,131 | $2,515,743 |
| June | $880,120 | $1,076,595 | $947,756 | $2,594,972 |
| July | $826,956 | $1,182,749 | $1,179,183 | $2,817,816 |
| Aug | $1,102,474 | $1,230,075 | $1,049,614 | $2,823,880 |
| Sept | $884,319 | $1,122,983 | $1,166,877 | $3,039,033 |

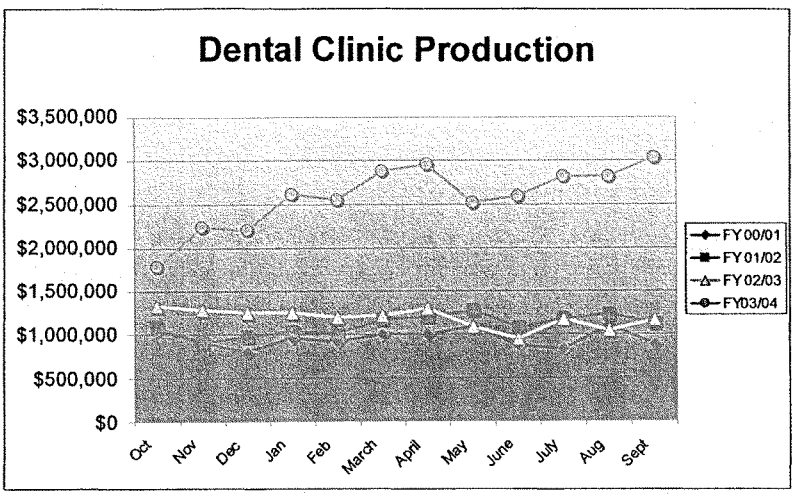
| | | | | |
|---|---|---|---|---|
| Total: | $11,432,455 | $5,367,545 | $14,276,690 | $31,015,247 |

The impact of increased efficiency and capacity (50 chairs) has been noticed by those seeking care. Children can usually make an appointment for routine care within three weeks. The adult backlog of care is still notable with most adult patients waiting six weeks for routine care. The emergency care is very efficient with 30 to 40 patients per day treated utilizing four chairs. The electronic record with digital radiographs also provides increased efficiency and communication between the two dental clinics. The productivity of the village delivery system is also enhanced by delivering care with two or three chairs and dental assistants.

The Southcentral Foundation also purchased and equipped a dental operating room at ANMC, reducing the waiting time for pediatric full mouth reconstruction. There are now less than 200 patients on the wait list, and it is decreasing. The Foundation also entered into an agreement to with Lutheran Medical Center in Brooklyn, New York to institute a residency program to train more pediatric dentists. This program will begin July 2005 with two residents and another two will be selected in 2006. The hope is to place more pediatric dentists in Alaska communities and to further reduce the backlog.

The costs to bring in dental efficiency experts (APC), train dental assistants, implement paperless/digital technology, and fly more equipment and staff to the villages are substantial. The Southcentral Foundation's ability to build a 27 chair clinic and a full-time dental operating room speak to its commitment to meeting customer needs. These improvements have resulted in better access and high staff morale and retention. The following graph (Figure B2) shows the dramatic increase in productivity when the efficiency models were implemented along with the additional capacity of the Fireweed clinic's 27 chairs. No additional staffing has been added since 2002.

**Figure B2**
**Productivity Increases in Fireweed Clinic**


Dental Clinic Production
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Oct
Nov
Dec
Jan
Feb
March
April
May
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July
Aug
Sept
FY 00/01
FY 01/02
FY 02/03
FY03/04

Pan American Health Organization
Regional Office of the World Health Organization

Technology and Health Services Delivery
Health Services Organization

IN REPLY REFER TO: THS/OS (ORH) 28.1 (028-05)

17 March 2005

Dr. Amid Ismail
University of Michigan
Cariology, Res Sci & Endo
2361 Dent
Ann Arbor, MI 48109-1078

Dear Dr. Ismail:

I write to you concerning the position of the Pan American Health Organization for the ART dental technique and or activities in the Region on that matter. We have been very excited to hear about the possibilities of the ADA utilizing this technique among others in the development of a new dental professional as part of your recommendations to address the challenges of the profession for the future.

PAHO as the regional office of the World Health Organization, began to endorse and promote the ART technique shortly after the endorsement the WHO in 1998. Indeed we presented a proposal for funding to the Inter American Development Bank and since April 2000 have been conducting one of the largest oral health studies in order to determine the comparative cost effectiveness of ART and amalgam for use in the public oral health programs in various settings in Latin America. The Proyecto PRAT which will be ending this year.

It is true to say therefore that over the past 5 to 7 years PAHO has been vigorously promoting ART for use in the public oral health services of the Region. We have also been pushing hard for the inclusion of this technique as part of the curriculum of dental schools in the Region. A partial list of the development of ART under the leadership of PAHO is as follows.

The direct training by PAHO of over 150 dentists and auxiliaries in over 12 training courses in the last 4 years. These courses have taken place in Ecuador, El Salvador, Mexico, Nicaragua, Panama, Trinidad and Uruguay.

The adoption by a number of countries of the wide scale use of ART in their public oral health services. Uruguay was the most recent having developed a plan with PAHO's assistance in January of 2005 to begin implementation in March of 2005. Mexico earlier has developed a plan to implement over 20 million ART restorations over a 3 year period.

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**Attachment D**
**Role of the Community Oral Health Provider**

The COHP is a member of a team that includes dentists, hygienists, dental health aides, and dental assistants. The COHP works and lives in a village and is assigned responsibility for a cluster of villages with a total population of about 2,000. The COHP works with one or more dental assistants using both portable and fixed dental equipment.

The primary objectives of COHPs are health promotion and disease prevention and management. They identify resources and develop networks with other social and health providers in the villages; design and implement group, as well as individually tailored oral health prevention programs that are integrated with other general health promotion activities in the villages; identify opportunities for fluoridating the water; educate and train other healthcare providers on how to screen for and advise residents to promote oral health.

As dental providers, COHPs provide screening and preventive services, temporary treatment of caries (ART), and treatment of mild periodontal diseases. Under the direction and approval of dentists assigned to lead the village dental team, COHPs manage pain and infection in emergency situations when dentists are not available.

With the epidemic of severe dental caries in Alaska, COHP training should focus on community-based health promotion, prevention, triage, emergency care, and temporization (ART). They should: 1) have training in community health and be a major advocate for oral health; 2) be assigned and evaluated based on progress in promoting oral health and reducing the burden of disease; 3) serve around 2,000 residents in contiguous clusters of villages; and 4) work with and under the general supervision of two or more specific dentists. The supervising dentists should define in writing the specific duties for each COHP, based on his/her clinical skills and the needs of the population.

In summary, COHPs, directed by dentists and assisted by dental health aides and dental assistants, should provide these services:

<u>Children (school-based)</u>

- Screening and treatment triage
- Prevention of incipient lesions (secondary prevention)
- Prophylaxis
- Education (diet and self care)
- Sealants
- Fluorides
- Atraumatic Restorative Treatment (ART)
- Emergency dental care for pain/infection under direct dentist supervision.

Adults

- Examination, detection, and assessment
- Treatment triage
- Primary and secondary prevention of caries
- Prophylaxis and scaling
- Atraumatic Restorative Treatment (ART)
- Emergency dental care for pain/infection under direct dentist supervision.

**Attachment E**
**Integration of Community Oral Health Provider**
**Into Village Dental Delivery System**

**Village Size:** The following plan is for large villages with 500 or more residents. For smaller villages the staff, equipment, and other resources are reduced, but the operating principals remain the same. Since most villages have fewer than 500 residents, two chairs will be the most common configuration.

**Chairs in Village:** 4 -5 (portable and/or fixed)

**Prior to visit:** Then COHP team take x-rays, screen all children and adults, provide personnel preventive services (e.g., sealants), excavate caries and place temporary restorations (ART), provide prophylaxes and scalings for children and adults with mild periodontal disease, estimate dental team treatment time, and schedule patients for treatment by the visiting dental team.

**Visiting Dental Team:** Dentist, dental hygienist, and three dental assistants.

**Visit:**

- Dentist verifies screening exams, prepares teeth for permanent restorations, completes complex restorations and assigns simple restoration placement and finishing to specially trained dental assistants and provides other services as needed.

- CPHP and hygienist provide local anesthesia for dentist's patients and hygienist provides prophylaxes/scalings to patients with moderate to severe periodontal disease.

- Dental assistants support dentist, insert and finish permanent restorations, and assist dental hygienist.

- COHP – Organizes patient visits and assists dentist and hygienist as needed.

**Team Productivity:**

- The combined team of dentist, hygienist, COHP, dental health aides, and dental assistants are expected to treat at least 30 patients per day.
- The team will remain in the village until all scheduled and available patients are seen.
- The team will visit each village or grouping of villages at least two times per year.

**After Team Visit:** COHP (and dental health aides) follows-up on high risk patients with intensive preventive services (e.g., fluoride varnish, prophylaxes, education) and directs community education programs.

ADA

American Dental Association
www.ada.org

July 28, 2005

The Honorable Byron L. Dorgan
United States Senate
Washington, DC 20510

RE: Response to Questions for Indian Health Care Improvement Act (S. 1057) Hearing on July 14, 2005

Dear Senator Dorgan:

This letter is in response to three questions posed by your office to me as the American Dental Association's witness at the July 14, 2005 joint hearing on the Indian Health Care Improvement Act, S. 1057.

Question 1

Dr. Brandjord, can you discuss the trend line in the dentist-to-population ratio? Do we as a nation, as a whole- not just Native America- face a shortage of dentists? Is it true that the number of dentists who retire each year is greater than the number of new dentists who graduate from dental school?

**Q1a.** Can you discuss the trend line in the dentist-to-population ratio?

Our projections show the workforce productive capacity will increase more rapidly than the U.S. population. We follow the actual number of dentists and the dentist-to-population ratios very closely. These are important data in their own right, but it is critical to look deeper and interpret these ratios in light of other important relevant factors to make them more accurate for workforce analysis. Using unadjusted ratios can lead to inaccurate conclusions, especially when looking at changes and trends in the workforce over time. For example, the unadjusted ratios do not take into consideration changes in the demand for dental care and the productive efficiency of dentists, both of which change, often very significantly.

Similar to what is happening in the overall U.S. economy, dentistry is experiencing notable increases in productivity. Computers, the internet, more automated accounting and practice management software are improving the efficiency of dental practices, as are improved dental materials, employment of additional and better-trained staff, and more and better equipment. Reduction in the prevalence of oral diseases is changing the nature of dental practice. Using raw population-to-dentists ratios overlooks all of the changes in

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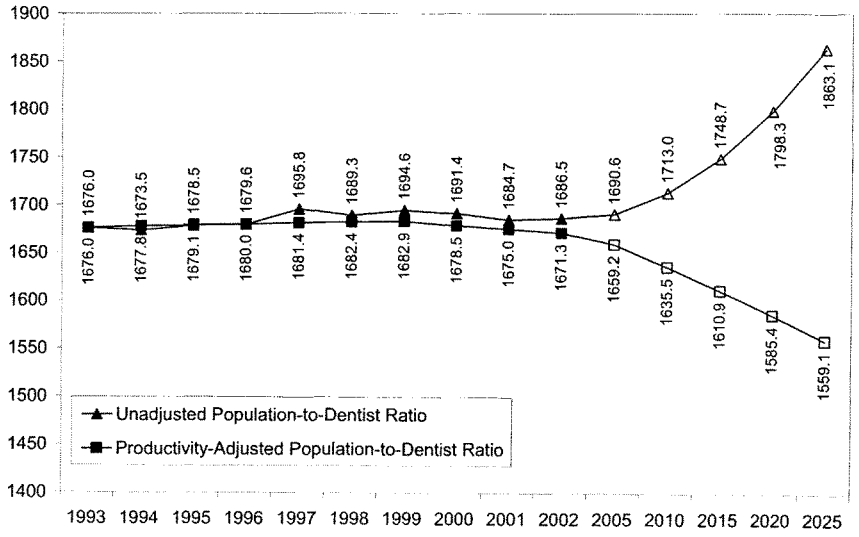
the capacity of dentists to provide dental care and can lead to profound miscalculations regarding the number of dentists required to service the American population.

To account for these important changes, we adjust the raw population to dentist ratios for changes in dental productivity. The impact of increases in productivity is apparent in the graph displayed below. The unadjusted population-to-dentist ratios indicate that the number of dentists in relation to the size of the population will decrease between 2005 and 2025. As illustrated above, that single data item neglects all of the significant relevant changes that have occurred and will continue to occur in dental practice. Analysis by a well-known team of economists indicates that dental productivity has been increasing by 1.12% annually. The graph shows that, when adjusted for very reasonable and sustainable growth in productivity, the dental workforce productive capacity will increase more rapidly than the U.S. population.

Figure 1: Actual and Projected Population per Active Private Practitioner Ratios, 1993-2025



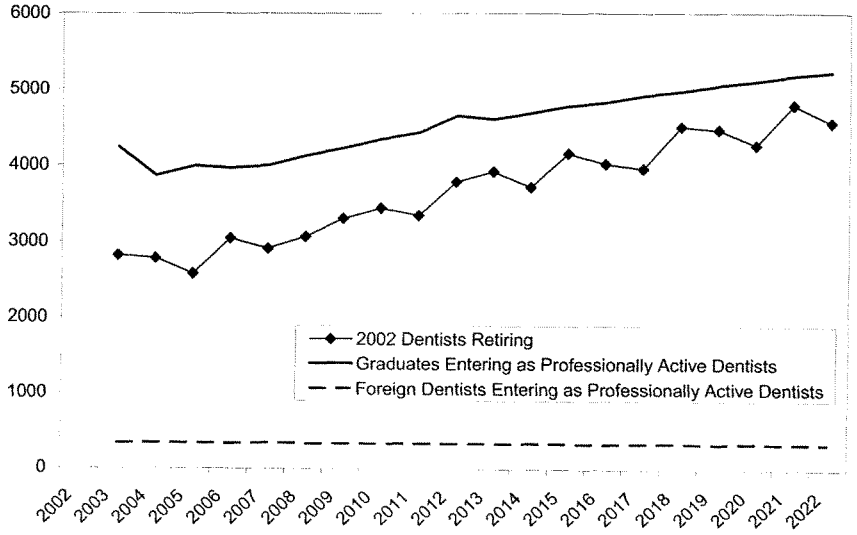

**Q1b.** Is it true that the number of dentists who retire each year is greater than the number of new dentists who graduate from dental school?

No. It is a common misperception that the number of dentists leaving practice is now and will continue to be greater than the number entering practice. Our data indicate this is not the case. The graph below shows that the number of dentists entering practice each year will continue to exceed the number of those leaving practice for the next twenty years. While the difference will narrow over time, the number of new dentists is expected to exceed the number leaving practice throughout the next two decades.

One reason some believe that the number of dentists leaving practice will be greater than the number entering practice in the future may be concern regarding the retirement of "baby-boom" dentists. During the 1970s and early 1980s, a large increase in the number of dental school graduates occurred, stimulated by growth in the number of dental schools and federal support for dental education. Dentists trained during that period will be reaching retirement age during the next twenty years.

However, enrollments in dental schools increased by over 15% between the early 1990s and the present. This increase is providing more dental school graduates each year. The ADA records the age of retirement of all retired dentists in the U.S. The retirement age of dentists is increasing gradually. Our forecasting models predict that this trend will continue (see Figure 2) because people are staying healthier longer and because many dentists, who are self-employed, are working longer to ensure adequate retirement funds.

Figure 2: Actual and Projected Number of Dentists Entering and Leaving Active Practice, 2002-2022



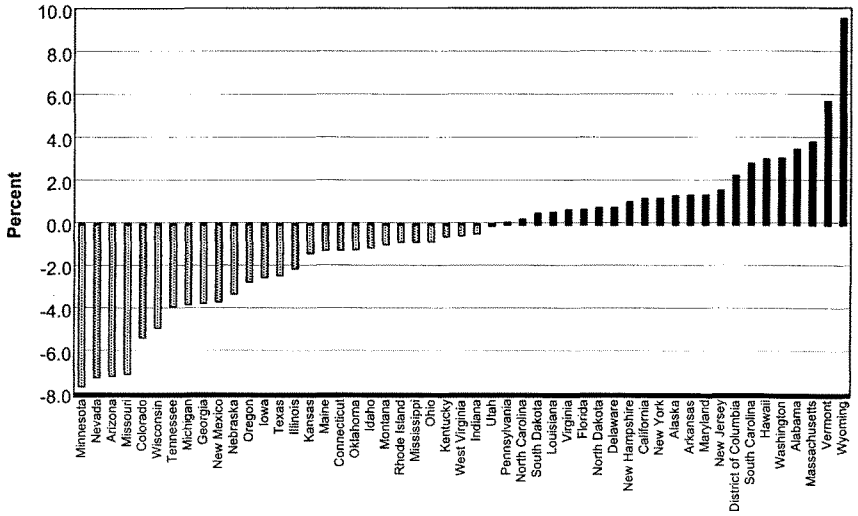
**Q1c.** Do we as a nation, as a whole- not just Native America- face a shortage of dentists?

No. The dental workforce for the nation as a whole should be sufficient. Near-term and long-term outlooks for the affordability and accessibility of dental care for the majority of Americans remain excellent, a situation that owes in no small part to dentistry's outstanding record of prevention, efficiency and cost-control. The answer to question #1a showed that the productive capacity of the dental workforce is likely to increase more rapidly than the U.S. population. This provides only part of the necessary information to assess the overall adequacy of the Nation's dental workforce. The growth in the demand for dental care must also be considered. The increase in capacity can accommodate the most likely growth patterns in dental demand. This means that the percent of the population that goes to the dentist can increase by 10%-15% in the next twenty years and the available dental workforce will have the capacity to provide that care. The amount of dental services needed among those who currently go to a dentist can also increase by 10%-15% in real terms and the workforce can still provide that care. Alternatively some combination of these two factors can increase by the same amount and the delivery system can accommodate the increase.

During the last decade, neither factor has increased at the rate that was just described. Consequently, the national dentist workforce will likely be adequate to respond to the demands placed on it. However, there are no final answers to workforce assessment. Circumstances can change. Unforeseen events could shift the dental workforce requirements in either direction. If major new programs are enacted (e.g., increased funding for disadvantaged children and adults), if unexpected declines in dental school graduates occur, or if productivity does not increase, the adequacy of the workforce will require re-evaluation. The nation and the dental profession must follow the national workforce trends carefully and be ready to act when circumstances warrant action

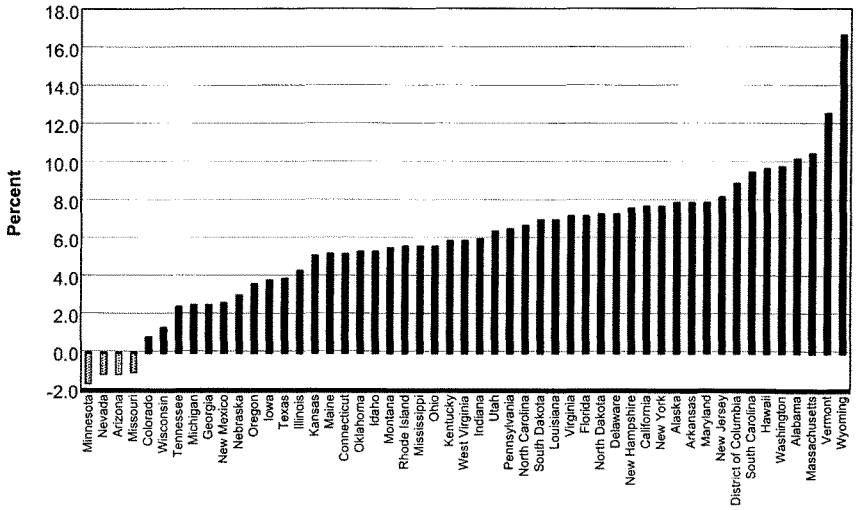
On the other hand, a recent analysis suggests that regional imbalances exit. These regional imbalances can be seen in Figure 3, which shows the percentage change in dentist-to-population ratios by state from 1993 to 1999. In about half of the states there was an increase in the number of dentists per 100,000 population and in about half there was a decrease. Some of the changes were modest, while others were relatively large. One factor contributing to these imbalances is that the population in the Sun Belt states is growing much more rapidly than the population in the rest of the country. Several rapidly growing states, such as Nevada, Arizona and Georgia, saw their dentist-to-population ratios decline although they registered large increases in the number of dentists. Their populations were simply growing too quickly for the increase in dentists to keep pace.

Figure 3: Percentage Change in the Dentist-to-Population Ratios, by State, 1993-1999




The previous graph shows the unadjusted dentist-to-population ratios for states. The following graph (figure 4) shows the state ratios adjusted for productivity improvements. The rationale for this adjustment was discussed earlier. The graph shows that most states experienced an increase in productive capacity, resulting in an adjusted increased dentist-to-population ratio.

Figure 4: Percentage Change in Productivity-Adjusted Dentist-to-Population Ratios, by State, 1993-1999




Imbalances due to growth are likely to be temporary. Market forces will respond to these imbalances over time and will reduce them. However, some areas of the U.S., including those where many Native Americans reside, have relatively few dentists to serve their populations and market forces alone are not likely to be sufficient to redress their imbalances. As detailed in our July 14 testimony, the ADA supports federal funding for loan repayments for Indian Health Service dentists and other approaches to increase the number of dentists available to provide care to Native Americans.

Question 2

Dr. Brandjord, ADA's objection to the provision of irreversible procedures by dental health aide therapists, as I understand your testimony, appears to be based on the concern that dental health aide therapists will provide substandard or unsafe care. Is ADA aware of any specific examples of substandard care provided by dental therapists in New Zealand or Canada or anywhere else where the therapist model has been used for many years?

You are correct that the ADA opposes Dental Health Aide Therapists (DHATs) performing irreversible surgical dental procedures due to our concern for patients' safety. Concerning the therapist program in New Zealand, where the Alaska DHATs are trained, J.W. Friedman of the New Zealand Division of Dental Health has stated "We are first rate technicians, not second rate dentists." [1] The ADA believes there is more to being competent than simply acquiring an acceptable level of clinical proficiency, especially when one is being asked to make significant health care judgments that could have life threatening consequences. A dentist's training involves more than manual training and that knowledge is critical in safely managing untoward events that could unexpectedly arise while performing extractions, pulpotomies (similar to root canals), and drilling teeth. Based on their limited training, the ADA does not believe DHATs have the requisite background to handle some of the emergencies that could arise. This is especially true for DHATs practicing in remote villages.

Evaluation of the use of dental auxiliaries from one country to another is difficult because a "dental nurse" and "dental therapist" do not have universally agreed upon definitions. Some would be classified as "dental assistants" in other countries and from country to country there is a variance of the conditions under which they are permitted to work. For example in Great Britain, a country which does not have the geographical challenges of Alaska, before a therapist begins treatment, a dentist must examine the patient, diagnose the condition and plan the treatment. Therapists in New Zealand predominately work in schools with relatively easy access to dentists. So, it is misleading to say that 42 countries have some form of a dental therapist, implying they are very similar to the Alaska DHAT. The bottom line is Americans enjoy the highest standard of oral health care in the world. That is the standard that should be emulated by tribal decision makers as American Indians and Alaska Natives deserve no less.

Question 3

Are there any circumstances under which the ADA would support the provision of irreversible procedures by a non-dentist?

Permitting non-dentists to perform the irreversible surgical procedures that the Alaska DHATs may be permitted to perform is in direct conflict with the ADA's Principles of Ethics and Code of Professional Conduct. The ADA believes there is a better way. As stated in our testimony on July 14, the ADA supports innovative approaches to getting Alaska Natives the care they need, such as the proposal of Drs. Bailit and Kovaleski and others that would make the current delivery system more efficient and envisions the use of a new support person – Community-based Oral Health Providers.

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[1] Dunning JM. Deployment and control of dental auxiliaries in New Zealand and Australia. J Amer Dent Assoc 1972; 85:618-26.

More generally, the Association supports appropriate expansion of duties for dental team members. In fact, the Association currently has a task force reviewing present and future workforce issues within the profession with a particular eye toward addressing the access barriers facing the underserved populations in our country.

Sincerely,

Robert M. Brandjord, D.D.S.
President-Elect

RMB:TS:nh

**Submitted by Richard Brannan**
**Chairman, Northern Arapaho Tribe**
**Before the Committee on Health, Education, Labor & Pensions**
**United States Senate**
**Hearing on Indian Healthcare Improvement Act**
**July 14, 2005**

## THE FACE OF HEALTHCARE ON THE WIND RIVER RESERVATION

Putting a face to the healthcare problems on the Wind River Reservation discusses the problems faced by two Tribal members – Francis Brown, and Elder, and Marcella Hope Yellow Bear, a child. Francis was unable to receive treatment for his brain tumor because of lack of funding, and Marcella was abused and killed by her parents, who were methamphetamine addicts. Both of these cases demonstrate the need for more funding for treatment and prevention programs on the Reservation.

## HEALTH DISPARITIES OF THE NORTHERN ARAPAHO

This discusses the enormous disparities in health problems when Reservations are compared to the rest of the United States. Examples cited are a 770% higher rate of alcoholism, a 650% higher rate of TB, a 420% higher rate of diabetes and a 91% higher rate of suicide.

## HEALTHCARE PROBLEMS AND PRIORITIES

This gives a listing of the most widely accepted healthcare problems and priorities on the Wind River Reservation and Indian Country in general. There is a list of 19 separate priorities, ranging from issues with Contract Health to tobacco use.

## INDIAN HEALTH CARE GENERALLY

This is a more detailed discussion of Indian health care in general. It suggests changes with direct clinical services, contract health, community health services, budgets and loans, facilities and related support, elderly and youth programs, family and domestic violence programs, veteran programs and gender issues.

## ELDER HEALTH AND LONG TERM CARE

This discusses the fact that the life expectancy for Indians is significantly shorter than the average U.S. citizen, and calls for better access to IHS services for the elderly, increased funding for preventative programs and dental care, and assistance with Medicare and Medicaid certification.

## HOUSING & SOCIAL SERVICES

This very briefly points out the need to improve housing and sewer and water facilities.

## CONCLUSION

Chairman Brannan expresses his support for S. 1057 and asks for full funding.

**Submitted by Richard Brannan**
**Chairman, Northern Arapaho Tribe**
**Before the Committee on Health, Education, Labor & Pensions**
**United States Senate**
**Hearing on Indian Healthcare Improvement Act**
**July 14, 2005**

**THE FACE OF HEALTHCARE ON THE WIND RIVER RESERVATION**

There are many statistics that justify the need for improving healthcare on the Wind River Reservation and Indian Country in general. I have listed a number of them in my written statement and I know you will hear them from others. What I want to spend my time here today doing is trying to put a face on the problem.

My testimony is in honor of Francis Brown, a respected Elder and ceremonial leader of the Northern Arapaho Tribe, and Marcella Hope Yellow Bear, a baby; both of whom died needlessly because of a lack of funding. Both of them suffered terribly.

Francis had 4 brain tumors. When he went to IHS for assistance, he was told there was no funding to help him get the care he needed.

Marcella Hope Yellow Bear was 18 months old when she died. Her entire short life was one of torture and pain. According to the newspaper accounts, she had an open hole through her chin, numerous broken bones, and burns on her body and the bottoms of her feet. She was found hanging from a coat hook in a closet. Physically abused and tortured. It was like someone shot an arrow through my heart when I was told.

Both of these deaths could have been prevented – the system – and all of us failed them because of lack of adequate funding.

For his entire life Francis Brown was one of the cultural and ceremonial leaders and elders of our Tribe. Among his many contributions, he helped preserve our medicine wheels and other sacred sites. His early loss robbed not only his family, but our Tribe of his cultural and ceremonial knowledge.

Marcella was a beautiful, innocent little baby – our hope for the future. In our Tribe we believe children are sacred, because they are not yet tainted by the world. Yet she was tortured

and killed by her own parents – both members of our Tribe, because of their addiction to methamphetamine. Those drugs, and others, including alcohol, are the scourge of our Reservation. As you can see from these two painful examples, we need funding for both prevention and treatment.

I am here today to give my support to Senate Bill 1057, but also to remind you of the need to fully fund it, and to remind you of the trust responsibility of the United States to Indian Tribes.

**HEALTH DISPARITIES OF THE NORTHERN ARAPAHO**

The Northern Arapaho Tribe has approximately 7,943 enrolled tribal members. The average family size is numbered at 4.5 (please note this family size is identified as persons living in the same dwelling and does not reflect out of home placement, extended family situations and kinship patterns which alter the make up of the family). Also, in the latest census figures, there is an indication that the make up of the Reservation residents is a much younger population with the average age being 23.4 years of age, with well over 4,000 children 18 years of age and younger.

Pressures to continue and reduce the costs of providing health care, especially in the area of diabetes, have had a major impact on the practice of medicine and will increasingly shape the way care is provided as our population ages. The Indian Health Service (I.H.S.) has struggled since its' inception in 1955 to provide adequate health care to Indian people and Alaska Natives and raise the health standards of American Indians and Alaska Natives, but they cannot do it alone. The Northern Arapaho contracts with I.H.S. to provide services to our enrolled members and other eligible under P.L. 93-638.

As an example of the extent of the health problems on the Wind River Reservation, here are a total of 736 diabetics serviced by our Northern Arapaho Diabetes Awareness Program. We contract with the state of Wyoming to provide diabetic services to the people we serve. We also partner with other agencies, such as Colorado State University and our own Wind River College in our campaign against the deadly disease of diabetes. We also work with our Community Garden project to encourage our people to grown their own food for a better diet and better eating life styles. Historically, Northern Arapaho people maintained traditional teachings and

practices which promoted health, prevented diseases and provided curative care to each tribal member. Often times we shared these with other tribes as they, too, shared theirs'. We want to share these practices with the I.H.S. medical staff and the approaches of modern medicine through Northern Arapaho ceremony, ritual, faith and herbal remedies. This way needs to be preserved and integrated into health systems. However, we need to be cautious so as not to exploit our Northern Arapaho practices.

Nationwide, the disparity in health and healthcare for Indians is staggering. The rate at which Indians are more likely to die from certain diseases ranges from 52 % for pneumonia and influenza, to 770% for alcoholism. Our people also suffer from diabetes at a rate 420% higher than the general population and tuberculosis at a rate 650% higher. In addition, our death rate from accidents is 208 % greater than the rest of the United States. Sadly, we also have a suicide rate that is 91% higher than the overall rate in the United Sates, with our young people (ages 15 to 34) the hardest hit. The life expectancy of an Indian in America is 5 years less than the general population.

The rates on the Wind River Reservation appear to reflect the national rates, and we are currently setting up our own data system that is tribal specific to Northern Arapaho to capture these statistics and study the possible causes. We want to advocate for a data collection/research center for the Northern Arapaho Tribe and the state of Wyoming. This would allow studies on diabetes and other illnesses that are specific to the Northern Arapaho Tribe as well as other health issues. We presently work with other state agencies and programs on the Wind River reservation, such as going into the schools and working with school staff and testing for conditions the are early indicators of diabetes. One such condition is Acanthosis Nigricans, which is a dark ring around the neck or patches of dark skin, which show up in American Indian and A.N. children. We also sponsor fun-walks in our Indian community on the reservation and work with the state staff in and around the area regarding diabetes issues. For the Northern Arapaho people, kidney transplants may become a reality for those with kidney disease in the near future. As a consequence, we hope to begin preparations for this possible outcome.

**HEALTHCARE PROBLEMS AND PRIORITIES**

On the Wind River Reservation specifically, and throughout Indian Country in general, there are a number of healthcare problems. In this statement, I will not go into a detailed discussion of each and every one of these problems, but will attempt to highlight a few. What follows here is a list of those problems that have generally been identified as the greatest priorities on our Reservation and in Indian Country.

To give you some feel for the magnitude of the problems, allow me to expand just on the fist one, Contract Health. In fiscal year 2005, on my Reservation, slightly less than $3,000,000 was obligated. Yet, over $6,000,000 was denied and another $3,000,000 was deferred.

1. Contract Health
2. Diabetes
3. Alcohol/Substance Abuse
4. Pharmacy
5. Heart Disease
6. Cancer
7. Mental Health
8. HP/DP
9. Injuries
10. Dental
11. Information Technology
12. Obesity
13. Elder Health Care
14. Maternal/Child Health
15. Respiratory problems
16. Chronic Disease
17. Lack of adequate EMS
18. STD's
19. Tobacco Use

**INDIAN HEALTH CARE GENERALLY**

It seems that each time the Arapaho tribe negotiates for health care monies; they face the threat of Indian health care being reduced as the federal budget grows, as administrative and FTE cuts are mandated and as IHS is forced to compete with other agencies for reduced amounts of discretionary dollars. The growth rate of the Arapaho tribe is moving at a fast pace and we are told that IHS funding will be cut but we are expected to meet the Healthy People 2010 Objectives. There has been specific health status objectives for Indian people included in the current Indian Health Care Improvement Act. We fully support those health status objectives, and offer the following suggestions additional suggestions:

1. Indian health status will not be met by funding a handful of projects with discretionary grants from agencies scattered throughout the Department. To best meet community needs of the Arapaho tribe, funding must come directly to tribal programs.
2. IHS budget must be adequate to provide care and preventative services to Indian people.
3. How is the IHS budget arrived at? Who determines the formula for IHS funding? The Arapaho tribe feels they are left out when decisions concerning the IHS budget(s) are made. We need to be included in all discussion(s) concerning IHS funding and once again we emphasize the principle of FULL DISCLOSURE. Some views the Arapaho tribe has about the IHS budget are:
    a. DIRECT CLINICAL SERVICES:
        i. When mandatories are presented to the Arapaho tribe, appropriate monies will be included for compensation.
        ii. Third party billing will not be counted to offset budget.
        iii. Whenever new building or additional construction to health facilities occurs, monies to provide for full staff will result along with operations and maintenance.
        iv. Increase in monies to the Arapaho tribe will address population growth. The Arapaho Tribe has a total population of 7,920 as of July 2005. At present, there are 20 applications for enrollment per month; thus far, all have been approved. If this trend continues, there will be a substantial population

increase in the near future.

b. CONTRACT HEALTH:
   i. The budget must adjust for medical inflation identified by the Bureau of Labor Statistics, Consumer Price Index.
   ii. Increased monies to address population growth.
   iii. The Catastrophic Health Emergency Fund will be budgeted at a level that **equally** covers all qualifying cases.
   iv. Research dollars should go directly to the tribes.

c. COMMUNITY HEALTH SERVICES:
   i. Appropriate increases in monies to compensate for all government mandates.
   ii. Increase in monies to match population growth.
   iii. Full funding to meet full staffing of new or additional building at health facilities.
   iv. Increases to meet demands of Amendments to the Indian Health Care Improvement Act.

d. BUDGETS AND LOAN:
   i. Any reduction in IHS budget will not impact on the direct delivery programs.
   ii. To assure Indian representation in the health professions, the scholarship and loan repayment program will increase.
   iii. Any monies designated as budget saving will be put in Contract Support coffers.
   iv. Monies will be available for all necessary contract support costs associated with 638 and self-governance tribes.

e. FACILITIES AND RELATED SUPPORT:
   i. The Arapaho tribe is in need of more medical staff, buildings and equipment to house them. This is especially true for the needs for more dentists optometrists, and podiatrists. As the Arapaho tribe has a high disproportionate number of diabetics to general population, we feel the need for more support to address this deadly disease. Diabetes often leads to

dialysis or amputation and with the amount of people on dialysis; we feel we need a dialysis center. The special diabetes grant will certainly help to fight this deadly disease but after funding for diabetes runs out; where do we go from there?

ii. There are two sites served by Tribal Health; one site is at Arapahoe and the other site is at Ethete. We have two buildings or modulars. The Ethete site houses the Tribal Health Administration, CHRs. The Arapahoe site houses the CHRs and other special programs. There are 10 employees at the Ethete site and 8 at the Arapahoe site. These are modular buildings and are going on their fourth year housing the Tribal Health programs and will need some major repair before too long. We are looking for permanent structures to house our Tribal Health programs.

iii. Transportation is a real problem for Tribal Health. We transport locally and out of state for medical and substance abuse issues. The CHRs do most of the transporting. Not too long ago, OMB felt the CHRs were nothing more than taxi cab drivers and as a consequence, the CHR budget was cut nationally. The Arapaho CHRs need to be relieved of this burden. At one time, at the early inception of HIS in 1955, this was their responsibility - patient transport. Throughout the years, this responsibility has shifted to the Tribe. We need to shift this responsibility back to IHS or be funded for more positions for transporters along with medically equipped transportation vehicles, medivacs and EMTs. The issue of liability is always there. According to our 638 contract we are not to transport out of our Service Delivery Area, which is basically the reservation but we do transport because our local IHS refuses to do so. We cannot let our Arapaho people suffer because of official ignorance.

f. ELDERLY:

i. The Elderly on the Wind River reservation need appropriate renovation/additional building to the nursing home on the Wind River reservation. Both the Arapaho and Shoshone members use Morning Star

Manor, a nursing home operated by the Shoshone tribe. Included in this need is more medical staff, specialized gerontology training and nutritional training to meet elderly needs. The elderly that choose to remain in their homes should be provided for in building repairs to their homes if needed or homes built for them. Most Arapaho Elderly choose to remain in their own homes.

g. YOUTH:

i. The youth of the Arapaho tribe also need buildings for preventive type activities. This includes space for recreation. There is a shortage of buildings or space to provide recreational activity for our youth on the Wind River Reservation. Again there is a demonstrated need for more dollars in this area. We need stronger programs geared to prenatal and newborns. The Northern Arapaho people feel that our newborn and young children are gifts and blessings from the Creator and we need take good care of them. Quality medical/nutritional care is a must for prenatal, babies and children. Absence and neglect of child restraints is a problem as evidenced by death and injury of our babies and young children. Parents cannot afford to purchase child restraints and other protective devices used in automobiles. This issue needs to be addressed.

h. FAMILY AND DOMESTIC VIOLENCE:

i. Family and Domestic violence is an issue that needs attention on the Wind River reservation. Certain programs address the problem of violence and abuse but to adequately house victims is a problem of social services program on the reservation. We need more dollars to address this growing social issue.

i. GENDER ISSUES:

i. Men and women health issues programs are needed, special clinics for men — i.e., prostate and colon cancer awareness; for women, mammography, breast and cervical cancer. More concern and awareness about sexually transmitted diseases should be a concern of I.H.S. and Tribal

Health agencies. We need successful community based programs directed at health issues for men and women. Included in this should be efforts to reach our youth about this awareness and concern.

j. VETERANS PROGRAM:

i. The Arapaho Tribe has a high number of veterans. Many of these veterans qualify for services through VA clinics and hospitals. A veteran's office on the Reservation could coordinate these services for our veterans. The Northern Arapaho tribe has a homeless veteran's program but needs enhancement. We need to provide counseling services to our veterans on benefits and entitlements of which many of our veterans qualify for.

**ELDER HEALTH AND LONG TERM CARE**

In 1972, the life expectancy for American Indians was 60 years of age. By 1990, life expectancy for Indians has increased to 73 years of age and by the year 2000 is expected to be just 3.4 years less than the general population of the U.S. Indian people are living longer; however, Indian elders comprise a major risk group for poor health, chronic disease, limited income, high medical expenditures, institutionalization and an increasing need for long term care. There is a need for improved and quality health care for the elderly on the Wind River reservation.

**SUGGESTIONS:**

1. Initiate demonstration project in which IHS and the Arapaho tribe will share the responsibility of the delivery of long-term care in a government-to-government partnership basis.
2. IHS must work closely with other DHHS and Federal agencies to focus funding and program development on Indian elder needs. The Arapaho tribe must receive direct funding.
3. IHS must improve access to IHS services and medical coverage by developing:
   a. Geriatric training for community health and clinical staff and fund home health positions.

b. Increased funding and give high priority to requests for more dentists, optometrists, and podiatrists and other specialized disciplines.

c. Expanded preventive services to elderly and include well-elder clinics in community education programs.

d. Clinical and community health outreach services to tribal operated long term care facilities.

4. Medicare and Medicaid Certification. The Arapaho tribe should be allowed flexibility in design and operation of home and community based long term care to meet the needs of the elders and to improve their functioning within the community. Medicare/Medicaid receipts will be used to maintain accreditation standards. Issues involving Medicaid/Medicare should be discussed/explained to the Arapaho people on the reservation by knowledgeable and component government representatives by establishing focus groups. Most Arapaho people do not understand the discount card. Some of our children who are in treatment in another state qualify for this program.

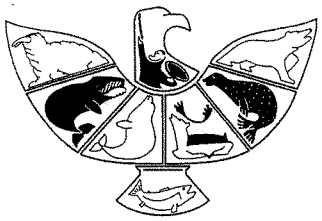
## HOUSING & SOCIAL SERVICES

Our living conditions continue to be poor. In addition to more housing we need to improve our sewer and water treatment facilities. There is a great need for additional access to low cost loans so that more of our people can obtain housing. Along with this goes the need for improved social services. Better childcare and greater access to mental health are two important needs.

## CONCLUSION

While much remains to be done on the Wind River Reservation and in Indian Country generally, much progress has been made. Infant mortality and maternal mortality has been significantly reduced. Deaths caused by homicide and accidental deaths have been reduced. One of the biggest gains has been made in tuberculosis, where a 53% reduction was made on Indian Reservations in the ten-year period of 1987 to 1997.

Still more remains to be done. Senate Bill 1057 is a good first step. While it may not offer everything we would hope for, it does make a great step forward. I am here to lend my support to the proposed legislation, and hope that the next step will be to fully fund the programs that are so desperately needed on our Reservations, and to ask the United States to live up to its Trust Responsibilities with regard to healthcare.



**Alaska Native Health Board**

101 Constitution NW, Ste 8B02 Phone: (202) 742-4430
Washington, DC 20001 Fax: (202) 742-4285

**July 14, 2005**

**TO: Chairman McCain and Chairman Enzi**
**Senate Committee on Indian Affairs**
**Senate Committee on Health, Education, Labor and Pensions**
**109th United States Congress**
**Washington DC 20510**

**RE: Written testimony for Trudy Anderson, Alaska Native Health Board President/CEO**

**INTRODUCTION**

Good afternoon, I am Trudy Anderson. I serve as the President/CEO for the Alaska Native Health Board. I am Inupiat and Yupik; I am an enrolled tribal member of the Nome Eskimo Community. The Alaska Native Health Board (ANHB) is a 23-member board entity, consisting of tribally elected or selected representatives of Alaska's Native regional health organizations and is recognized as the statewide Native voice on health care issues. The purpose of our organization is to "advance the spiritual, physical, mental, social, cultural well-being and the pride of Alaska Native people,"

The State of Alaska is 586,000 square miles and makes up approximately 1/5 of the landmass of the entire United States. There are 229 tribes in Alaska, making up almost ½ of the tribes in America.

ANHB is comprised of 23 member organizations. These organizations either have Title I contract or Title V compact with the Indian Health Service to carrying out health care delivery in their area. Alaska is the only area in the nation where 99% of health programs are managed by Native organizations. The ANHB brochure provided to you lists the entities.

The Alaska Native Health care is delivered through a referral system.

As you may already know, are the Community Health Aide Practioner's (CHA/Ps) are the backbone of the system. There are approximately 500 CHA/P local employees working in 178 communities. They serve as the first responders, along with Village Public Safety Officers, to any situation.

When a patient needs a higher level of care, they are transported to one of six regional hospitals (as available in the area). The six regional hospitals are located in: Barrow, Kotzebue, Nome, and Bethel. Dillingham and Sitka.

The flagship statewide hospital – the Alaska Native Medical Center – serves as the final referral facility. This is the only level II trauma center in the State of Alaska. If specialty services are not available at ANMC, patients will then be transferred to a private facility.

It is important to note that Native health organizations not only serve a Native population. They are – in many areas – the only health service providers available.

The Alaska Tribal Health System represents diverse organizations and Alaskan people. Because we have 229 federally recognized tribes that live across 586,000 miles of road less land, it was crucial for to develop this innovative and essential statewide health system.

**DENTAL CRISIS**

- Alaskan children suffer from tooth decay at 2-1/2 times the national rate. 1/3 of school children miss school because of dental pain and 25% report avoiding laughing or smiling because of the way their teeth look.

- The number of Alaska Natives has doubled since 1970 and there is an epidemic of dental caries in Alaska Native villages.

**TRAINING**

The Alaska Native Health Board endorsed the Dental Health Aide Program to begin planning, certification, and drafting standards. Experienced Public Health Dentists, local community members, Community Health Aide Practitioner Directors and Aides, attorneys and other experts convened to carry out ANHB's directive to create a Dental Health Aide Program. We now are at the stage that individuals have been trained and are now in their preceptorship training in regional hospitals with dentists. Dental therapists have a two-year training program and dentists train four years. The dental therapy program has a more clinical focus to learn the competencies within their more limited scope of practice. The dental health aide therapist's competence assessments are equal to the requirements of an accredited dental school.

There is bi-annual recertification for the dental therapists where they are required to demonstrate their clinical competencies. A 3-month or longer preceptorship under a dentist is required before dental health aides are allowed to practice independently. The DHAT is then able to work under a consultation/referral with the dentist who supervised their preceptorship. This preceptorship is more stringent than what is required by other dental professions. All Alaskan tribal health programs, including the dental health aide program, are scrutinized independently by national hospital accreditation organizations. Dental professionals in private practice are not held to same standard.

**RECRUITMENT/RETENTION**

In 1991, a dental manpower study was conducted in Alaska. If the IHS/Tribal health system doubled the number of dentists, it would take 10 years to eliminate the unmet need for dental services.

For the 85,000 Alaska Natives who live in the 200 villages without road access, the only time dental services are available is when a dentist flies in to conduct a dental clinic. Alaska Tribal Health Programs experience a 25% vacancy rate among dentists and a 30% average annual turnover rate. Tribal health programs have increased their dental budgets above the IHS allocation of funds so that they could increase salaries. But dentists don't choose to live in remote, isolated communities or to travel nearly every week by small planes to even more remote villages to conduct clinics in buildings without even running water.

**"VOLUNTEER PROGRAM"**

There have been suggestions that having dentists volunteer would provide a viable solution to the dental problems of rural Alaska. The proposed volunteer program suggested by the American Dental Association would not be effective in reducing the rate of dental disease. One of the issues with the volunteer program is that there is no continuity of care for the people of the villages. Volunteer dentists would not be able to develop a long-term relationship with the population that they serve. The dental therapists are Alaska Natives from the rural community and have strong ties to the community. They will provide a more consistent basis of care. Alaskan Natives will be empowered to take care of their own people.

Another issue that has been brought to our attention is that the American Dental Association has approached Congress requesting an appropriation through the Indian Health Service to fund this 'volunteer' program. As you may already know, the Indian Health Service continues to be 40% under funded. We feel the ADA is misleading the public and congressional representatives when claiming they have a solution to address our dental disparities.

**PUBLIC HEALTH SUPPORT**

Other organizations with a profound interest in public health –but no profit motive—have all come out in support of the Dental Health Aide Therapist program. These include the Indian Health Service, under director Dr. Charles Grim, himself a dentist. The Alaska Department of Health and Social Services, who's Commissioner, Joel Gilbertson, said (DHAT) "holds great promise for addressing the profound dental problems of rural Alaskans, and we applaud Congress for giving the program a chance to demonstrate its potential for success."

In addition, the American Association of Public Health Dentistry and the Oral Health Section of the American Public Health Association both support of the Dental Health Aide Therapy program in Alaska. The support of these national public health dentistry associations illustrates the fact that only private dentists oppose the Dental Health Aide Therapy program. Private dentists have a financial motivation; public health dentists are motivated to elevate the dental health for the betterment of the general public.

**SUMMARY**

- **The Dental Health Aide Program is a local solution to a local crisis**. This program will be as

successful as the Community Health Aide Provider Program is because of local residents receiving training, employment, and providing high quality care to their community.

- Dental health aides will have had as many hours of educational clinical experience in the limited number of procedures as most dentists receive during their educational program.

- Dental health aides is **supported by telemedicine access** to the dentist who will be able to actually view the same tooth and x-rays that the DHAT is examining.

- Dental health aides are **subject to biannual recertification** and continuing education requirements.

- Mid-level providers have been successful in delivering other types of health care.

- Due to the distance and isolation of these communities, dental care is only offered on a very basic level. With dental health aides to address these basic needs, then the dentist would have more time to perform root canals, dentures, crowns, bridges, and orthodontics.

- Dental therapists will be able to raise dental awareness. Once the overall general dental aptitude is increased then the need for re-treatment would be reduced.

- **Is there any evidence that the Dental Health Aide Therapy program is effective**? DHAs are new to the United States, but New Zealand has a 75-year history of success in using dental health paraprofessionals. The World Health Organization shows that dental health aide/therapists now work in 42 countries, including Australia, Hong Kong, Great Britain, and Canada. After Canada started its program, the ratio of teeth pulled to teeth fixed dropped from over 50% to less than 10%. A thorough study of the Canadian effort compared the work of dental therapists and dentists and found that the quality of restorations by therapists equals that of dentists.

- While DHAs are new to the US, a role model exists in medicine -- the Community Health Aides. The Community Health Aide Program has been used as a model by President Bush to address the HIV/AIDS crisis in South Africa and to build a health system in Afghanistan. It is proven that CHAPs have had a major impact on increased access to general medical care.

- Dental Therapists will also positively impact dental health care in Alaska.

# Seattle Indian Health Board

*A Multi-Service Community Health Center for Medical, Dental, Mental Health, Substance Abuse, and Community Education.*

TESTIMONY
U. S. Senate Committee on Indian Affairs
U. S. Senate Committee on Health, Education, Labor, & Pensions
Thursday, July 14, 2005
430 Dirksen Senate Office Building
Washington, D.C. 20510

Mr. Chairman.

My name is Ralph Forquera. I am the Executive Director for the Seattle Indian Health Board, a position I have held since January of 1990. I am also the Director for the Urban Indian Health Institute, a division of the Seattle Indian Health Board established in July of 2000 to conduct research and perform epidemiologic studies on the health of urban Indians. I am an enrolled member of the Juaneno Band of California Indians, a state-recognized Indian tribe from the San Juan Capistrano region of southern California.

The Seattle Indian Health Board is a community health center, established in 1970 as a free clinic in what was then a U. S. Public Health Service Hospital in central Seattle. We are currently under a contract and hold several grants from the Indian Health Service under Title V of the Indian Health Care Improvement Act. We are one of 34 such non-profit, Indian-controlled corporations that contract with the Indian Health Service under Title V.

Twenty of the 34 existing urban Indian health organizations offer direct health care. The remaining 14 programs provide health education, information and referral assistance, and other services designed to improve access to health care. In addition, urban Indian health organizations play an important cultural role in many cities by offering programs and services that are culturally-appropriate and socially acceptable to the wide array of Indian people living in cities. In my organization in Seattle, we serve Indian people from over 150 American Indian tribes and Alaska Native villages each year. The role of providing an identifiable and culturally acceptable place in American cities for Indian people is an often overlooked effect of these programs that in many ways has become an essential part of the healing process for Indian people who often feel abandoned and isolated in American cities.

According to the 2000 census, the majority of Indian people in the United States now live in American cities. Over 70% of Americans self-identifying as American Indian alone or of mixed race on the census were living in American cities.

The trend toward urbanization has been steady since the 1950s when it was the policy of this nation to relocate Indians into cities in an ill-fated attempt to assimilate Indians into the broader society. Up to 160,000 Indian people were directly affected by the relocation and termination policies. There remains a sizeable number of urban Indians who carry the emotional scars of this

experience with them, in some cases greatly influencing their behaviors and ability to trust government institutions, including our programs.

Little is known about the overall health status of urban Indians across the nation. While urban Indian health has been a part of the Indian Health Service for nearly 30 years, only recently have formal efforts to document the health of urban Indians been attempted.

The lack of available data has made it difficult to defend the need for help in addressing the growing health crisis among urban Indians. However, in March of 2004, the Urban Indian Health Institute released a first national report documenting severe health disparities among urban Indians. Using data from the National Center for Health Statistics and the 1990 and 2000 U. S. Census, data known to be woefully inadequate, the report still found significantly higher rates of illness and identified multiple known risk factors that likely contribute to these findings. The report brought greater attention to the plight of urban Indians and helped us to begin to build interest in looking at the health of this population. The report documented, for the first time, our anecdotal assertions that urban Indians were experiencing ill health in disproportionate numbers. A principle partner in this work today is the Indian Health Service which has now included us as one of the 10 Indian Health Service regional tribal epidemiology centers – ours being the only center with a national focus on urban Indians.

Title V provides the critical link in recognizing that Indian Country encompasses both reservation and urban communities. The 34 urban Indian health organizations reflect the nature of their local communities. They offer not only services, but a place of Indian identity that is frequently lacking for Indian people in American cities. In the broadest sense of healing, finding a place of belonging and acceptance can have a powerful positive effect on the health of Indian people.

Our ability to focus on Indian people and not be encumbered by the restrictive nature of limiting services to federally-recognized tribal members adds to our capacity to heal old wounds.

Title V is the only direct authority that specifically defines a health care role for the Indian Health Service in addressing the needs of urban Indians. For this reason, Title V is an essential tool in assuring that urban Indians are not forgotten as a group of Americans in need of health improvements.

In the request for my participation in this hearing today, two specific questions were posed for me to address. The first deals with the extension of Federal Tort Claim Act protection for urban Indian health organizations. The second is a concern that has periodically been brought up by the Department of Justice regarding the equal protection provisions of the Constitution and the fact that

urban Indians are not subject to tribal governments with powers of self-governance.

With regard to the Federal Tort Claim Act Coverage issue, similar protections have been extended to community health centers through the Public Health Services Act. Those of us who receive funding through the Bureau of Primary Health Care are already eligible for FTCA protection. It would seem to me that extending this protection to urban Indian health programs would add minimal risk to the government given that many of the current urban programs do not offer direct health care at this time. Inclusion could save considerable expense for those programs who are now purchasing private liability insurance to support their work. The resulting savings could be used to provide needed services.

It should also be noted that the Title V program was crafted using the community health centers as a model. The extension of a similar privilege for another group of federally-sponsored safety net providers seems a fair and equitable action.

With regard to the Department of Justice's concern about equal protection matters, I first need to state that I am not an attorney nor am I professionally trained in this area. However, it seems to me that the enactment of Title V defined a special class of health care provider similar to various special arrangements made through other federal programs like the Federally Qualified Health Center program in BPHC and disproportionate share hospital payment

structure under CMS. Clearly the Federal government has a rational basis for providing funding, tax breaks, and other benefits it deems to be in the interest of the government or society in general and that rational basis should allow such distinctions to withstand an equal protection challenge. In the case of the urban Indian health programs, the Congress has a clear rational basis for its decision to provide programs, services and funding to urban Indians. After all, it was the ill conceived policies of relocaton and termination that led to the the removal of large numbers of Indian people from the reservations to the cities. Congress dealt with Indians as a special class of citizens then and it clearly can and should do so now as it tries to rationally address the consequences of those policies.

The structure of the Title V program, that of using a non-profit, Indian-controlled corporate structure, offers the full benefits of the self-determination principles called for in President Nixon's Special Message to the Congress in July of 1970 that forms the foundation of today's federal Indian policy. Successful urban Indian organizations, in some respects, embody the spirit of self-determination. Our use of IHS funds to leverage other public and private resources to extend our capacity to serve urban Indians is exactly what I believe the authors of Title V intended.

It seems clear that the Congress has the authority and the will to direct a program to address identified and documented health disparities affecting urban

American Indians and Alaska Natives. In these times of a rapid change in the health care system in America and the sharp escalation in the cost of health care, the importance of having organizations devoted to assuring access and quality health care for Indian people makes good public policy. It is fitting that the Congress continue this policy by reauthorizing Title V.

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Permit us to continue our effort to raise the health of Indian people, both on and off reservation, to its highest possible level. Provide us with the authority, the guidance, and the financial resources needed to achieve this noble goal.

Thank you for offering me this opportunity to testify today. I will be happy to answer any questions.

AN URBAN INDIAN HEALTH INSTITUTE REPORT

# The Health Status of Urban American Indians and Alaska Natives

## An Analysis of Select Vital Records and Census Data Sources

March 16, 2004

UIHI
Urban Indian Health Institute
A division of the Seattle Indian Health Board

This report was prepared by Public Health – Seattle & King County on contract with the Seattle Indian Health Board's Urban Indian Health Institute.

The Urban Indian Health Institute (UIHI) is a division within the Seattle Indian Health Board (SIHB), a community health center targeting urban American Indians and Alaska Natives. The UIHI provides centralized nationwide management of health surveillance, research, and policy considerations regarding the health status deficiencies affecting urban American Indians and Alaska Natives.

Cover artwork by Joyce Troyer-Willson who is a member of the Tsimshian Tribe from Ketchikan, Alaska. She belongs to the Gishbuwidwada (Blackfish) Clan. Ms. Troyer-Willson served as a member of the SIHB Board of Directors for 10 years and served as Board President from 1985 to 1990. Her portfolio includes a totem pole raised in her ancestral village of Metlakatla, Alaska.

To learn more about the Urban Indian Health Institute and to obtain copies of this report, please go to the website, www.uihi.org.

**Urban Indian Health Institute**
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ACKNOWLEDGEMENTS

The UIHI would like to recognize the Public Health – Seattle & King County for their assistance in making this report possible. We would like to extend a special thank you to Mike Smyser, MPH from the Epidemiology, Planning and Evaluation Unit for all his hard work and dedication to this project.

The UIHI would also like to recognize the Indian Health Service, National Epidemiology Program whose mission is to provide a solid foundation for public health interventions and functions. The UIHI serves as the only urban focused "Tribal" Epidemiology center and is essential to completing the picture of National Indian Health status.

## INTRODUCTION

The Urban Indian Health Institute (UIHI), a division of the Seattle Indian Health Board, was created in July of 2000 as a national center to study health and social problems faced by urban American Indians and Alaska Natives. In spite of a growing awareness that more Indian people now live in American cities than on Indian reservations, federal policy toward Indian affairs continues to focus its information-gathering and financial resources on reservation communities. The UIHI assumed this lack of attention by those responsible for implementing the federal Indian policy had resulted in limited data describing the conditions faced by urban Indians, which subsequently delays successful interventions in urban environments. But this was a hypothesis, not a statement of fact.

To this end, we examined the most often used sources of national data from an urban Indian perspective. We believed we would find both technical problems as well as numeric problems with existing data that would limit its usefulness. But we also felt by gathering and analyzing existing data, we could document the shortcomings of our current understanding of urban Indians and perhaps raise the interest of both public and private authorities that might share in our desire to aid this under-recognized group of Americans.

This report provides a thorough review of national data on urban Indians from the U. S. Census and the National Center for Health Statistics. The report is intentionally limited to the U. S. counties served by the 34 non-profit Indian organizations that contract with the federal Indian Health Service. In reviewing the data, an additional 60 metropolitan areas had large enough AI/AN populations who could potentially benefit from an Urban Indian Health Organization in their area.

The report illustrates some of the difficulties we face in trying to study a highly diverse and geographically dispersed urban Indian population, a fundamental characteristic of urban Indians today. Problems with statistical methodologies as well as the need for a greater sensitivity to confidentiality when dealing with Indian communities show up in the report figures. These are not unique factors to urban Indians, but they show some of the challenges we face as our work progresses.

I wish to thank the Public Health – Seattle & King County for their assistance in compiling this report. Their technical capabilities have taught us a great deal about the scientific difficulties we face. I would also like to thank Dr. Philip R. Lee, former Assistant Secretary for Health during the Clinton Administration and an internationally recognized authority on health policy for giving us a letter endorsing the study. In spite of the shortcomings in the presented data, we believe the findings illustrate that urban Indians face significant health and social problems that are not being adequately addressed by the federal government if the goal of reducing health disparities for minority populations by 2010 is to be achieved.

In the future, the Urban Indian Health Institute will issue other reports and more targeted information to help urban Indian organizations, government agencies, and policy makers with their work. We invite your thoughts, comments, and suggestions on this report and questions that you may have about urban Indians that can help us plan and direct our studies.

Ralph Forquera, Executive Director
Urban Indian Health Institute
Seattle Indian Health Board

STANFORD UNIVERSITY
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(650) 725-0336 • FAX (650) 725-5451

February 2004

To Interested Parties,

Throughout the decade of the 1990s, proposals to address spiraling health care costs and the unequal manner in which health care is delivered in this nation gave rise to a new found recognition of health disparities, particularly among America's poor and ethnic minority populations. In my role as Assistant Secretary for Health, I was privileged to have the opportunity to visit many times with one gravely underserved group, American Indians. To this end, I participated in a series of listening sessions across Indian Country where I learned a great deal about the challenges Indians faced in getting proper health care. One group in particular stood out, the urban Indian.

Urban Indians represent the largest segment of Indian people in the United States. But because they no longer live on Indian reservations, they frequently lose health care benefits promised to them by the United States government for giving up their lands. Many urban Indians struggle with the move to American cities and all too frequently experience poorer health than others and formidable barriers in accessing health care services.

The federal Indian Health Service provides a miniscule amount of money each year to fund non-profit, urban Indian health agencies to help improve access to health care. But as more and more Indians move to American cities, this help never close to adequate becomes merely a drop in the bucket. The lack of adequate information to justify the need for greater assistance has been an excuse used to limit resources directed at urban Indians.

This report, for the first time, documents the severe health disparities experienced by urban Indians. The findings, while limited because of inadequate data and financial sources directed to assist urban Indians, likely underestimate the full extent of the health problems. However, the report clearly shows that urban Indians are at a greater risk of poor health than most other Americans.

As the debate over how to address health disparities in America continues, it is important that the health of urban Indians be added along side reservation Indians and other disenfranchised groups. This report makes it clear that to leave this gravely underserved population from policies and programs designed to address improvements in health care for all Americans is unacceptable. The first Americans should be the first priority in achieving the goal of Healthy People 2010 to eliminate health disparities.

Sincerely,

Philip R. Lee, M.D.
Consulting Professor of Human Biology, Stanford University
and Professor of Social Medicine (Emeritus), Department of Medicine,
and Senior Advisor, Institute for Health Policy Studies, School of Medicine, UCSF

## Report Highlights – At a Glance

At the turn of the 20th century, over one million Americans reporting American Indian or Alaska Native (AI/AN) heritage on the 2000 census lived in 34 urban areas which are currently served by Urban Indian Health Organizations (UIHO) funded in part by the U.S. Indian Health Service. This report briefly reviews selected census, mortality, and birth data in an effort to assess the health status of Urban Indians living in UIHO service areas. Key findings from this assessment include:

***Population Statistics and Socioeconomic Status (SES)***

- Four million Americans indicated on the 2000 census that they were of American Indian or Alaska Native heritage. Of these, nearly 70% lived in urban areas and 25% lived in counties served by UIHO.
- Based on 1999 income, nearly one in four Indians (25%) residing in UIHO areas lived in poverty [i.e., below 100% of Federal Poverty Level (FPL)] and nearly half (48%) lived in households with incomes below 200% FPL. These rates are substantially higher than the rates for the general (all races combined) population (i.e., 14% below 100% FPL and 30% below 200% FPL).
- Similar disparities which may put Indians at a disadvantage with respect to better health and health care access compared to the general population are evident in other socioeconomic (SES) and census indicators (e.g., educational attainment, employment status, single-parent status, disability).
- SES and other census indicators for AI/AN alone or in combination with other races were in general slightly better than the rates for persons reporting AI/AN race alone. However, for all measures examined, significant disparities remained when either group was compared to the general population.

***Maternal and Child Health***

- Over the 1991 to 2000 period, the annual average number of births to AI/AN mothers in UIHO areas was 8,000.
- Over the 1991 to 2000 period, AI/AN mothers living in UIHO areas were less likely than the total for all mothers in these areas to deliver infants with low birth weights. However, several factors that may be associated with poor infant health were more common among children of AI/AN mothers. These factors included: 1) mother's age less than 18 (80% higher than the rate for all mothers combined), 2) single marital status (73% higher), 3) premature delivery (13% higher and increasing over time), 4) late or no prenatal care (115% higher and decreasing), and 5) smoking during pregnancy (61% higher and decreasing).
- Over the period from 1995 to 2000, infant mortality among children born to AI/AN mothers living in UIHO service areas was 33% higher than the rate for all children. This rate has remained level over this time period, while the general rate has decreased.
- Sudden Infant Death Syndrome was the leading cause of infant death among children born to AI/AN mothers living in UIHO service areas. The rate of SIDS was 157% higher when compared to the overall rate for all children combined.

***General Mortality***

- Available mortality data for the period 1990 to 1999 pertaining to Indians living in UIHO service area and nationwide are substantially underreported due to miscoding of Indian race on death certificates.
- Despite racial miscoding on death records, several significant disparities are evident with respect to higher rates of death due to accidents (38% higher than the general population rate), chronic liver disease and cirrhosis (126% higher), and diabetes (54% higher). Alcohol-related deaths in general were 178% higher than the rate for all races combined.

This assessment documents SES and health indicators demonstrating both progress toward better health among Indians living in UIHO areas, and also the existence and continuation of substantial health disparities when compared to the general population. Improvements in data collection pertaining to AI/AN race are urgently needed to better understand the true health status of Indians living both in urban areas and nationwide and to accomplish national goals of eliminating health disparities by the year 2010.

## A. Overview and Methods

More American Indians and Alaska Natives (AI/AN) now live in major metropolitan regions of the nation than on Indian reservations. The 2000 census found that nearly 70% of Americans self-identifying as American Indian or Alaska Native alone or in combination with another race were living in urban areas. In spite of this geographic shift, and because the urban Indian populations in these areas are geographically dispersed and relatively small compared to the general population, little is known about their general health status.

The U.S. Indian Health Service (IHS) has recognized this geographic shift for many years and to better provide services to Indians living in urban areas, has provided funding to non-tribal, non-profit agencies that provide either direct or referral health services to Urban Indians living in 34 major metropolitan urban areas (Figure A-1, and Appendix A-1). These agencies in this report are referred to collectively as Urban Indian Health Organizations (UIHO).

This report examines several sources of data in order to better describe the health status and health needs of AI/AN living in areas served by the Urban Indian Health Organizations.

### Methods

*Types of Data.* Four major national sources of data for which AI/AN race is collected were used. These sources of data include:

1) 1990 and 2000 U.S. Census data,
2) Mortality records derived from death certificates covering the period from 1990 to 1999;
3) Natality or birth certificate data for the period 1991 to 2000; and
4) Combined infant mortality and birth data for the period 1995 to 2000.

Due to the unavailability of infant mortality data for the years 1992 to 1994, only the years 1995 to 2000 were analyzed.

**Figure A-1. Cities with Urban Indian Health Organizations funded by the U.S. Indian Health Service, 2003.**

*Geography.* The smallest geographic unit available to all datasets was the county of residence. Data, therefore, are analyzed according to UIHO service areas that comprise counties designated by each program as the location in which a significant number or proportion of their patients or clients reside (see Appendix A-1 for a list of counties included in program service areas). The combined infant mortality-natality data, however, were further restricted to counties with populations of 250,000 or more based on the 1990 census for confidentiality reasons (see Appendix A-1). In general, it is important to keep in mind that Indians living in counties included as UIHO service areas undoubtedly obtain health services or health referrals from other agencies (including IHS facilities located on reservations) both inside and outside of the local UIHO service area counties. This report, therefore, is intended to reflect only the health status and potential need of Indians living in these areas, and not the care or services provided by the UIHO.

*Race Classifications.* The AI/AN race classification in this report has several variations due to the manner in which this information has been collected. Mortality, natality, and linked birth/mortality data utilize five racial categories (white, black, AI/AN, Asian/Pacific Islander, and Other) as was collected in the 1990 census. Data from the 2000 census, however, allowed for six main racial categories (white, black, AI/AN, Asian, Hawaiian or other Pacific Islander, and Other). The 2000 census also allowed persons completing the census to choose whether they were of mixed racial backgrounds. In this report "American Indian/Alaska Native," "AI/AN," and "Indian" are used interchangeably and, unless otherwise specified, refer to a *single* race category that is applicable, but not necessarily always completely comparable, to all datasets analyzed for this report.

*Calculation of Rates.* In order to make comparisons between populations living in different areas, rates are calculated which generally include the number of events divided by the relevant population. As an example, a mortality rate is calculated by dividing the number of deaths by the population. These rates, however, may be affected by age differences in the make up of the population. In the case of mortality, it would naturally be expected that an area with a large proportion of elderly residents would have a higher death rate than one with a smaller proportion of elderly residents. With the exception of age-specific rates, all mortality rates reflecting the entire population are age-adjusted to a standardized year 2000 age distribution[i].

*Statistical Population Estimates.* Mortality and birth rate populations are calculated using population estimates based on the 2000 census which have been adjusted to reflect 1990 census racial groupings. These estimates, created by the U.S. National Centers for Health Statistics, are called "bridged" race populations.[ii]

*Statistical Significance.* The term "significant" when comparing numerical data implies a statistically significant difference in rates. In this report error margins or 95% confidence intervals (CIs), a measure that reflects the effect of random chance associated with the occurrence of an event, are reported in the appendices. When the CIs of rates being compared do not overlap, the rates are said to be "statistically significant" or unlikely to occur as a matter of random chance.

*Adjustment Factors for Racial Miscoding in Vital Records.* Substantial miscoding of AI/AN race on vital records has been documented.[iii,iv] Although adjustment factors have been developed and used by Indian Health Service at the regional and state levels, these adjustment factors are not used in this report since they were not developed for use at the county level. In addition, the IHS adjustment factors were created by matching death records with IHS patient registries. These estimates of miscoding, therefore, likely underestimate persons who are

not enrolled in the IHS system. This may be particularly true for persons who live in urban settings who either never use IHS facilities or who are not members of Federally recognized tribes who would, therefore, not be entitled to IHS services.

*Disease Classification.* Leading causes of both infant and general mortality in this report are classified using the Tenth Revision of the International Classification of Diseases (ICD-10) which began to be used with U.S. mortality records in 1999. Prior to 1999, data were coded using ICD-9. Since mortality data presented in this report are derived from data which used different systems, all leading causes of death for pre-1999 records have definitions using either ICD-9 or ICD-10 codes and discrepancies that arise between the two systems are adjusted using comparability ratios developed by the U.S. National Centers for Health Statistics.[v]

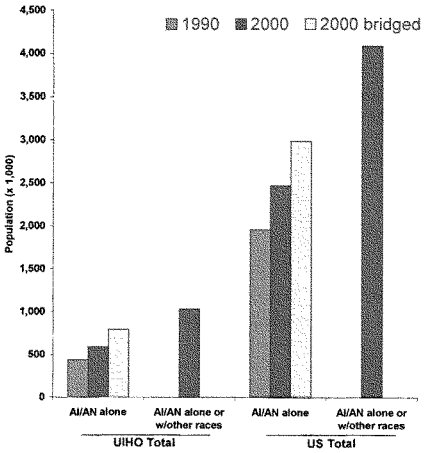
*Analysis Restrictions.* In general, with the exception of census data, data are presented as a ten-year average in the case of mortality (1990-99) and natality data (1991-2000), and as a six-year average for infant mortality records. These averages improve the stability of the estimates and protect individual confidentiality. In addition, mortality and natality data are not presented when the number of events (e.g., births, deaths) for a particular area is less than ten.

*Data Analysis.* The results presented in this report were created using VistaPHw software created by Public Health – Seattle & King County for analysis of vital statistics and census data.[vi]

### B. Population Statistics

- On the 2000 U.S. Census over four million Americans indicated their racial background to be American Indian or Alaska Native (AI/AN) alone or in combination with another race (Figure B-1 and Appendix B-1).
- The 2000 census was the first in the nation's history to allow persons to identify as one or more races. Of those identifying as AI/AN, approximately 60% or two and a half million persons identified as AI/AN alone.
- The 1990 census, however, allowed only one race selection, thus making direct comparisons to the 2000 census difficult. Since many vital statistics measures have depended on the single race designation allowed in the 1990 census, the U.S. National Centers for Health Statistics (NCHS) have developed "bridged" population estimates based on the 2000 census which are in the single race categories similar to the 1990 census. Using these bridged population figures, NCHS estimates that in 2000 nearly three million Americans (an increase of over 50% from 1990) would have been likely to self-identify as AI/AN if they had been asked about their race in the same manner as on

**Figure B-1. American Indian/Alaska Native population living in Urban Indian Health Organization (UIHO) service areas and US Total, 1990 and 2000.**



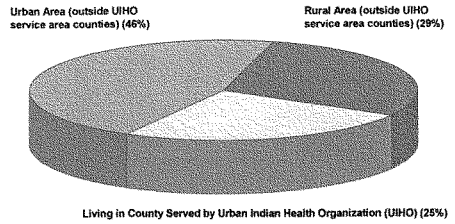

Source: 1990 and 2000 U.S. Census.
Bridged estimates developed by U.S. National Center for Health Statistics (http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm).

the 1990 census (Figure B-1 and Appendix B-1). In addition, nearly 800,000 AI/AN (an increase of over 80% compared to the 439,000 who self-identified as AI/AN in 1990) would be living in UIHO service areas.

- Of the persons who identified themselves as AI/AN alone or in combination with some other race, one quarter (25%) lived in counties served by UIHO (Figure B-2 and Appendix B-2). Another 46% of Indians, however, lived in census defined urban areas which lay outside UIHO service areas.

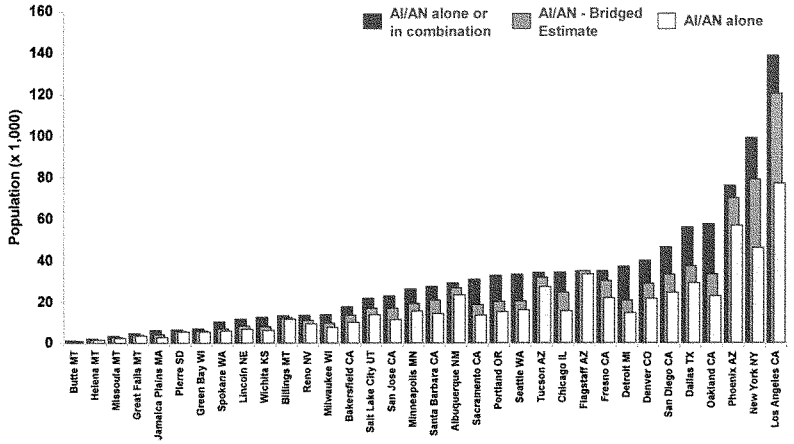
- The population of Indians living in counties served by UIHO varies substantially by location of the organization. Populations of AI/AN alone or in combination with other races range from about 1,000 in the Butte MT area to nearly 140,000 in the Los Angeles CA area (Figure B-3 and Appendix B-1).

**Figure B-2. American Indian and Alaska Native population residing in the U.S., 2000.**




Source: U.S. Census 2000

**Figure B-3. American Indian/Alaska Native (AI/AN) population living in Urban Indian Health Organization service areas, 2000.**

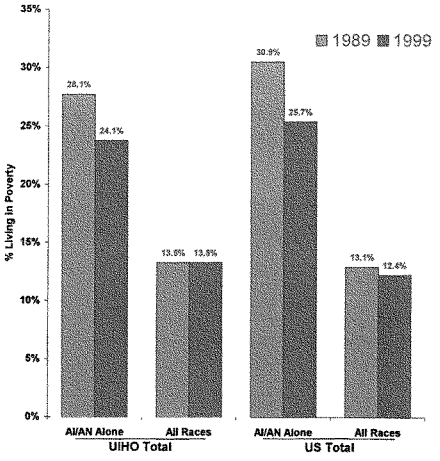



Source: 2000 U.S. Census.

### Poverty Status

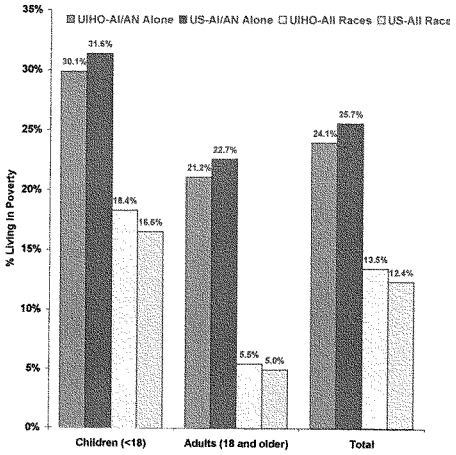
- According to 1999 income reported on the 2000 U.S. Census, nearly one in four Indians (24%) residing in UIHO service areas lived in households with incomes below poverty (Figure B-4 and Appendix B-3). While this rate was lower than the rate recorded for 1989 (28%), it was nearly twice as high as the rate for all persons living in these areas (14%).
- The poverty rate for all AI/AN living in the U.S. was slightly higher than for those living in the urban organization areas (26% and 24%, respectively).
- The highest rates of poverty were among Indian children living in the urban organization areas and in the U.S. as a whole (30% and 32%, respectively) (Figure B-5). These rates were nearly twice as high as the corresponding total populations (18% and 17%, respectively).
- Poverty rates for Indian adults were lower than the rates for children (21% for adult Indians in urban organization areas and 23% for Indians nationwide), but nearly four times higher than the comparable general adult rates (6% and 5%, respectively).
- In 1999, nearly half (48%) of Indians living in UIHO service areas lived in households with incomes below 200% of poverty (Appendix B-4). This rate was similar to the rate for all AI/AN nationwide (51%), but was substantially higher than the rate for the general population (about 30% in both the UIHO areas and nationwide).
- AI/AN poverty in UIHO service areas ranged from 13% in the San Jose CA service counties to 56% in the Butte MT area (Figure B-6, Appendices B-3 and B-4). In all areas, AI/AN poverty exceeded the rates for the corresponding total population (e.g., 8% and 15% in the San Jose and Butte areas, respectively.)

**Figure B-4. Poverty status, 1989 and 1999.**



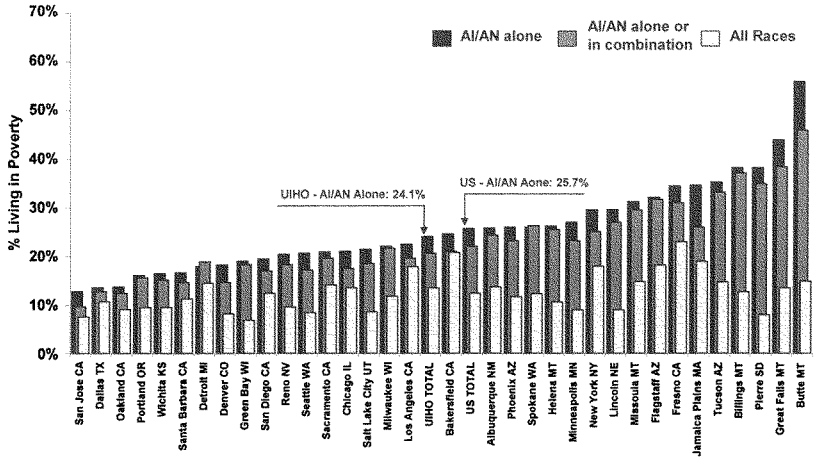

Source: 1990 and 2000 U.S. Census

**Figure B-5. Poverty status by age groupings, 1999.**




Source: 2000 U.S. Census

**Figure B-6. Percent living in households with income less than poverty, 1999.**



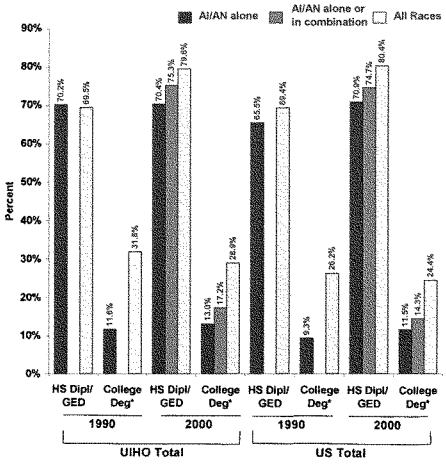

Source: 2000 U.S. Census.

- Poverty among AI/AN alone or in combination with other races was somewhat lower than the AI/AN alone rate, but still substantially higher than the corresponding total rates for all races combined.

## Educational Attainment

- In 2000, about 70% of Indians, age 25 and older, who lived in UIHO service areas and nationwide reported having a high school diploma or GED compared to 80% for the general population (Figure B-7 and Appendix B-5).
- The percentage of AI/AN who lived in UIHO areas and reported having a 4-year college degree or higher, was less than half the rate for the general population (13% and 29%, respectively).

**Figure B-7. Educational attainment (age 25 and older), 1990 and 2000.**

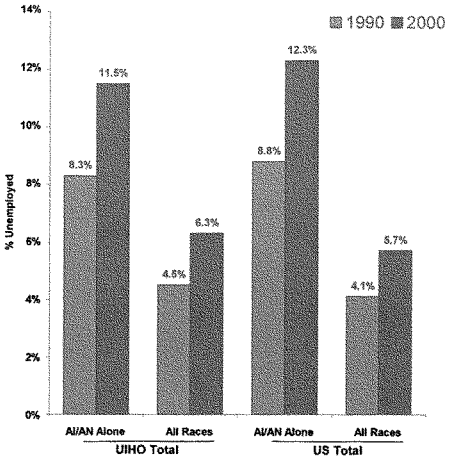



*College degree refers to a four-year bachelor's degree or higher.

### Employment Status

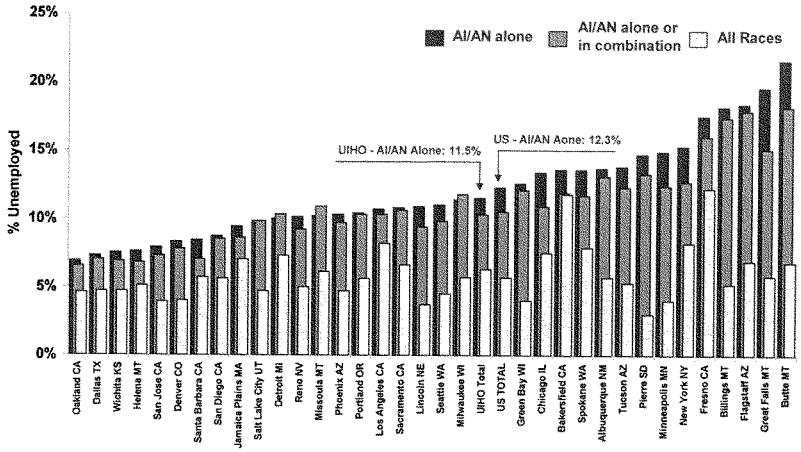
- In 2000, unemployment among AI/AN was similar in both urban and national settings with about 12% of AI/AN reporting not being employed. Unemployment among the total population, however, was half the AI/AN rate or 6% (Figure B-8, B-9 and Appendix B-6).
- In general unemployment rates reported in the 2000 census were higher than those reported in 1990. These differences, however, may have been due to differences in the way employment-related questions were asked on census forms.[vii]
- Unemployment varied greatly by service area with 7% of AI/AN reporting being unemployed in the Oakland CA area and 22% in the Butte MT area (Figure B-9 and Appendix B-6).

**Figure B-8. Unemployment trends, 1990 and 2000.**




Source: 1990 and 2000 U.S. Census

**Figure B-9. Unemployment by service areas, 2000.**

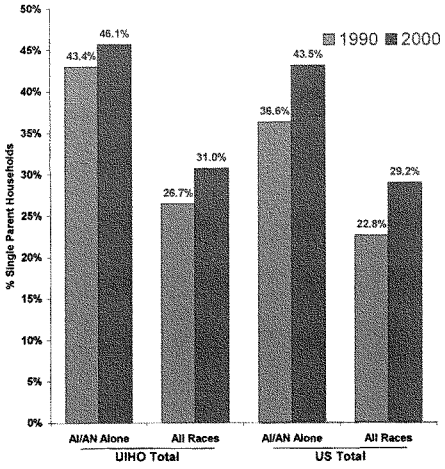



Source: 2000 U.S. Census.

## Single Parent Households

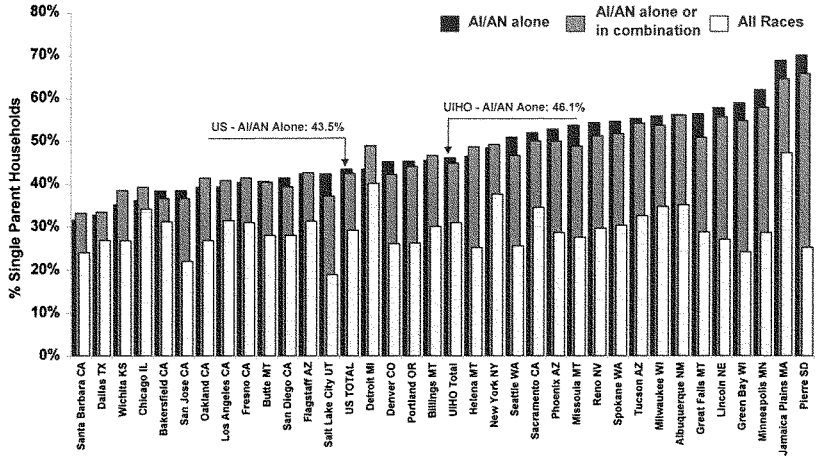
- In 2000, more children under the age of 18 lived in households with only a single parent present than in 1990 (Figure B-10 and Appendix B-7).
- Among Indians, 46% of households were headed by a single parent in the urban organization areas, compared to 44% for all Indians nationwide. All race population totals were significantly lower, with 31% of households in the urban organization areas being headed by a single parent and 29% nationwide.
- Considerable variation exists by region with 32% of AI/AN households in the Santa Barbara CA area having a single parent compared to the Pierre SD area where 70% of households had only a single parent (Figure B-11 and Appendix B-7).

**Figure B-10. Single parent households, 1990 and 2000.**




Source: 1990 and 2000 U.S. Census

**Figure B-11. Single parent households by service areas, 2000.**

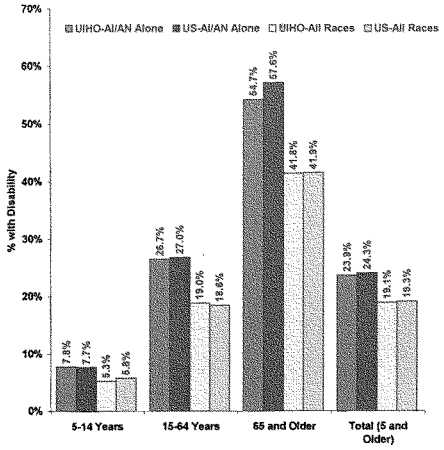



Source: 2000 U.S. Census.

## Disability Status

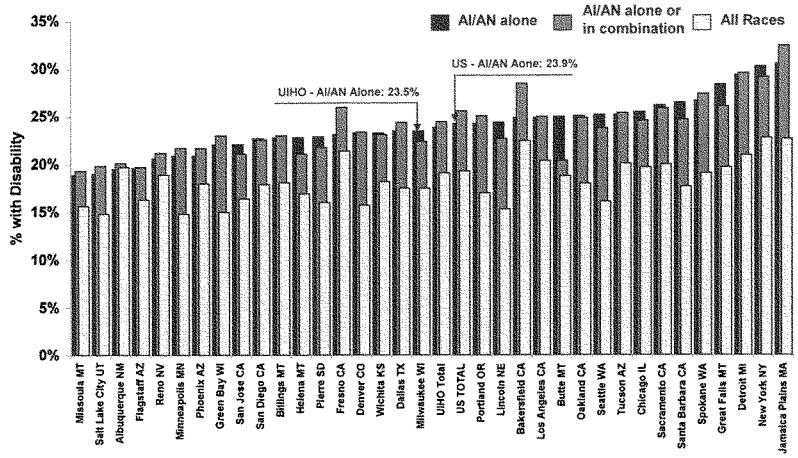
- In 2000, nearly one in four (24%) Indians in both urban organization areas and nationwide reported having a disability compared to one in five persons (19%) in general (Figure B-12 and Appendix B-8).
- Substantial disparities in the percentages of persons having a disability among AI/AN are particularly evident at older ages. Among persons 15 to 64 years of age, 27% of Indians reported having a disability compared to 19% overall. For persons 65 years and older, 55% to 58% of Indians living in urban organization areas and nationwide, respectively, reported having a disability, compared to 42% of persons of all races taken as a whole.
- Reports of disability also varied by area, ranging from 19% of Indians in the Missoula MT area reporting a disability to 30% in the Jamaica Plains MA area (Figure B-13 and Appendix B-8).

**Figure B-12. Disability by age groups, 2000.**




Source: 2000 U.S. Census

**Figure B-13. Disability status by service areas, 2000.**



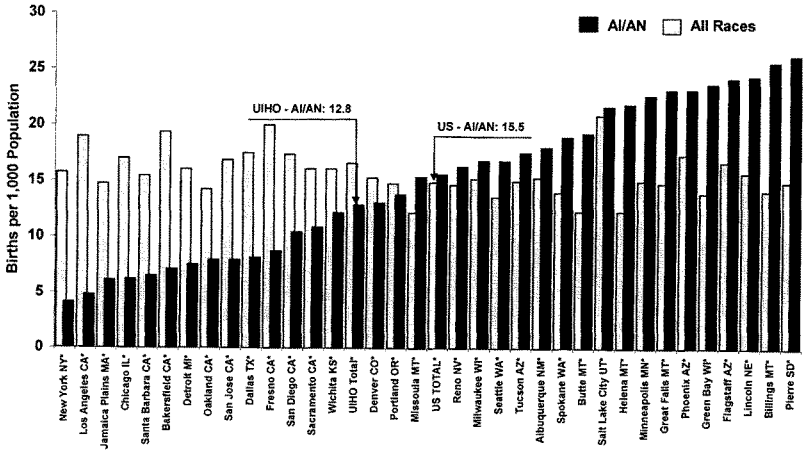

Source: 2000 U.S. Census.

## C. Maternal and Child Health

### Birth Statistics

- Close to 400,000 infants were born to mothers who reported that they were of American Indian or Alaska Native heritage over the ten-year period from 1991 to 2000. Of these, over 80,000 or an average of 8,000 infants annually were born in counties served by Urban Indian Health Organizations. (Appendix C-1).
- Although the national AI/AN birth rate during the 1991 to 2000 period was higher than the general U.S. birth rate (15.5 and 14.8 per 1,000 persons, respectively), the AI/AN rate in urban organization counties was nearly one quarter lower than the general birth rate recorded in these areas (12.8 and 16.5 per 1,000 person, respectively). (Figure C-1 and Appendix C-1).
- Some of the differences observed between rates in the urban organization counties may be due to racial misclassification on birth certificates. This is especially evident with respect to individual organization area rates, which range from 4 births per 1,000 persons in the New York NY area to 26 births per 1,000 persons in the Pierre SD area. In particular, AI/AN birth rates that are well below the overall U.S. rate should be examined further to determine whether racial miscoding on the birth certificates in these areas is a major source of the observed discrepancies.

**Figure C-1. Births to mothers who are American Indians/Alaska Natives (AI/AN) living in Urban Indian Health Organization (UIHO) service areas, 1995-2000.**

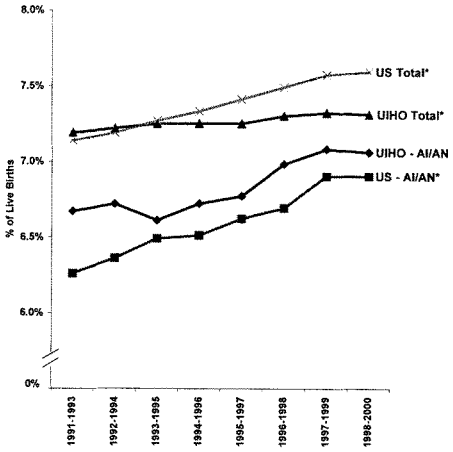



*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Low Infant Birth Weight

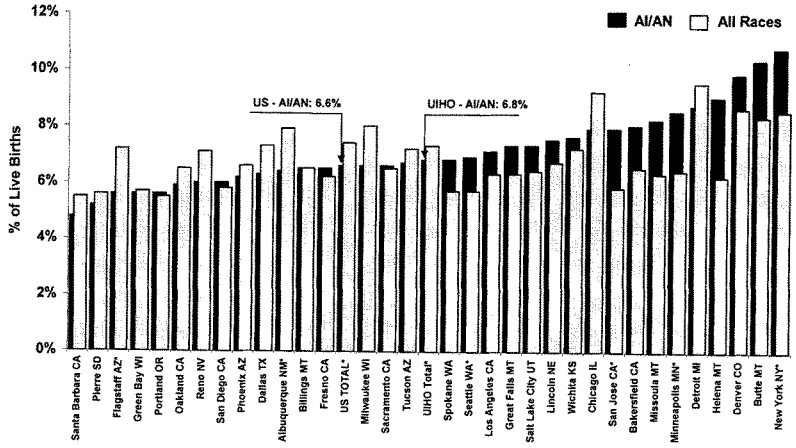
- From 1991 to 2000, a significantly lower percentage of infants of AI/AN mothers were born in UIHO service areas and nationwide with low birth weight (less than 2,500 grams) compared with the rates for all infants combined (Figure C-2 and Appendix C-2).
- However, this trend was not consistent in all urban organization areas, with the lowest rates of low infant birth weight being observed in Santa Barbara CA (4.8%) and the highest rate observed in the New York NY area (10.7%).
- The rate of infants with low birth weight has also increased significantly nationwide and among all races in the UIHO areas (Figure C-3)

**Figure C-3. Low birth weight trends, three-year averages, 1991-2000.**




* Significant increasing trend. Source: U.S. Centers for Health Statistics.

**Figure C-2. Low birth weight by service areas, ten-year averages, 1991-2000.**

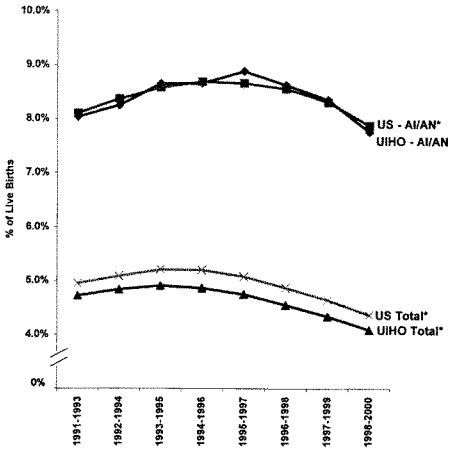



Notes: Results pertain to UIHO service areas with 10 or more occurrences of low birth weight to AI/AN mothers.
*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Births to Teenage Mothers and Mother's Marital Status

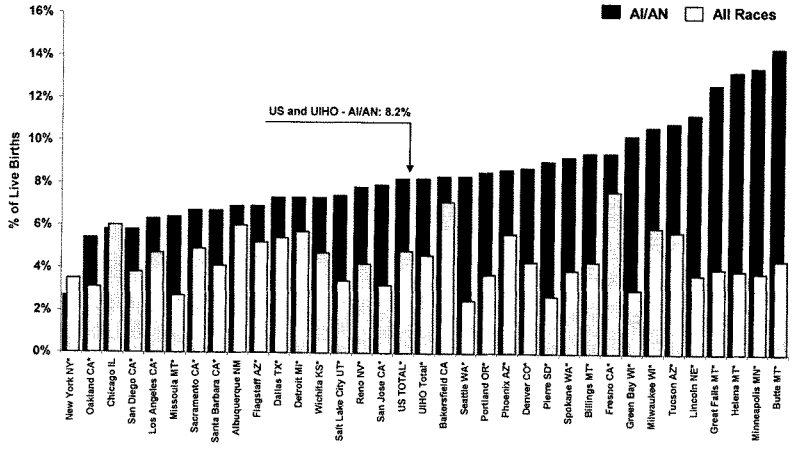
- Births to Indian mothers under age 18, in UIHO areas and nationwide, accounted for approximately 8% of the infants born in the period from 1991 to 2000. This rate was significantly higher than the rate for all mothers which was about 5% both nationwide and in the urban organization counties (Figure C-4 and Appendix C-2).
- Over this 10-year period, however, the rate of teen mothers has dropped significantly among AI/AN mothers nationwide and among all mothers both nationwide and in the urban organization areas (Figure C-5).
- In addition, over half of all children born to Indian mothers were born to mothers who were not married (60% in UIHO areas and 57% nationwide). These rates are substantially higher than the corresponding all-race rates (35% in the UIHO counties and 32% nationwide). (Appendix C-2).

**Figure C-5. Trends in births to teen mothers (age 18 and under), three-year averages, 1991-2000.**




* Significant decreasing trend. Source: U.S. Centers for Health Statistics.

**Figure C-4. Births to teen mothers (age 18 and under) by service areas, ten-year averages, 1991-2000.**

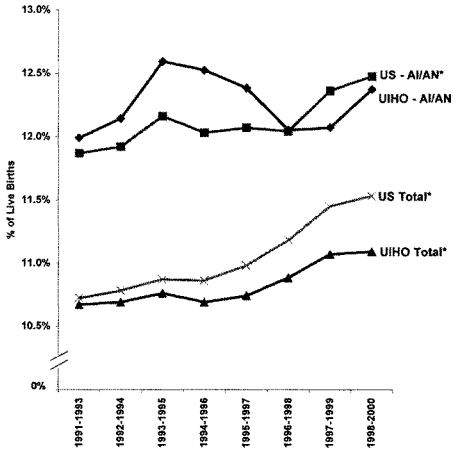



Notes: Results pertain to UIHO service areas with 10 or more occurrences of births to teen AI/AN mothers.
*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Premature Births

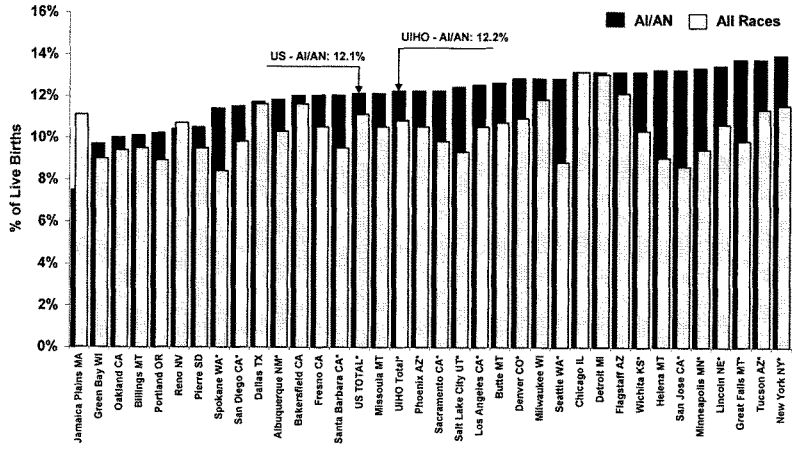
- The rate of premature births to AI/AN mothers (about 12% in both UIHO areas and nationwide) was significantly higher than the rates for all races combined in corresponding areas (approximately 11%) (Figure C-6 and Appendix C-2).
- Similar to the rates for all races combined, rates of prematurity have also increased significantly for AI/AN mothers nationwide during the period from 1991 to 2000 (Figure C-7).
- Variations by organization areas are also evident with the lowest rates of prematurity among AI/AN mothers occurring in the Jamaica Plains MA area (8%) and the highest rate occurring in the New York NY area (14%) (Figure C-6 and Appendix C-2).

**Figure C-7. Trends in premature births, three-year averages, 1991-2000.**




* Significant increasing trend. Source: U.S. Centers for Health Statistics.

**Figure C-6. Premature births by service areas, ten-year averages, 1991-2000.**

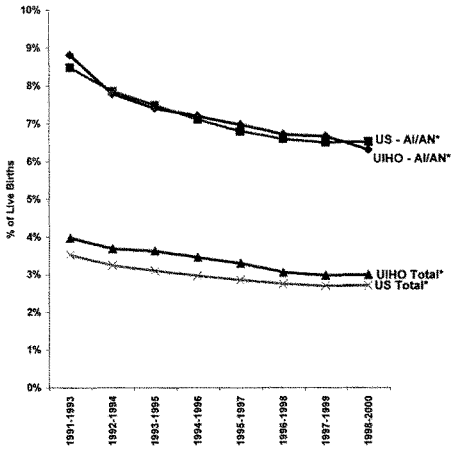



Notes: Results pertain to UIHO service areas with 10 or more premature births to AI/AN mothers.
*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Late or No Prenatal Care

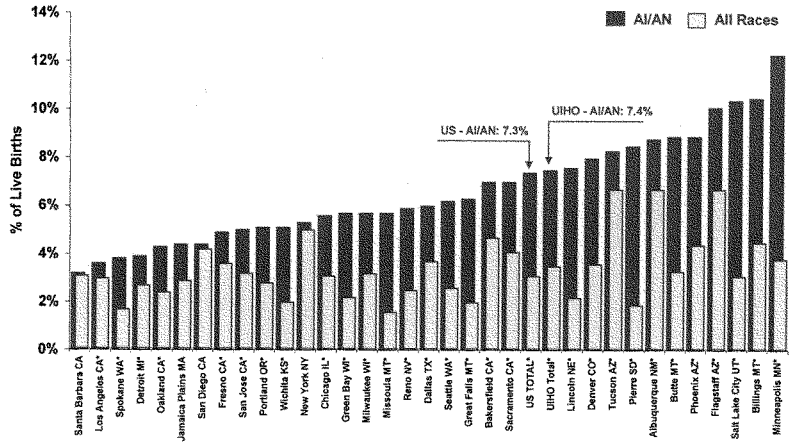
- Over 7% of AI/AN mothers both in UIHO service areas and nationwide who delivered children over the period from 1991 to 2000 either did not receive prenatal care until the 3rd trimester of pregnancy or did not receive it at all. These rates were significantly higher than the corresponding rates for all mothers combined with about 3% receiving late or no prenatal care (Figure C-8 and Appendix C-2).
- Despite continuing overall disparities, the rate in receiving late or no prenatal care has decreased significantly, both nationally and in the urban organization areas (Figure C-9).
- Rates of receiving late or no prenatal care varied greatly by urban organization areas, with the lowest rates observed in the Santa Barbara CA (3%) area and the highest rates in the Minneapolis MN area (12%) (Figure C-8 and Appendix C-2).

**Figure C-9. Trends in receiving late or no prenatal care, 1991-2000.**




* Significant trend. Source: U.S. Centers for Health Statistics.

**Figure C-8. Late or no prenatal care by service areas, ten-year average, 1991-2000.**

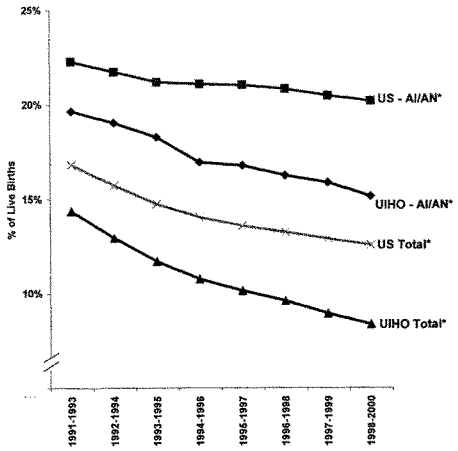



Notes: Results pertain to UIHO service areas with 10 or more to AI/AN mothers who received late or no prenatal care to AI/AN mothers.
*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Smoking during Pregnancy

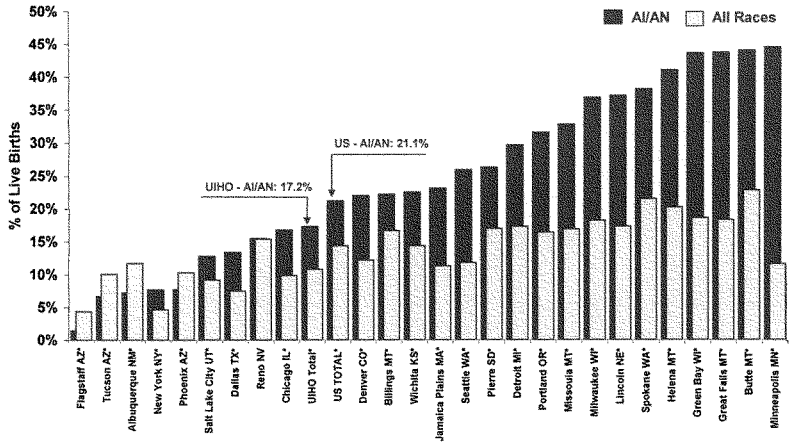
- At both the urban organization and national levels, the rates of smoking during pregnancy by AI/AN mothers were significantly higher (17% in UIHO areas and 21% nationwide) than the rates for mothers of all races combined (about 11% in UIHO areas and 14% nationwide) (Figure C-10 and Appendix C-2).
- The rate of smoking over the 10-year period from 1991 to 2000, however, has decreased significantly both in UIHO areas and nationwide (Figure C-11).
- These rates differed significantly by organization area and ranged from about 1% in the Flagstaff AZ area to 45% in the Minneapolis MN area (Figure C-10 and Appendix C-2).

**Figure C-11. Trends in smoking during pregnancy, three-year averages, 1991-2000.**




* Significant downward trend. Source: U.S. Centers for Health Statistics.

**Figure C-10. Smoking during pregnancy by service areas, ten-year averages, 1991-2000.**

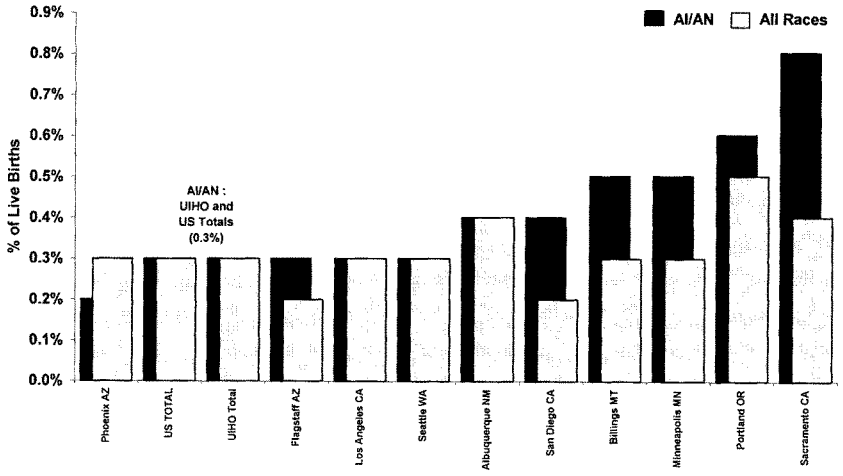



Notes: Results pertain to UIHO service areas with 10 or more births to AI/AN mothers who smoked during pregnancy.
*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Alcohol Use during Pregnancy

- At both the urban organization and national levels, the rates of alcohol consumption during pregnancy by mothers were the same among Indians as for all races, or 0.3% (Figure C-12 and Appendix C-2).
- No significant trends were observed over the 10-year period from 1991 to 2000.
- Although some differences were observed with respect to alcohol consumption during pregnancy in some of the UIHO areas when the rates for Indian mothers were compared to all race totals, these differences were not statistically significant (Figure C-12 and Appendix C-2).

**Figure C-12. Use of alcohol during pregnancy by service areas, ten-year average, 1991-2000.**

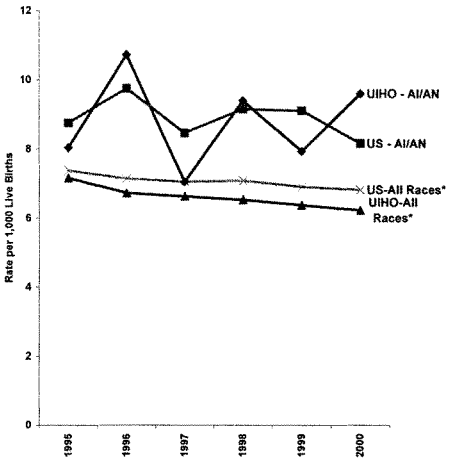



Notes: Results pertain to UIHO service areas with 10 or more to births to AI/AN mothers who consumed alcohol during pregnancy.
*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

## Infant Mortality

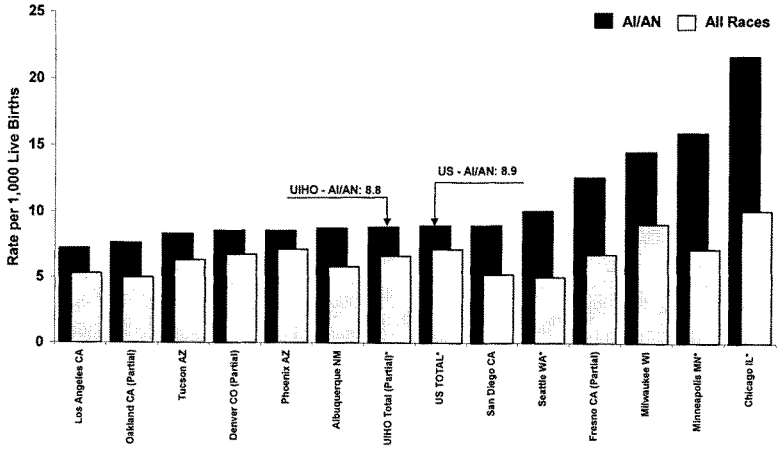
- The average mortality rates over the period 1995 to 2000 among infants born to AI/AN mothers are nearly the same in UIHO areas with county populations over 250,000 and nationwide (8.8 and 8.9 per 1,000 live births, respectively) (Figure C-13 and Appendix C-3). Both rates, however, were significantly higher than the rates corresponding to the general populations of these areas (6.6 and 7.1 per 1,000 live births, respectively).
- Although mortality rates declined over the period from 1995 to 2000 among infants of all races combined, both in the UIHO areas and nationwide, no significant trends are evident among infants born to AI/AN mothers (Figure C-14).
- Among UIHO areas, infant mortality ranged from 7.2 per 1000 live births in the Los Angeles CA area to 21.5 per 1000 live births in the Chicago area.

**Figure C-14 Trends in infant mortality, 1995-2000**




*Significant downward trend.
Source: U.S. Centers for Health Statistics.

**Figure C-13. Infant mortality by service areas, six-year averages, 1995-2000.**

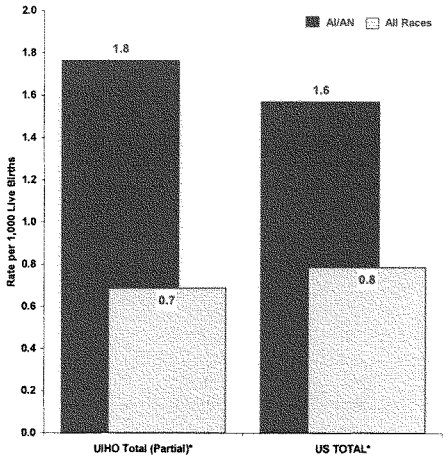



Notes: Results pertain to UIHO service areas with 10 or infant deaths to AI/AN mothers.
*Significant difference between rates for AI/AN and all races combined.
"Partial" refers to the inclusion of only those counties with a 1990 population of 250,000 or more.
Source: U.S. Centers for Health Statistics

### Infant Mortality due to SIDS

- Sudden Infant Death Syndrome (SIDS) was the leading cause of death among infants born to AI/AN mothers living in UIHO counties with populations of 250,000 or more. The AI/AN rate was over twice as high as the rate for all infants in the corresponding area (1.8 and 0.7 per 1,000 live births, respectively) (Figure C-15).
- The SIDS mortality rate among children born to AI/AN mothers nationwide (1.6 per 1,000 live births) was not statistically different than the UIHO area rate.

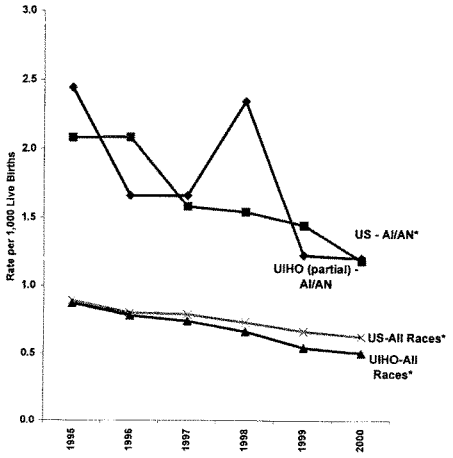
**Figure C-15. Infant mortality due to SIDS, 1995-2000.**




*Significant difference between AI/AN and All Races rates.
"Partial" refers to the inclusion of only those counties with a 1990 population of 250,000 or more. Source: U.S. Centers for Health Statistics

- Although a significant downward trend in mortality is observed for infants born to AI/AN mothers nationwide over the 1995 to 2000 period, no significant trend is evident among those living in the UIHO areas (Figure C-16). The overall trends for SIDS deaths in the general population during this period were downward in both UIHO areas and nationwide.

**Figure C-16. Trends in infant mortality due to SIDS, 1990-1999.**

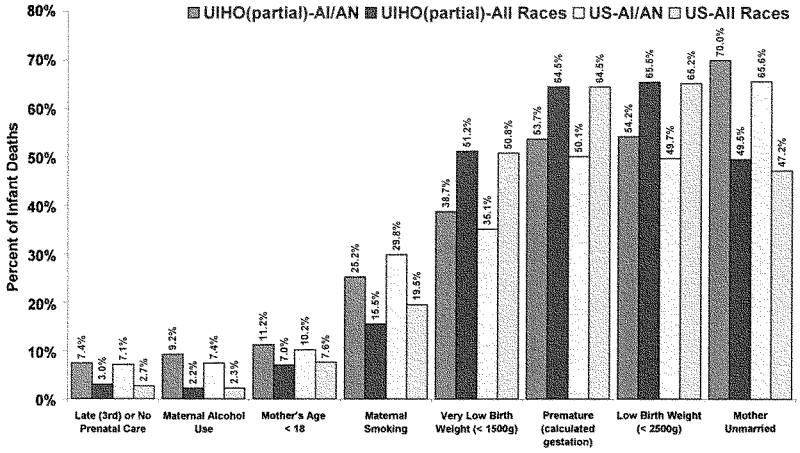



*Significant downward trend. Source: U.S. Centers for Health Statistics.
"Partial" refers to the inclusion of only those counties with a 1990 population of 250,000 or more. Source: U.S. Centers for Health Statistics

**Factors Associated with Infant Deaths**

- The most common factors associated with death among infants born to AI/AN mothers living in UIHO areas over the period from 1995 to 2000 were single marital status (associated with 70% of the infant deaths), low birth weight (54%), and prematurity (54%) (Figure C-17 and Appendix C-4). Very low birth weight of the infant was associated with 39% of the infant deaths. Of these factors, only single marital status was more common among AI/AN mothers than among mothers of all races combined (i.e., 70% and 50%, respectively).
- Smoking during pregnancy (25%), mother's age less than 18 (11%), maternal alcohol consumption (9%), and late or no prenatal care (7%) were all significantly more common among AI/AN mothers with infant deaths than among all mothers combined.

**Figure C-17. Factors associated with infant deaths, six-year averages, 1995-2000.**




All AI/AN rates were significantly different than the corresponding rates for all races combined. "Partial" refers to the inclusion of only those counties with a 1990 population of 250,000 or more. Source: U.S. Centers for Health Statistics

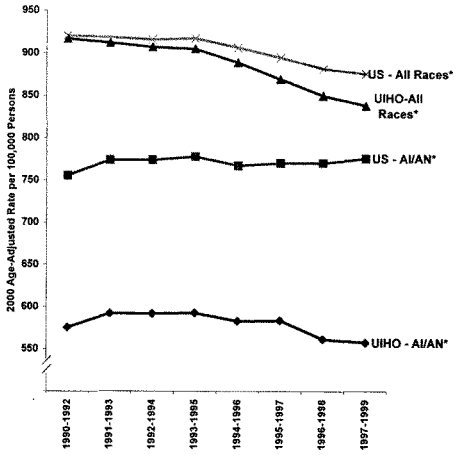
## D. General Mortality Statistics

Miscoding of Indian race on death certificates has been documented in several sources[iii, iv] and adjustment factors have been developed to address misreporting at a regional level.[iv] However, currently available adjustment factors were not developed for use at the county level and, therefore, are not reflected in the results presented in this report, nor do the adjustment factors apply to some urban areas where rates may be half or less than half the rate for the general population in the UIHO areas combined. Therefore, many of the results presented here may be unrealistically low due to these misreporting problems. Those areas where rates fall well below the rates for the general population living in the UIHO areas should especially be targeted for efforts to devise strategies for improving the collection of racial background on vital statistics records.

### All Causes of Mortality

- During the 10-year period from 1990 to 1999 nearly 100,000 deaths nationwide have been reported among Indians. Of these nearly one fifth (about 18,000 or an annual average of 1,800) have been among Indians living in UIHO service areas (Appendix D-1).
- While this period has seen a significant decrease in mortality among all races both nationwide and in the urban organization areas, Indian mortality nationwide has increased (Figure D-1). However, in urban organization areas there has been a significant decline in reported deaths.

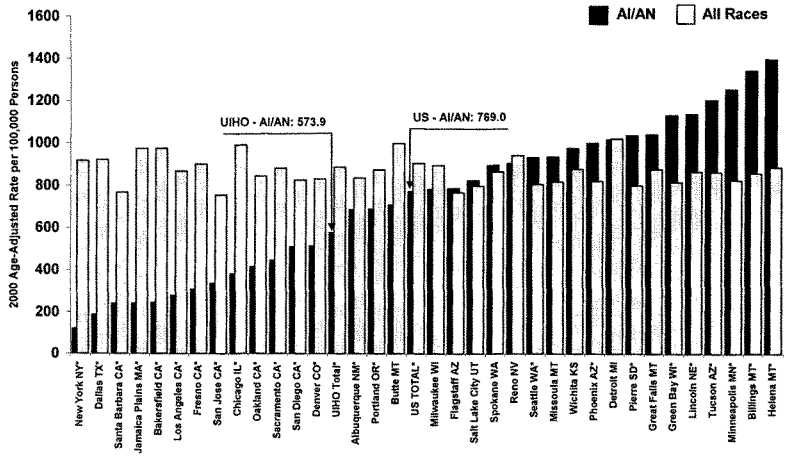
**Figure D-1. Mortality trends, three-year averages, 1990-1999.**




*Significant downward trend.
Source: U.S. Centers for Health Statistics.

- Significant discrepancies between age-adjusted AI/AN and total mortality rates exist. For example, the ten-year average rate of total mortality was 883.2 deaths per 100,000 persons living in UIHO areas, the rate among AI/AN living in these areas was 35% lower, or 573.9 per 100,000. Nationwide the AI/AN rate was somewhat higher (569.0 per 100,000) or about 15% less than the total rate (about 902.1 per 100,000) (Figure D-2 and Appendix D-1).
- By organization area, mortality rates range from a low of 120.1 per 100,000 in the New York NY area to 1,387.6 in the Helena MT area.

**Figure D-2. Mortality by service areas, ten-year averages, 1990-1999.**

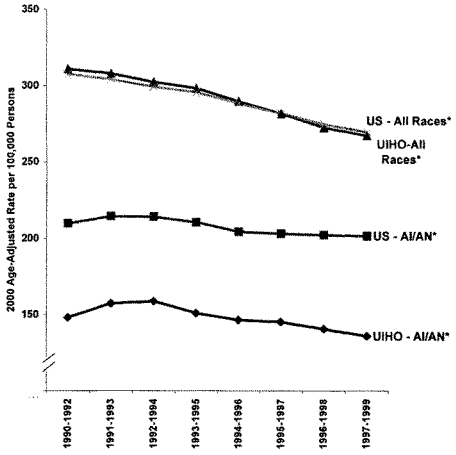



Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths.
*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Heart Disease Mortality

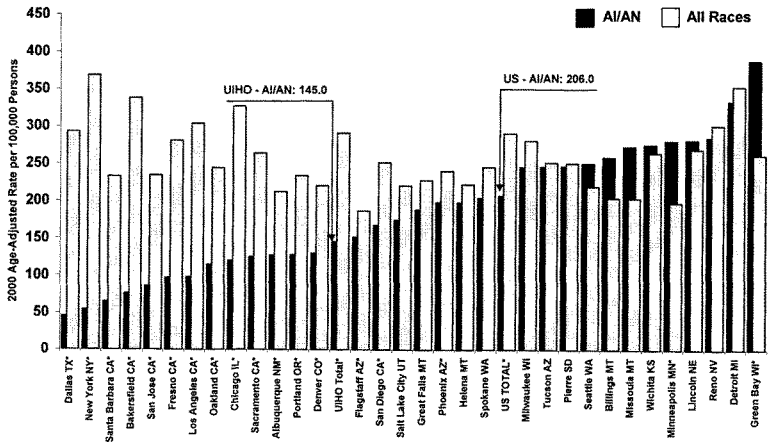
- Although the general heart disease mortality rates both in UIHO areas and nationwide have been nearly the same (10-year average about 290 per 100,000), significant differences exist between the rates for AI/AN living in the urban organization areas and nationwide (10-year average rate was 145.0 per 100,000 among AI/AN in UIHO areas, while 206.0 per 100,000 for nationwide) (Figure D-3 and Appendix D-1).
- Heart disease mortality has decreased significantly during the period 1990 to 1999 among Indians and among the general population (Figure D-4).
- By area, the rates among AI/AN ranged from 45.7 per 100,000 in the Dallas TX area to 385.4 per 100,000 in the Green Bay WI area.
- Significantly higher rates between AI/AN and all races were observed in the Minneapolis MN and Green Bay WI areas.

**Figure D-4. Trends in heart disease mortality, three-year averages, 1990-1999.**




*Significant downward trend.
Source: U.S. Centers for Health Statistics.

**Figure D-3. Heart disease mortality by service areas, ten-year averages, 1990-1999.**

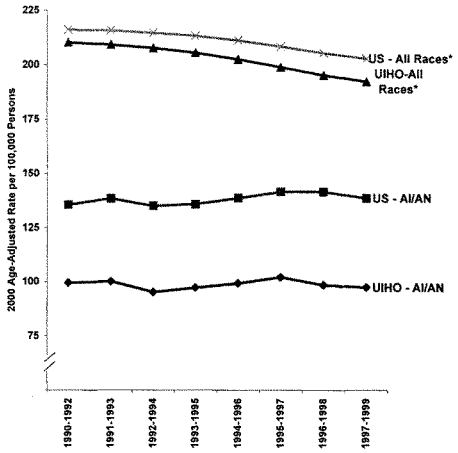



Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths due to heart disease.
*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Cancer Mortality

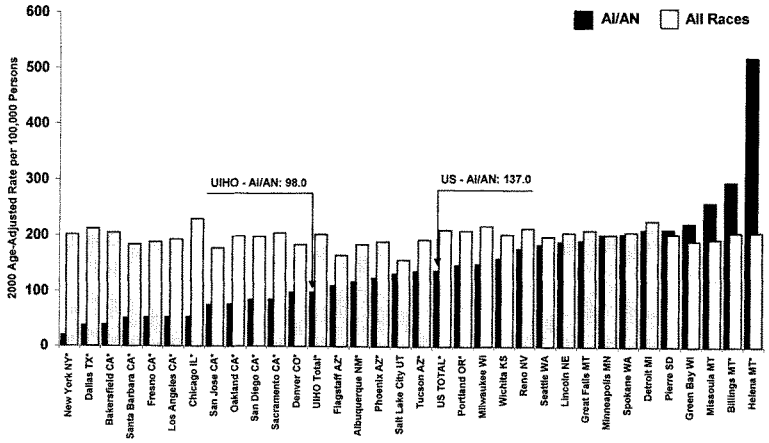
- Cancer was the 2nd leading cause of death among Indians both in the urban organization areas and nationwide.
- The 10-year average rate for AI/AN was significantly lower for AI/AN living in the urban organization areas compared with Indians nationwide (98.0 per 100,000 compared to 137.3 per 100,000, respectively). These rates were both substantially lower than the total rates both nationwide and in the urban organization areas (210.0 per 100,000 and 201.8 per 100,000, respectively). (Figure D-5 and Appendix D-1).
- Cancer mortality rates ranged by area from 20.0 per 100,000 in the New York NY area to 295.2 per 100,000 in the Billings MT area.
- While the overall all-race cancer rate has begun to decrease during the period from 1990 to 1999, the cancer rate among AI/AN has remained level (Figure D-6).

**Figure D-6. Trends in cancer, three-year averages, 1990-1999.**




*Significant downward trend.
Source: U.S. Centers for Health Statistics.

**Figure D-5. Cancer mortality by service areas, ten-year averages, 1990-1999.**

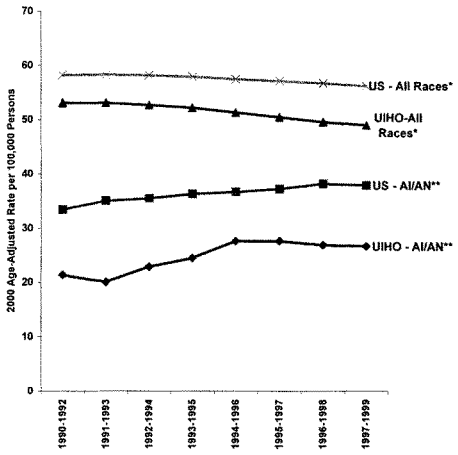



Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths due to cancer.
*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Lung Cancer Mortality

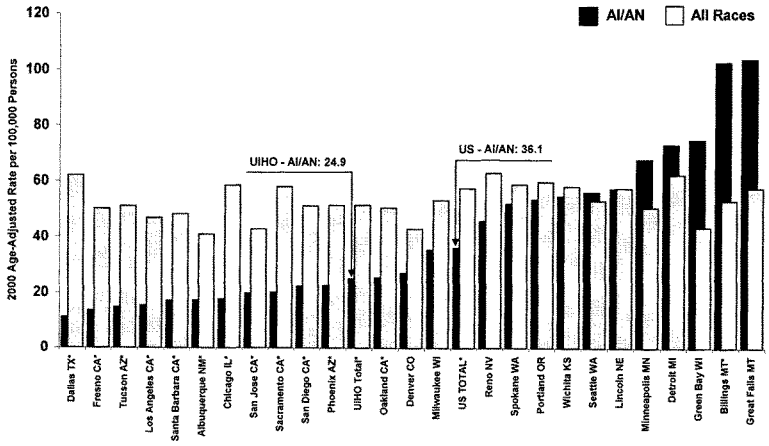
- Lung cancer mortality was the leading type of cancer among Indians living in the UIHO areas and nationwide.
- The average ten-year rates over the period from 1990 to 1999 among AI/AN living in the UIHO areas were lower than the rate for Indians nationwide (24.9 per 100,000 and 36.1 per 100,000, respectively). These rates were both significantly below the cancer mortality rates for all races (51.2 per 100,000 in UIHO areas and 57.3 per 100,000 nationwide) (Figure D-7 and Appendix D-1).
- Lung cancer mortality rates ranged from 15.4 per 100,000 in the Los Angeles CA area to 102.2 per 100,000 in the Billings MT area.
- Despite decreasing overall lung cancer rates both nationwide and in the UIHO areas, lung cancer among Indians in both urban organization areas and nationwide has increased (Figure D-8).

**Figure D-8. Trends in lung cancer mortality, three-year averages, 1990-1999.**




*Significant downward trend. ** Significant increasing trend.
Source: U.S. Centers for Health Statistics.

**Figure D-7. Lung cancer mortality by service areas, ten-year average, 1990-1999.**

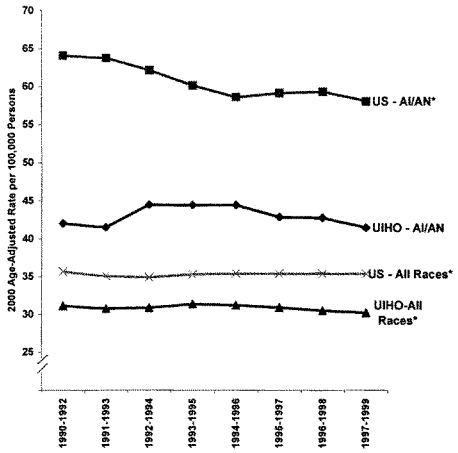



Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths due to lung cancer.
*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Unintentional Injury Mortality

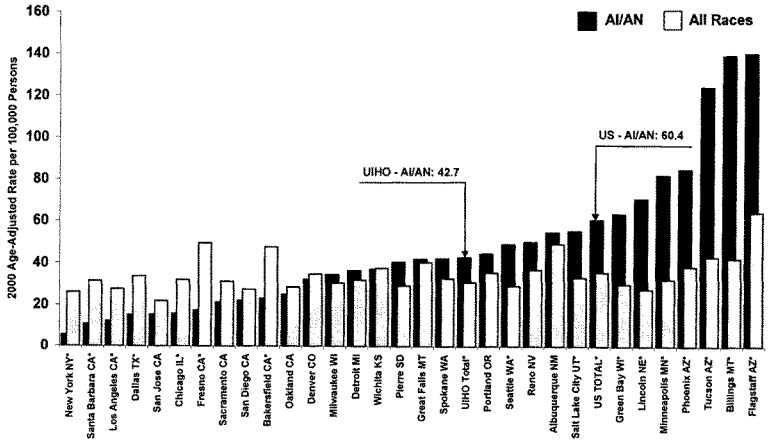
- Mortality due to accidents or unintentional injury was the 3rd leading cause of death among Indians living in UIHO areas.
- Despite underestimates resulting from misclassification of Indian race on death certificates, unintentional injury mortality among Indians in both the urban organization areas and nationwide (42.7 per 100,000 and 60.4 per 100,000, respectively) significantly exceeded the comparable overall rates (30.9 per 100,000 and 36.1 per 100,000, respectively). (Figure D-9 and Appendix D-1).
- Mortality rates ranged from 5.6 per 100,000 (New York NY) to 139.7 per 100,000 (Flagstaff AZ).
- During the 1990 to 1999 period, the rate of unintentional injury mortality decreased overall nationwide and in the urban organization areas and among Indians nationwide (Figure D-10).

**Figure D-10. Trends in unintentional injury mortality, three-year averages, 1990-1999.**




*Significant downward trend.
Source: U.S. Centers for Health Statistics.

**Figure D-9. Unintentional injury mortality by service areas, ten-year averages, 1990-1999.**

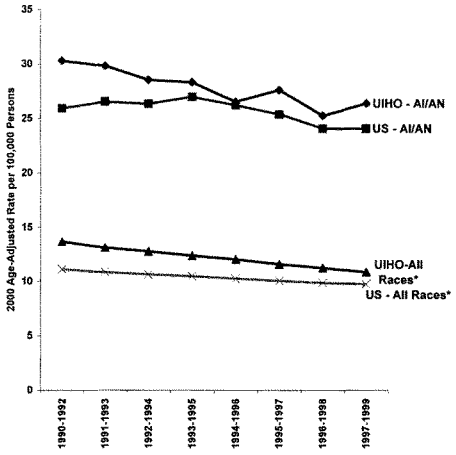



Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths due to unintentional injuries.
*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Chronic Liver Disease and Cirrhosis Mortality

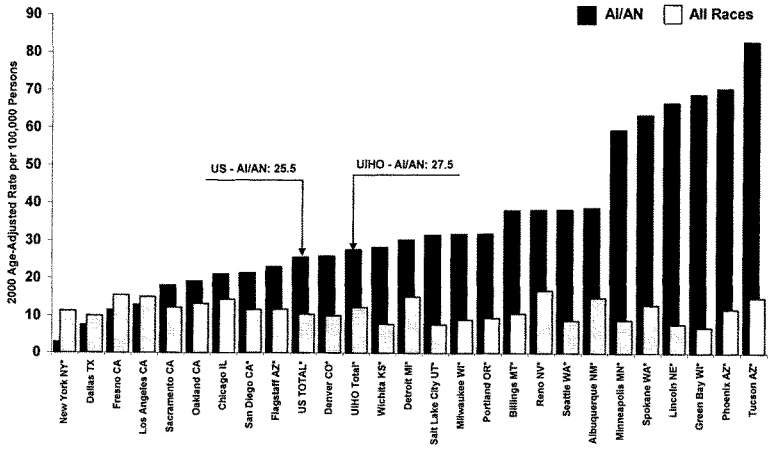
- Mortality due to chronic liver disease and cirrhosis was the 4th leading cause of death among Indians living in the urban organization areas.
- The mortality rate due to this condition over the period from 1990 to 1999 among Indians in UIHO areas was 27.5 per 100,000 and 25.5 per 100,000 nationwide. Both rates were significantly higher than the comparable all-race rates (12.2 per 100,000 and 10.4 per 100,000, respectively) (Figure D-11 and Appendix D-1).
- Mortality rates ranged by area from 2.9 per 100,000 in the New York NY area to 82.3 per 100,000 in the Tucson AZ area.
- Despite overall decreases nationwide and in the urban organization areas from 1990 to 1999, the rates of mortality among Indians have not changed significantly during this time period (Figure D-12).

**Figure D-12. Trends in chronic liver disease mortality, three-year averages, 1990-1999.**




*Significant downward trend.
Source: U.S. Centers for Health Statistics.

**Figure D-11. Chronic liver disease mortality by service areas, ten-year average, 1990-1999.**

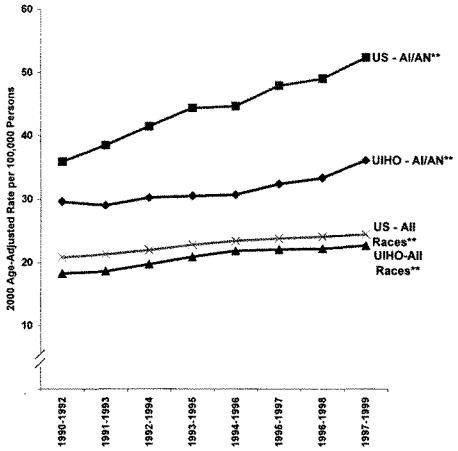



Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths due to chronic liver disease.
*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Diabetes Mortality

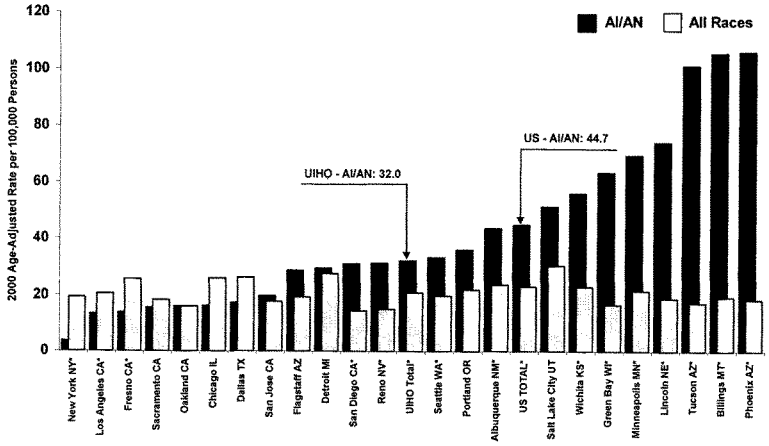
- Mortality due to diabetes mellitus was the 5th leading cause of death among Indians living in UIHO service areas.
- Over the period from 1990 to 1999 diabetes mortality among Indians in UIHO service areas and nationwide (32.0 and 44.7 per 100,000, respectively) was significantly higher than among the general population (20.8 and 22.9 per 100,000, respectively) (Figure D-13 and Appendix D-1).
- The Indian diabetes mortality rates varied substantially by organization area ranging from a low of 3.7 per 100,000 in the New York NY to 105.3 per 100,000 in the Phoenix AZ area.
- While a significant increase in diabetes mortality is evident in both UIHO areas and nationwide, diabetes mortality is increasing at a faster rate among AI/AN than among the general population (Figure D-14).

**Figure D-14. Trends in diabetes mortality, three-year averages, 1990-1999.**




** Significant increasing trend.
Source: U.S. Centers for Health Statistics.

**Figure D-13. Diabetes mortality by service areas, ten-year average, 1990-1999.**

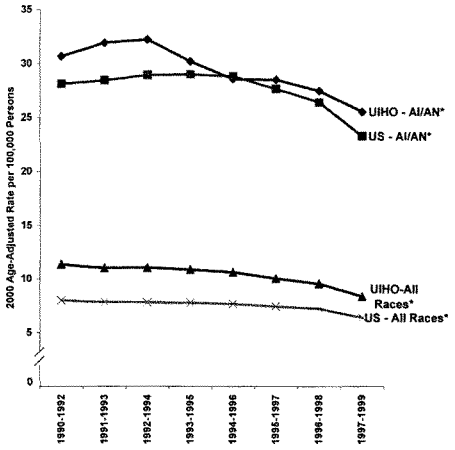



Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths due to diabetes.
*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Alcohol-Related Mortality

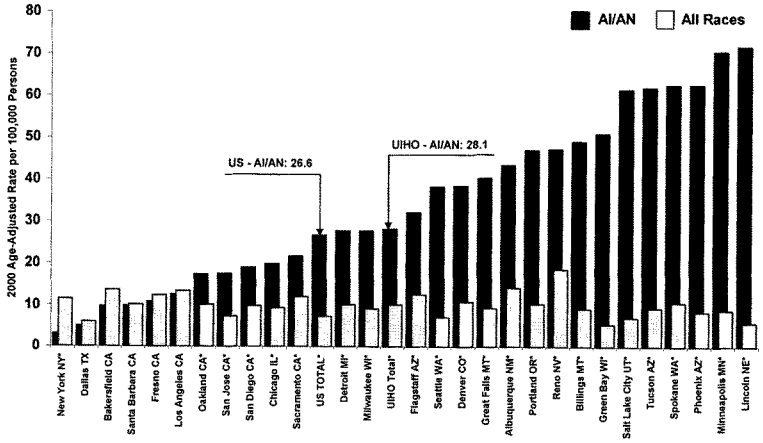
- Alcohol-related mortality includes causes of death that are likely to be associated with alcohol misuse. From 1990 to 1999, Indians living in UIHO service areas and nationwide had significantly higher rates of alcohol-related mortality (28.1 and 26.6 per 100,000, respectively) than the general population (10.1 and 7.3 per 100,000, respectively) (Figure D-15 and Appendix D-1).
- By area, alcohol-related mortality ranged from 3.1 per 100,000 in the New York NY area to 71.3 in the Lincoln NE area.
- Alcohol-related mortality has decreased over the time period from 1990 to 1999 both among Indians and the general population (Figure D-16). However, some of the decrease in mortality in this category may be offset with the significant increase in drug-related mortality that has also occurred over this time period (Appendix D-1).

**Figure D-16. Trends in alcohol-related mortality, three-year averages, 1990-1999.**




*Significant downward trend.
Source: U.S. Centers for Health Statistics.

**Figure D-15. Alcohol-related mortality by service areas, ten-year averages, 1990-1999.**




Notes: Results pertain to UIHO service areas with 10 or more AI/AN deaths due to alcohol-related causes.
*Significant difference between rates for AI/AN and all races combined. Source: U.S. Centers for Health Statistics.

### Age-Specific Mortality

Age-specific mortality for Indians living in UIHO service areas and nationally is detailed in Appendix D-2.

- With the exception of children age one to 14, age-specific mortality for Indians living in UIHO areas is lower than corresponding rates for the general population. These differences are likely due to misclassification of Indian race on death certificates.
- Among Indian children ages one to 14, the UIHO area rate is nearly the same as the corresponding rate for children of all races living in these areas.
- For all age groups examined, the UIHO area rates among AI/AN in each of the age specific groups were lower than the rates for all Indians nationwide.

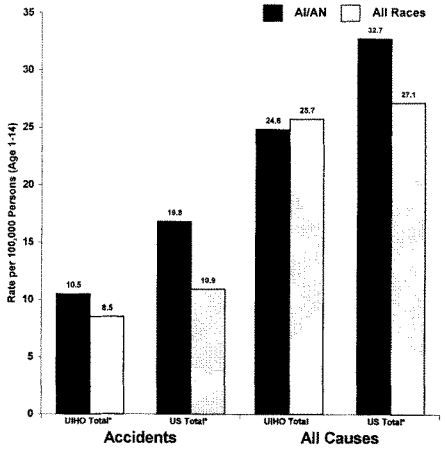
### Ages One to 14 Years

- The leading cause of death among Indian children who were one to 14 years in age and living in urban organization areas was accidents or unintentional injury. The rate of death among these children was significantly higher than for the general population (10.5 and 8.5 per 100,000, respectively) (Figure D-17).

### Ages 15 to 24 Years

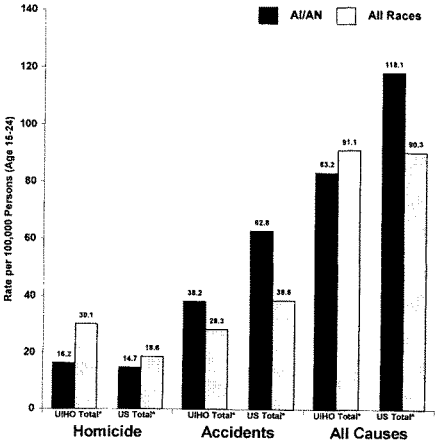
- In the urban organization areas, the leading cause of death among teenagers and young adults ages 15 to 24 was accidents, which occurred at a rate significantly higher than the rate for all teens and young adults in this age group (38.2 and 28.3 per 100,000, respectively) (Figure D-18).
- Homicide, the second leading cause of death among AI/AN was significantly lower than the corresponding rate for all races combined (16.2 and 30.1 per 100,000, respectively).

**Figure D-17. Mortality among persons ages one to 14 years, ten-year averages, 1990-1999.**




*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

**Figure D-18. Mortality among persons ages 15 to 24 years, ten-year averages, 1990-1999.**

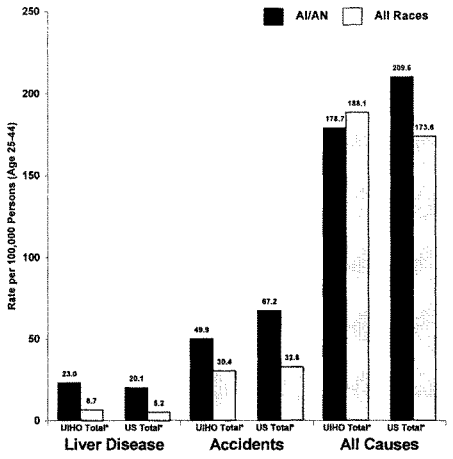



*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Ages 25 to 44 Years

- Among Indians age 25 to 44 living in the urban organization areas, accidents and liver disease were the first and second leading causes of death, respectively. In both instances, the AI/AN rates were higher than the corresponding general population rates for these ages (Figure D-19).

**Figure D-19. Mortality among persons ages 25 to 44 years, ten-year average, 1990-1999.**

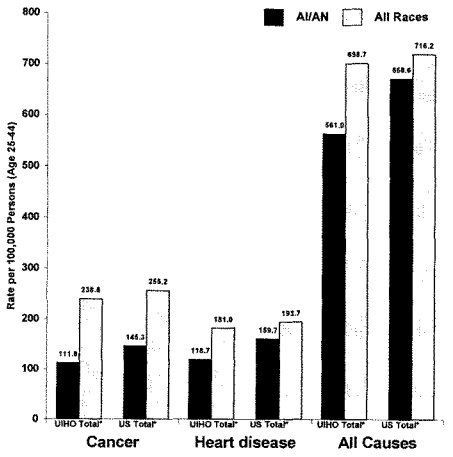



*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Ages 45 to 64 Years

- Heart disease and cancer were the first and second leading causes of death among Indians age 45 to 64 living in the urban organization areas. Mortality rates for both of these causes of death, however, were significantly lower the corresponding rates for this age group with all races are combined (Figure D-20).

**Figure D-20. Mortality among persons ages 45 to 64 years, ten-year averages, 1990-1999.**

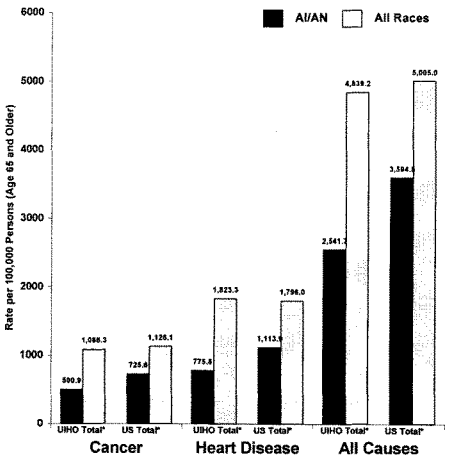



*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### Ages 65 Years and Older

- Similar to Indians ages 46 to 64 living in UIHO areas, the first and second leading causes of death were heart disease and cancer, respectively. In both cases the rates were significantly below the corresponding general rates for persons in this age group living in these areas (Figure D-21).

**Figure D-21. Mortality among persons ages 65 years and older, 1990-1999.**




*Significant difference between rates for AI/AN and all races combined.
Source: U.S. Centers for Health Statistics.

### E. Summary and Recommendations

This assessment documents SES and health indicators from census and selected vital record sources demonstrating both progress toward better health among Indians living in UIHO areas, and also the existence and continuation of substantial health disparities when compared to the general population.

From census data, significant disparities are evident with respect to rates of poverty, disability status, and other socioeconomic indicators (i.e., educational attainment, employment status, and single-parent status). These disparities are likely to put Indians at a disadvantage with respect to better health and health care access compared to the general population. These disparities are also generally consistent for AI/AN living in any of the 34 UIHO areas, although rates may differ considerably from one area to the next.

Although there is a large degree of consistency in disparities with respect to SES and disability status measures across UIHO service areas, these disparities are in many cases not reflected in currently available mortality and natality data. This discrepancy is most likely due to miscoding of AI/AN race on vital records such as birth and death certificates.

Improvements in data collection pertaining to AI/AN race are urgently needed to better understand the true health status of Indians living both in urban areas and nationwide. These improvements are particularly needed in light of national efforts to eliminate health disparities among Indians and other racial groups by the year 2010.[viii] Without accurate data, it is not possible to assess the true need for programs to address existing health disparities. In the case of mortality data, misclassification of AI/AN race on death certificates is likely to be so large that many disparities go undetected and unmonitored. Improvement in data quality is not evident for the time periods analyzed.

Based on this assessment, several improvements in data collection and analysis may be helpful in future assessments of the health status of Indians living in UIHO service areas and Indians living in urban areas in general:

- Additional and new studies are needed to understand why mortality rates for Indians living in some urban areas are substantially below that of the general population. Some possible factors that may contribute to this effect include: 1) miscoding of AI/AN race on birth and death certificates; 2) existing population bridging methods may have inadvertently produced population estimates which may be inaccurate in some areas; and 3) rates may also reflect some degree of reality if substantial numbers of Indians living in some urban areas return to their reservations for health services available through the Indian Health Service or to be with family and other tribal members during periods of illness or at the end of life.
- Health departments in areas where miscoding on death certificates appears to be extremely high should be encouraged to conduct call back or other types of surveys to determine local rates of misclassification. In addition, these programs need to work more closely with persons and agencies completing death certificates to ensure accurate coding on these forms. Benchmarks need to be established and improvements in coding need to be monitored over time to ensure progress.
- Due to smaller populations or numbers of events in some areas, creation of grouped areas or regions may be helpful to ensure that relevant data are available for all areas. With respect to combined infant mortality and natality, data for counties with less than 250,000 persons are needed to improve the availability of estimates for all UIHO areas.
- Until issues with racial misclassification are resolved to a point where these data are more reliable, creation of natality and mortality estimates adjusted to reflect socioeconomic characteristics of areas may be helpful, particularly in areas where misclassification may be very high and estimates are correspondingly unrealistic.
- Future studies of the health status of Indians living in UIHO service area and of Urban Indians also need to include assessments of other sources of data reflecting health behaviors and social determinants of health (such as economic opportunity, daily stress, discrimination when seeking health services, mental health, trust or confidence in the health care system, language or other cultural factors). All of these factors and many others influence an individual's health outlook and need to be considered when developing strategies to improve the health of American Indians and Alaska Natives and other populations.

## F. References

[i] U.S. National Center for Health Statistics. Age adjustment using the 2000 projected U.S. population. *Statistical Notes*. 2001 (Number 20).
[ii] U.S. National Center for Health Statistics. United States Census 2000 Populations with Bridged Race Categories" (Series 2, No. 135). 2003
[iii] U.S. National Center for Health Statistics. Quality of death rates by race and Hispanic origin: a summary of current research, *Vital and Health Statistics*. 1999. (Series 2, No. 128)
[iv] U.S. Indian Health Service. Adjusting for miscoding of Indian race on state death certificates, November 1996.
[v] U.S. Nation Center for Health Statistics. Comparability of cause of death between ICD-9 and ICD-10: preliminary estimates. *National Vital Statistics Reports* . 2001. 49 (2).
[vi] http://www.vistaphw.net and http://www.doh.wa.gov/OS/Vista/HOMEPAGE.HTM
[vii] U.S. Census Bureau. Technical Documentation: Census 2000 Summary File 3, 2002 (Data Note 4).
[viii] http://www.healthypeople.gov

**Appendix A-1. Urban Indian Health Organizations, by city location and service area counties**

| Urban Organization Name | Location by City and State | Service Area Counties | Service Area Counties (pop. > 250,000 in 1990) |
|---|---|---|---|
| First Nations Community Health Source | Albuquerque, NM | Bernalillo | Bernalillo |
| Bakersfield American Indian Health Project | Bakersfield, CA | Kern | * |
| Indian Health Board of Billings, Inc. | Billings, MT | Big Horn and Yellowstone | * |
| North American Indian Alliance | Butte, MT | Silver Bow | * |
| American Indian Health Services of Chicago, Inc. | Chicago, IL | Cook | Cook |
| Urban Inter-Tribal Center | Dallas, TX | Collin, Dallas, Denton, Ellis, Hood, Johnson, Kaufman, Parker, Rockwall, Tarrant and Wise | Collin, Dallas, Denton and Tarrant |
| Denver Indian Health and Family Services | Denver, CO | Adams, Arapahoe, Boulder, Denver, Douglas, Gilpin and Jefferson | Adams, Arapahoe, Denver and Jefferson |
| American Indian Health and Family Services | Detroit, MI | Genesee, Ingham, Kent and Wayne | Genesee, Ingham, Kent and Wayne |
| Native Americans for Community Action | Flagstaff, AZ | Coconino | |
| Fresno Indian Health Association | Fresno, CA | Fresno, Madera and Tulare | Fresno and Tulare |
| Indian Family Health Center | Great Falls, MT | Cascade | * |
| United Amerindian Health Center, Inc. | Green Bay, WI | Brown and Door | * |
| Helena Indian Alliance | Helena, MT | Jefferson, and Lewis & Clark | * |
| North American Indian Center of Boston, Inc. | Jamaica Plains, MA | Suffolk | Suffolk |
| Nebraska Urban Indian Health Coalition | Lincoln, NE | Douglas, Lancaster, Sarpy, Washington (NE) and Woodbury (IA) | Douglas |
| United American Indian Involvement Inc | Los Angeles, CA | Los Angeles | Los Angeles |
| Gerald L. Ignace Indian Health Center, Inc. | Milwaukee, WI | Milwaukee and Waukesha | Milwaukee and Waukesha |
| Indian Health Board of Minneapolis | Minneapolis, MN | Hennepin and Ramsey | Hennepin and Ramsey |
| Missoula Indian Center | Missoula, MT | Missoula | * |
| American Indian Community House | New York, NY | Bronx, Essex, Kings, Nassau, New York, Queens, Richmond and Westchester | Bronx, Kings, Nassau, New York, Queens, Richmond and Westchester |
| Native American Health Center | Oakland, CA | Alameda, Contra Costa, Marin, San Francisco and San Mateo | Alameda, Contra Costa, San Francisco and San Mateo |
| Native American Community Health Center | Phoenix, AZ | Maricopa | Maricopa |
| South Dakota Urban Indian Health, Inc. | Pierre, SD | Brown, Hughes, Minnehaha and Stanley | * |
| Native American Rehabilitation Assoc. of the NW, Inc. | Portland, OR | Clackamas, Multnomah, Washington (OR) and Clark (WA) | Clackamas, Multnomah, Washington (OR) |
| Nevada Urban Indian, Inc. | Reno, NV | Carson City, Churchill, Douglas, Storey and Washoe | Washoe |
| Sacramento Urban Indian Health Project, Inc. | Sacramento, CA | Sacramento | Sacramento |
| Indian Walk-In Center | Salt Lake City, UT | Davis, Salt Lake, Tooele, Utah and Weber | Salt Lake and Utah |
| San Diego American Indian Health Center | San Diego, CA | San Diego | San Diego |
| Indian Health Center of Santa Clara Valley, Inc | San Jose, CA | Santa Clara | Santa Clara |
| American Indian Health & Services | Santa Barbara, CA | San Luis Obispo, Santa Barbara, and Ventura | Santa Barbara and Ventura |
| Seattle Indian Health Board | Seattle, WA | King | King |
| N.A.T.I.V.E. Project | Spokane, WA | Spokane | Spokane |
| Inter-Tribal Health Care Center | Tucson, AZ | Pima | Pima |
| Hunter Health Clinic | Witchita, KS | Butler, Reno, Sedgwick and Sumner | Sedgwick |

* No service area counties had populations greater than 250,000 in 1990.

**Appendix B-1. Population of American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| | 1990 Census | | | 2000 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Census | | | | Bridged Race* | | | |
| Health Organization Service Area | AI/AN alone | % of All Race Total | All Race Total | AI/AN alone | % of All Race Total | AI/AN alone or w/other races | % of All Race Total | AI/AN alone | Difference (Census-Bridged) | % of All Race Total | All Race Total |
| US TOTAL | 1,959,234 | 0.8% | 248,709,873 | 2,475,956 | 0.9% | 4,119,301 | 1.5% | 2,995,603 | 519,647 | 1.1% | **281,421,906** |
| UIHO Total | 438,506 | 0.8% | 56,733,125 | 589,283 | 0.9% | 1,030,579 | 1.6% | 794,445 | 205,162 | 1.2% | **66,066,846** |
| Albuquerque NM | 16,296 | 3.4% | 480,577 | 23,175 | 4.2% | 28,857 | 5.2% | 26,514 | 3,339 | 4.8% | **556,678** |
| Bakersfield CA | 7,026 | 1.3% | 543,477 | 9,999 | 1.5% | 17,399 | 2.6% | 13,519 | 3,520 | 2.0% | **661,645** |
| Billings MT | 9,524 | 7.6% | 124,756 | 11,510 | 8.1% | 13,143 | 9.3% | 12,238 | 728 | 8.6% | **142,023** |
| Butte MT | 520 | 1.5% | 33,941 | 704 | 2.0% | 1,021 | 3.0% | 839 | 135 | 2.4% | **34,606** |
| Chicago IL | 10,289 | 0.2% | 5,105,067 | 15,496 | 0.3% | 33,941 | 0.6% | 24,367 | 8,871 | 0.5% | **5,376,741** |
| Dallas TX | 19,336 | 0.5% | 3,949,075 | 29,037 | 0.6% | 55,809 | 1.1% | 37,044 | 8,007 | 0.7% | **5,120,721** |
| Denver CO | 11,492 | 0.8% | 1,412,959 | 21,358 | 0.9% | 39,606 | 1.6% | 28,682 | 7,324 | 1.2% | **2,405,327** |
| Detroit MI | 15,877 | 0.5% | 3,324,689 | 14,568 | 0.4% | 36,817 | 1.1% | 20,533 | 5,965 | 0.6% | **3,350,958** |
| Flagstaff AZ | 28,233 | 29.2% | 96,591 | 33,161 | 28.5% | 34,579 | 29.7% | 34,642 | 1,481 | 29.8% | **116,320** |
| Fresno CA | 12,529 | 1.2% | 1,067,501 | 21,739 | 1.7% | 34,732 | 2.7% | 29,994 | 8,255 | 2.3% | **1,290,537** |
| Great Falls MT | 3,072 | 4.0% | 77,691 | 3,394 | 4.2% | 4,555 | 5.7% | 3,782 | 388 | 4.7% | **80,357** |
| Green Bay WI | 4,047 | 1.8% | 220,284 | 5,374 | 2.1% | 6,798 | 2.7% | 5,885 | 511 | 2.3% | **254,739** |
| Helena MT | 1,177 | 2.1% | 55,434 | 1,264 | 1.9% | 1,945 | 3.0% | 1,470 | 206 | 2.2% | **65,765** |
| Jamaica Plains MA | 2,087 | 0.3% | 663,906 | 2,689 | 0.4% | 6,054 | 0.9% | 4,002 | 1,313 | 0.6% | **689,807** |
| Lincoln NE | 5,823 | 0.7% | 847,551 | 6,714 | 0.7% | 11,543 | 1.2% | 8,270 | 1,556 | 0.9% | **959,128** |
| Los Angeles CA | 45,508 | 0.5% | 8,863,164 | 76,988 | 0.8% | 138,696 | 1.5% | 120,262 | 43,274 | 1.3% | **9,519,338** |
| Milwaukee WI | 7,666 | 0.6% | 1,263,990 | 7,582 | 0.6% | 13,640 | 1.0% | 9,737 | 2,155 | 0.7% | **1,300,931** |
| Minneapolis MN | 19,421 | 1.3% | 1,518,196 | 15,384 | 0.9% | 26,021 | 1.6% | 19,003 | 3,619 | 1.2% | **1,627,235** |
| Missoula MT | 1,818 | 2.3% | 78,687 | 2,193 | 2.3% | 3,243 | 3.4% | 2,590 | 397 | 2.7% | **95,802** |
| New York NY | 30,672 | 0.3% | 9,521,930 | 45,866 | 0.4% | 98,922 | 1.0% | 78,879 | 33,013 | 0.8% | **10,305,132** |
| Oakland CA | 21,462 | 0.6% | 3,686,592 | 22,635 | 0.5% | 57,262 | 1.4% | 33,130 | 10,495 | 0.8% | **4,123,740** |
| Phoenix AZ | 38,017 | 1.8% | 2,122,101 | 56,706 | 1.8% | 75,867 | 2.5% | 69,897 | 13,191 | 2.3% | **3,072,149** |
| Pierre SD | 994 | 6.7% | 14,817 | 5,282 | 2.6% | 6,425 | 3.2% | 5,666 | 384 | 2.8% | **202,994** |
| Portland OR | 6,734 | 1.2% | 583,887 | 15,024 | 0.8% | 32,460 | 1.8% | 19,989 | 4,965 | 1.1% | **1,789,457** |

Source: 1990 and 2000 U.S. Census

**Appendix B-1. Population of American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| | 1990 Census | | | 2000 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Census | | | | Bridged Race* | | | |
| Health Organization Service Area | AI/AN alone | % of All Race Total | All Race Total | AI/AN alone | % of All Race Total | AI/AN alone or w/other races | % of All Race Total | AI/AN alone | Difference (Census-Bridged) | % of All Race Total | All Race Total |
| Reno NV | 7,543 | 2.2% | 343,211 | 9,308 | 2.0% | 13,345 | 2.9% | 10,862 | 1,554 | 2.4% | **460,583** |
| Sacramento CA | 12,068 | 1.2% | 1,041,219 | 13,359 | 1.1% | 30,649 | 2.5% | 18,469 | 5,110 | 1.5% | **1,223,499** |
| Salt Lake City UT | 10,641 | 0.8% | 1,362,418 | 13,681 | 0.8% | 21,575 | 1.2% | 16,816 | 3,135 | 1.0% | **1,743,185** |
| San Diego CA | 20,066 | 0.8% | 2,498,016 | 24,337 | 0.9% | 46,177 | 1.6% | 33,072 | 8,735 | 1.2% | **2,813,833** |
| San Jose CA | 9,269 | 0.6% | 1,497,577 | 11,350 | 0.7% | 22,648 | 1.3% | 16,864 | 5,514 | 1.0% | **1,682,585** |
| Santa Barbara CA | 10,463 | 0.8% | 1,255,786 | 14,225 | 1.0% | 27,234 | 1.9% | 20,681 | 6,456 | 1.5% | **1,399,225** |
| Seattle WA | 17,305 | 1.1% | 1,507,319 | 15,922 | 0.9% | 33,022 | 1.9% | 20,247 | 4,325 | 1.2% | **1,737,034** |
| Spokane WA | 5,539 | 1.5% | 361,364 | 5,847 | 1.4% | 10,212 | 2.4% | 6,866 | 1,019 | 1.6% | **417,939** |
| Tucson AZ | 20,330 | 3.0% | 666,880 | 27,178 | 3.2% | 33,910 | 4.0% | 31,653 | 4,475 | 3.8% | **843,746** |
| Wichita KS | 5,662 | 1.0% | 542,472 | 6,234 | 1.0% | 12,472 | 2.1% | 7,981 | 1,747 | 1.3% | **603,087** |

Source: 1990 and 2000 U.S. Census

**Appendix B-2. Population of American Indians and Alaska Natives (AI/AN) living in U.S. Census Defined Urban Areas within Urban Indian Health Organization service area counties (UIHO), 2000**

| | 2000 | | | | | |
|---|---|---|---|---|---|---|
| Health Organization Service Area | Estimated AI/AN alone urban population | % of AI/AN alone urban Populatin | Total AI/AN alone population | Estimated AI/AN alone or w/other races urban population | % of AI/AN alone or w/other races urban population | Total AI/AN alone or w/other races population |
| US TOTAL | 1,504,379 | 60.8% | **2,475,956** | 2,819,854 | 68.5% | **4,119,301** |
| UIHO Total | 518,135 | 87.9% | **589,283** | 941,418 | 91.3% | **1,030,579** |
| Albuquerque NM | 20,847 | 90.0% | **23,175** | 26,239 | 90.9% | **28,857** |
| Bakersfield CA | 8,851 | 88.5% | **9,999** | 15,080 | 86.7% | **17,399** |
| Billings MT | 4,670 | 40.6% | **11,510** | 5,949 | 45.3% | **13,143** |
| Butte MT | 670 | 95.2% | **704** | 918 | 89.9% | **1,021** |
| Chicago IL | 15,496 | 100.0% | **15,496** | 33,941 | 100.0% | **33,941** |
| Dallas TX | 25,731 | 88.6% | **29,037** | 49,575 | 88.8% | **55,809** |
| Denver CO | 20,577 | 96.3% | **21,358** | 38,175 | 96.4% | **39,606** |
| Detroit MI | 13,732 | 94.3% | **14,568** | 34,897 | 94.8% | **36,817** |
| Flagstaff AZ | 15,487 | 46.7% | **33,161** | 16,538 | 47.8% | **34,579** |
| Fresno CA | 17,141 | 78.8% | **21,739** | 27,941 | 80.4% | **34,732** |
| Great Falls MT | 3,113 | 91.7% | **3,394** | 4,076 | 89.5% | **4,555** |
| Green Bay WI | 4,347 | 80.9% | **5,374** | 5,596 | 82.3% | **6,798** |
| Helena MT | 766 | 60.6% | **1,264** | 1,227 | 63.1% | **1,945** |
| Jamaica Plains MA | 2,689 | 100.0% | **2,689** | 6,054 | 100.0% | **6,054** |
| Lincoln NE | 6,504 | 96.9% | **6,714** | 11,253 | 97.5% | **11,543** |
| Los Angeles CA | 76,309 | 99.1% | **76,988** | 137,242 | 99.0% | **138,696** |
| Milwaukee WI | 7,476 | 98.6% | **7,582** | 13,403 | 98.3% | **13,640** |
| Minneapolis MN | 15,338 | 99.7% | **15,384** | 25,911 | 99.6% | **26,021** |
| Missoula MT | 1,658 | 75.6% | **2,193** | 2,467 | 76.1% | **3,243** |
| New York NY | 45,709 | 99.7% | **45,866** | 98,502 | 99.6% | **98,922** |
| Oakland CA | 22,312 | 98.6% | **22,635** | 56,359 | 98.4% | **57,262** |
| Phoenix AZ | 49,700 | 87.6% | **56,706** | 67,977 | 89.6% | **75,867** |
| Pierre SD | 4,538 | 85.9% | **5,282** | 5,521 | 85.9% | **6,425** |
| Portland OR | 13,847 | 92.2% | **15,024** | 29,748 | 91.6% | **32,460** |

Source: 2000 U.S. Census

**Appendix B-2. Population of American Indians and Alaska Natives (AI/AN) living in U.S. Census Defined Urban Areas within Urban Indian Health Organization service area counties (UIHO), 2000**

| | 2000 | | | | | |
|---|---|---|---|---|---|---|
| Health Organization Service Area | Estimated AI/AN alone urban population | % of AI/AN alone urban Populatin | Total AI/AN alone population | Estimated AI/AN alone or w/other races urban population | % of AI/AN alone or w/other races urban population | Total AI/AN alone or w/other races population |
| Reno NV | 6,877 | 73.9% | **9,308** | 10,701 | 80.2% | **13,345** |
| Sacramento CA | 12,951 | 96.9% | **13,359** | 29,734 | 97.0% | **30,649** |
| Salt Lake City UT | 13,222 | 96.6% | **13,681** | 20,774 | 96.3% | **21,575** |
| San Diego CA | 20,147 | 82.8% | **24,337** | 40,979 | 88.7% | **46,177** |
| San Jose CA | 11,297 | 99.5% | **11,350** | 22,447 | 99.1% | **22,648** |
| Santa Barbara CA | 13,596 | 95.6% | **14,225** | 25,727 | 94.5% | **27,234** |
| Seattle WA | 14,788 | 92.9% | **15,922** | 31,457 | 95.3% | **33,022** |
| Spokane WA | 5,469 | 93.5% | **5,847** | 9,335 | 91.4% | **10,212** |
| Tucson AZ | 18,435 | 67.8% | **27,178** | 24,705 | 72.9% | **33,910** |
| Wichita KS | 5,298 | 85.0% | **6,234** | 10,520 | 84.3% | **12,472** |

Source: 2000 U.S. Census

**Appendix B-3. Percent of American Indians and Alaska Natives (AI/AN) with household incomes below poverty living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| | 1990 | | | | | | 2000 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AI/AN alone | | | All Races | | | AI/AN alone | | | AI/AN alone or w/other races | | | All Races | | |
| Health Organization Service Area | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total |
| US TOTAL | 38.8% | 26.8% | 30.9% | **18.3%** | **11.3%** | **13.1%** | 31.6% | 22.7% | 25.7% | 27.1% | 19.5% | 22.0% | **16.6%** | **5.0%** | **12.4%** |
| UIHO Total | 36.8% | 24.1% | 28.1% | **19.6%** | **11.4%** | **13.5%** | 30.1% | 21.2% | 24.1% | 25.6% | 18.2% | 20.6% | **18.4%** | **5.5%** | **13.5%** |
| Albuquerque NM | 32.9% | 28.4% | 30.0% | **20.0%** | **12.6%** | **14.6%** | 30.9% | 23.6% | 25.8% | 28.1% | 22.6% | 24.4% | **18.4%** | **5.6%** | **13.7%** |
| Bakersfield CA | 28.9% | 15.1% | 18.5% | **24.8%** | **13.3%** | **16.9%** | 30.0% | 22.1% | 24.6% | 26.2% | 18.5% | 21.0% | **28.2%** | **7.9%** | **20.8%** |
| Billings MT | 55.4% | 44.8% | 49.4% | **18.6%** | **12.5%** | **14.2%** | 45.8% | 32.7% | 38.2% | 43.9% | 32.2% | 37.1% | **17.7%** | **5.0%** | **12.7%** |
| Butte MT | 67.9% | 32.2% | 42.5% | **19.4%** | **13.1%** | **14.7%** | 88.4% | 44.9% | 55.9% | 67.4% | 38.3% | 45.9% | **19.5%** | **6.4%** | **14.9%** |
| Chicago IL | 24.6% | 17.5% | 19.4% | **22.3%** | **11.5%** | **14.2%** | 28.4% | 17.7% | 21.0% | 22.4% | 15.4% | 17.5% | **19.3%** | **5.3%** | **13.5%** |
| Dallas TX | 17.5% | 14.5% | 15.3% | **15.7%** | **10.2%** | **11.7%** | 17.9% | 11.9% | 13.5% | 16.2% | 11.2% | 12.7% | **14.2%** | **4.2%** | **10.7%** |
| Denver CO | 34.1% | 22.0% | 25.4% | **14.9%** | **9.9%** | **11.2%** | 23.4% | 16.3% | 18.2% | 17.4% | 13.4% | 14.6% | **10.1%** | **3.4%** | **8.2%** |
| Detroit MI | 39.1% | 25.5% | 29.7% | **26.1%** | **14.5%** | **17.7%** | 20.0% | 17.0% | 17.9% | 23.5% | 16.8% | 18.8% | **20.0%** | **5.7%** | **14.5%** |
| Flagstaff AZ | 47.2% | 43.7% | 45.3% | **26.8%** | **21.3%** | **23.1%** | 36.6% | 28.9% | 32.1% | 35.8% | 28.8% | 31.7% | **22.7%** | **7.6%** | **18.2%** |
| Fresno CA | 37.6% | 17.9% | 24.2% | **32.1%** | **16.5%** | **21.4%** | 43.4% | 29.5% | 34.4% | 39.0% | 26.7% | 31.0% | **32.1%** | **8.8%** | **23.0%** |
| Great Falls MT | 60.3% | 44.6% | 51.5% | **17.6%** | **12.2%** | **13.7%** | 52.3% | 39.2% | 43.9% | 44.0% | 34.7% | 38.4% | **19.2%** | **5.3%** | **13.5%** |
| Green Bay WI | 50.2% | 31.8% | 38.6% | **12.3%** | **8.1%** | **9.2%** | 22.3% | 17.3% | 19.0% | 20.8% | 16.7% | 18.3% | **8.4%** | **2.8%** | **6.8%** |
| Helena MT | 27.1% | 24.0% | 25.0% | **14.7%** | **9.8%** | **11.2%** | 39.6% | 20.2% | 26.2% | 33.7% | 20.9% | 25.5% | **13.1%** | **4.5%** | **10.6%** |
| Jamaica Plains MA | 53.0% | 27.6% | 35.3% | **27.9%** | **15.7%** | **18.1%** | 46.6% | 28.7% | 34.6% | 35.4% | 22.4% | 26.0% | **25.2%** | **8.6%** | **19.0%** |
| Lincoln NE | 55.4% | 33.7% | 42.3% | **13.0%** | **9.1%** | **10.2%** | 34.5% | 27.0% | 29.6% | 33.9% | 22.9% | 27.0% | **11.6%** | **3.6%** | **9.0%** |
| Los Angeles CA | 24.7% | 14.5% | 17.1% | **21.9%** | **12.7%** | **15.1%** | 28.1% | 20.0% | 22.5% | 24.5% | 17.5% | 19.6% | **24.6%** | **7.2%** | **17.9%** |
| Milwaukee WI | 36.2% | 19.0% | 24.9% | **21.7%** | **9.6%** | **12.8%** | 28.0% | 18.8% | 22.0% | 26.4% | 18.5% | 21.6% | **18.0%** | **4.3%** | **11.8%** |
| Minneapolis MN | 57.2% | 36.2% | 44.4% | **14.9%** | **8.4%** | **9.9%** | 32.4% | 24.3% | 27.0% | 25.6% | 21.7% | 23.2% | **12.6%** | **3.6%** | **9.0%** |
| Missoula MT | 64.4% | 42.8% | 50.5% | **19.6%** | **16.1%** | **17.0%** | 36.9% | 27.7% | 31.2% | 31.7% | 28.2% | 29.5% | **15.2%** | **7.0%** | **14.8%** |
| New York NY | 29.5% | 20.8% | 23.1% | **24.9%** | **13.4%** | **16.0%** | 37.3% | 25.6% | 29.5% | 33.6% | 21.5% | 25.1% | **25.3%** | **7.6%** | **18.0%** |
| Oakland CA | 16.0% | 13.1% | 13.7% | **13.0%** | **8.1%** | **9.2%** | 15.5% | 13.1% | 13.7% | 13.6% | 11.9% | 12.4% | **11.3%** | **3.9%** | **9.1%** |
| Phoenix AZ | 40.8% | 31.1% | 34.8% | **17.3%** | **10.6%** | **12.3%** | 31.1% | 23.2% | 26.0% | 27.3% | 20.9% | 23.2% | **15.9%** | **4.7%** | **11.7%** |
| Pierre SD | 70.4% | 45.7% | 56.3% | **13.9%** | **8.9%** | **10.4%** | 40.0% | 37.0% | 38.2% | 37.5% | 33.1% | 34.9% | **9.4%** | **3.4%** | **8.0%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-3. Percent of American Indians and Alaska Natives (AI/AN) with household incomes below poverty living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| Health Organization Service Area | 1990 | | | | | | 2000 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AI/AN alone | | | All Races | | | AI/AN alone | | | AI/AN alone or w/other races | | | All Races | | |
| | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total | Children (<18) | Adults (18 and older) | Total |
| Portland OR | 33.5% | 26.0% | 28.1% | **16.8%** | **12.0%** | **13.1%** | 17.5% | 15.6% | 16.1% | 17.4% | 14.9% | 15.6% | **11.8%** | **4.0%** | **9.5%** |
| Reno NV | 29.0% | 22.9% | 24.7% | **11.0%** | **8.5%** | **9.1%** | 24.1% | 18.5% | 20.4% | 21.4% | 16.7% | 18.3% | **12.7%** | **3.9%** | **9.6%** |
| Sacramento CA | 27.4% | 16.6% | 19.7% | **19.9%** | **9.8%** | **12.5%** | 26.5% | 18.6% | 20.9% | 25.7% | 16.6% | 19.6% | **20.6%** | **5.4%** | **14.1%** |
| Salt Lake City UT | 38.4% | 33.2% | 35.4% | **11.7%** | **10.0%** | **10.6%** | 23.8% | 20.3% | 21.4% | 21.2% | 17.0% | 18.5% | **9.1%** | **3.5%** | **8.6%** |
| San Diego CA | 22.5% | 15.3% | 17.4% | **16.2%** | **9.7%** | **11.3%** | 26.4% | 16.4% | 19.4% | 22.7% | 14.6% | 17.0% | **16.9%** | **5.0%** | **12.4%** |
| San Jose CA | 21.0% | 11.4% | 13.9% | **10.5%** | **6.6%** | **7.5%** | 15.3% | 11.7% | 12.7% | 11.6% | 8.9% | 9.7% | **9.0%** | **3.2%** | **7.5%** |
| Santa Barbara CA | 17.1% | 13.5% | 14.5% | **12.1%** | **9.1%** | **9.8%** | 20.6% | 14.9% | 16.6% | 16.4% | 13.8% | 14.6% | **13.4%** | **4.8%** | **11.3%** |
| Seattle WA | 35.2% | 22.0% | 25.6% | **9.8%** | **7.4%** | **8.0%** | 26.3% | 18.6% | 20.6% | 20.8% | 15.9% | 17.2% | **9.9%** | **3.6%** | **8.4%** |
| Spokane WA | 38.8% | 29.6% | 32.6% | **16.9%** | **12.5%** | **13.7%** | 29.1% | 24.7% | 26.0% | 32.7% | 23.4% | 26.3% | **15.0%** | **5.2%** | **12.3%** |
| Tucson AZ | 57.7% | 49.3% | 52.4% | **23.5%** | **15.1%** | **17.2%** | 40.2% | 32.6% | 35.2% | 38.2% | 30.6% | 33.2% | **20.0%** | **6.1%** | **14.7%** |
| Wichita KS | 23.2% | 18.2% | 19.9% | **14.1%** | **9.1%** | **10.5%** | 19.7% | 14.9% | 16.5% | 18.0% | 13.7% | 15.1% | **12.2%** | **3.7%** | **9.5%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-4. Percent of American Indians and Alaska Natives (AI/AN) with household incomes below poverty living in Urban Indian Health Organization service area counties (UIHO), 2000**

| Health Organization Service Area | Living in Poverty (<100%) | | | Living in Poverty (<200%) | | |
|---|---|---|---|---|---|---|
| | AI/AN Alone | AI/AN alone or w/ other races | All Races | AI/AN Alone | AI/AN alone or w/ other races | All Races |
| **US TOTAL** | 25.7% | 22.0% | 12.4% | 51.4% | 46.0% | 29.6% |
| **UIHO Total** | 24.1% | 20.6% | 13.5% | 48.2% | 42.7% | 30.4% |
| **Albuquerque NM** | 25.8% | 24.4% | 13.7% | 55.8% | 52.9% | 32.9% |
| **Bakersfield CA** | 24.6% | 21.0% | 20.8% | 51.2% | 46.4% | 45.5% |
| **Billings MT** | 38.2% | 37.1% | 12.7% | 63.9% | 63.5% | 33.0% |
| **Butte MT** | 55.9% | 45.9% | 14.9% | 74.5% | 66.9% | 37.4% |
| **Chicago IL** | 21.0% | 17.5% | 13.5% | 42.7% | 36.6% | 29.5% |
| **Dallas TX** | 13.6% | 12.7% | 10.7% | 32.5% | 30.5% | 27.5% |
| **Denver CO** | 18.2% | 14.6% | 8.2% | 37.7% | 33.0% | 21.0% |
| **Detroit MI** | 17.9% | 18.8% | 14.5% | 38.6% | 39.6% | 30.5% |
| **Flagstaff AZ** | 32.1% | 31.7% | 18.2% | 61.8% | 61.3% | 39.2% |
| **Fresno CA** | 34.4% | 31.0% | 23.0% | 59.9% | 55.6% | 48.9% |
| **Great Falls MT** | 43.9% | 38.4% | 13.5% | 74.4% | 66.1% | 36.7% |
| **Green Bay WI** | 19.0% | 18.3% | 6.8% | 45.6% | 46.4% | 20.4% |
| **Helena MT** | 26.2% | 25.5% | 10.6% | 54.0% | 49.6% | 28.2% |
| **Jamaica Plains MA** | 34.6% | 26.0% | 19.0% | 52.7% | 47.8% | 36.7% |
| **Lincoln NE** | 29.7% | 27.0% | 9.0% | 57.9% | 52.7% | 23.9% |
| **Los Angeles CA** | 22.5% | 19.6% | 17.9% | 49.6% | 43.1% | 39.9% |
| **Milwaukee WI** | 22.0% | 21.6% | 11.8% | 42.5% | 42.1% | 26.0% |
| **Minneapolis MN** | 27.0% | 23.2% | 9.0% | 50.2% | 45.7% | 21.4% |
| **Missoula MT** | 31.2% | 29.5% | 14.8% | 56.6% | 56.7% | 35.4% |
| **New York NY** | 29.5% | 25.1% | 18.0% | 55.8% | 47.4% | 34.6% |
| **Oakland CA** | 13.7% | 12.4% | 9.1% | 32.1% | 28.1% | 21.3% |
| **Phoenix AZ** | 26.0% | 23.2% | 11.7% | 51.8% | 48.5% | 29.2% |
| **Pierre SD** | 38.2% | 34.9% | 8.0% | 64.1% | 60.4% | 23.1% |

Source: 2000 U.S. Census

**Appendix B-4. Percent of American Indians and Alaska Natives (AI/AN) with household incomes below poverty living in Urban Indian Health Organization service area counties (UIHO), 2000**

| Health Organization Service Area | Living in Poverty (<100%) | | | Living in Poverty (<200%) | | |
|---|---|---|---|---|---|---|
| | AI/AN Alone | AI/AN alone or w/ other races | All Races | AI/AN Alone | AI/AN alone or w/ other races | All Races |
| Portland OR | 16.1% | 15.6% | 9.5% | 37.1% | 37.4% | 24.2% |
| Reno NV | 20.5% | 18.3% | 9.6% | 47.1% | 43.9% | 25.8% |
| Sacramento CA | 20.9% | 19.6% | 14.1% | 40.6% | 40.3% | 31.9% |
| Salt Lake City UT | 21.4% | 18.5% | 8.6% | 45.5% | 41.6% | 25.4% |
| San Diego CA | 19.4% | 17.0% | 12.4% | 44.2% | 40.2% | 30.6% |
| San Jose CA | 12.7% | 9.7% | 7.5% | 29.1% | 25.2% | 17.9% |
| Santa Barbara CA | 16.6% | 14.6% | 11.3% | 36.0% | 33.0% | 28.0% |
| Seattle WA | 20.6% | 17.2% | 8.4% | 37.8% | 34.1% | 19.6% |
| Spokane WA | 26.0% | 26.3% | 12.3% | 55.5% | 55.8% | 31.3% |
| Tucson AZ | 35.2% | 33.2% | 14.7% | 60.3% | 58.1% | 35.1% |
| Wichita KS | 16.5% | 15.1% | 9.5% | 37.0% | 36.6% | 26.2% |

Source: 2000 U.S. Census

**Appendix B-5. Educational Attainment of American Indians and Alaska Natives (AI/AN) at age 25 or older living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| | 1990 | | | | 2000 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AI/AN alone | | All Races | | AI/AN alone | | AI/AN alone or w/other races | | All Races | |
| Health Organization Service Area | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher |
| US TOTAL | 65.5% | 9.3% | **69.4%** | **26.2%** | 70.9% | 11.5% | 74.7% | 14.3% | **80.4%** | **24.4%** |
| UIHO Total | 70.2% | 11.6% | **69.5%** | **31.8%** | 70.4% | 13.0% | 75.3% | 17.2% | **79.6%** | **28.9%** |
| Albuquerque NM | 79.8% | 14.3% | **78.8%** | **30.0%** | 82.4% | 15.0% | 83.8% | 18.0% | **84.4%** | **30.5%** |
| Bakersfield CA | 62.3% | 6.1% | **64.1%** | **16.8%** | 63.8% | 6.9% | 69.5% | 7.8% | **68.5%** | **13.5%** |
| Billings MT | 72.9% | 10.9% | **78.9%** | **24.4%** | 77.4% | 11.5% | 77.3% | 12.1% | **87.5%** | **25.4%** |
| Butte MT | 60.1% | 0.0% | **77.6%** | **18.6%** | 74.4% | 8.4% | 80.9% | 9.1% | **85.1%** | **21.7%** |
| Chicago IL | 70.1% | 16.0% | **61.1%** | **35.1%** | 65.8% | 15.3% | 75.2% | 23.5% | **77.7%** | **28.0%** |
| Dallas TX | 74.1% | 15.8% | **71.5%** | **33.0%** | 75.0% | 18.8% | 79.4% | 20.9% | **80.0%** | **28.6%** |
| Denver CO | 75.8% | 13.1% | **80.9%** | **34.5%** | 77.5% | 17.0% | 81.4% | 20.1% | **87.1%** | **36.4%** |
| Detroit MI | 69.7% | 9.7% | **58.3%** | **31.0%** | 75.1% | 11.8% | 77.7% | 13.6% | **79.9%** | **19.8%** |
| Flagstaff AZ | 51.7% | 5.0% | **67.1%** | **36.5%** | 62.7% | 7.8% | 63.4% | 8.2% | **83.8%** | **29.9%** |
| Fresno CA | 64.9% | 7.6% | **61.9%** | **17.4%** | 60.5% | 7.1% | 65.1% | 8.7% | **65.7%** | **15.3%** |
| Great Falls MT | 62.6% | 7.3% | **80.7%** | **20.6%** | 71.5% | 7.2% | 74.5% | 8.8% | **87.1%** | **21.5%** |
| Green Bay WI | 63.3% | 3.5% | **81.2%** | **18.5%** | 77.3% | 11.0% | 77.8% | 12.7% | **86.5%** | **22.3%** |
| Helena MT | 74.6% | 14.1% | **85.4%** | **27.9%** | 79.7% | 11.3% | 82.6% | 13.6% | **91.2%** | **31.0%** |
| Jamaica Plains MA | 71.4% | 16.7% | **64.9%** | **38.3%** | 60.4% | 12.9% | 69.3% | 17.8% | **78.1%** | **32.5%** |
| Lincoln NE | 74.3% | 12.4% | **81.6%** | **28.2%** | 76.4% | 9.6% | 81.5% | 12.9% | **88.3%** | **29.6%** |
| Los Angeles CA | 72.1% | 13.4% | **63.4%** | **29.0%** | 59.3% | 11.6% | 68.9% | 17.3% | **69.9%** | **24.9%** |
| Milwaukee WI | 70.3% | 5.6% | **72.7%** | **27.6%** | 75.2% | 11.0% | 77.5% | 13.4% | **83.6%** | **26.7%** |
| Minneapolis MN | 69.1% | 9.1% | **84.3%** | **33.6%** | 72.4% | 11.8% | 76.5% | 14.3% | **89.7%** | **37.6%** |
| Missoula MT | 80.6% | 17.6% | **84.1%** | **29.1%** | 80.3% | 19.3% | 83.5% | 19.7% | **91.0%** | **32.8%** |
| New York NY | 64.7% | 18.9% | **60.2%** | **36.6%** | 58.7% | 13.9% | 67.2% | 19.8% | **75.3%** | **29.7%** |
| Oakland CA | 76.7% | 16.0% | **76.5%** | **38.7%** | 76.5% | 19.8% | 82.4% | 24.9% | **84.2%** | **38.8%** |
| Phoenix AZ | 66.9% | 7.7% | **78.9%** | **24.7%** | 73.0% | 11.2% | 74.6% | 13.3% | **82.5%** | **25.9%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-5. Educational Attainment of American Indians and Alaska Natives (AI/AN) at age 25 or older living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| Health Organization Service Area | 1990 | | | | 2000 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AI/AN alone | | All Races | | AI/AN alone | | AI/AN alone or w/other races | | All Races | |
| | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher | High School Diploma or GED | 4 Year College Degree or Higher |
| Pierre SD | 66.2% | 8.2% | **81.8%** | **28.3%** | 73.9% | 9.3% | 75.2% | 9.9% | **88.1%** | **26.0%** |
| Portland OR | 73.2% | 10.9% | **79.3%** | **27.2%** | 80.6% | 15.5% | 82.5% | 17.5% | **87.5%** | **29.6%** |
| Reno NV | 71.2% | 8.8% | **80.5%** | **22.0%** | 76.8% | 9.3% | 79.5% | 11.8% | **84.6%** | **22.6%** |
| Sacramento CA | 76.2% | 13.2% | **76.5%** | **28.7%** | 77.2% | 13.6% | 80.5% | 15.6% | **83.3%** | **24.8%** |
| Salt Lake City UT | 72.1% | 8.0% | **85.0%** | **24.0%** | 78.0% | 12.9% | 80.2% | 15.3% | **88.0%** | **27.2%** |
| San Diego CA | 75.9% | 12.0% | **77.9%** | **29.3%** | 73.3% | 13.8% | 78.2% | 17.9% | **82.6%** | **29.5%** |
| San Jose CA | 74.6% | 17.6% | **79.7%** | **34.9%** | 71.2% | 16.3% | 77.3% | 21.6% | **83.4%** | **40.5%** |
| Santa Barbara CA | 72.8% | 10.5% | **78.3%** | **26.0%** | 68.9% | 13.5% | 76.2% | 17.1% | **80.9%** | **27.6%** |
| Seattle WA | 76.1% | 12.4% | **84.9%** | **36.2%** | 79.5% | 18.2% | 83.8% | 22.9% | **90.3%** | **40.0%** |
| Spokane WA | 79.2% | 9.6% | **82.8%** | **22.2%** | 82.2% | 13.3% | 82.1% | 15.9% | **89.1%** | **25.0%** |
| Tucson AZ | 55.9% | 5.3% | **77.6%** | **26.2%** | 65.3% | 9.4% | 69.3% | 12.7% | **83.4%** | **26.7%** |
| Wichita KS | 75.2% | 8.9% | **77.5%** | **24.3%** | 79.1% | 12.9% | 80.3% | 15.7% | **85.1%** | **23.6%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-6. Unemployment Status of American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| Health Organization Service Area | 1990 | | 2000 | | |
|---|---|---|---|---|---|
| | AI/AN Alone | All Races | AI/AN Alone | AI/AN alone or w/ other races | All Races |
| **US TOTAL** | 8.8% | **4.1%** | 12.3% | 10.5% | **5.7%** |
| **UIHO Total** | 8.3% | **4.5%** | 11.5% | 10.3% | **6.3%** |
| **Albuquerque NM** | 8.5% | **4.4%** | 13.7% | 13.1% | **5.7%** |
| **Bakersfield CA** | 6.6% | **5.9%** | 13.6% | 11.9% | **11.8%** |
| **Billings MT** | 19.7% | **4.4%** | 18.2% | 17.4% | **5.2%** |
| **Butte MT** | 15.0% | **5.7%** | 21.6% | 18.2% | **6.8%** |
| **Chicago IL** | 10.2% | **5.3%** | 13.4% | 10.9% | **7.5%** |
| **Dallas TX** | 6.3% | **4.2%** | 7.3% | 7.0% | **4.7%** |
| **Denver CO** | 8.5% | **4.0%** | 8.3% | 7.8% | **4.0%** |
| **Detroit MI** | 11.6% | **6.6%** | 10.0% | 10.3% | **7.3%** |
| **Flagstaff AZ** | 11.2% | **6.0%** | 18.4% | 17.9% | **6.9%** |
| **Fresno CA** | 7.9% | **6.2%** | 17.5% | 16.0% | **12.2%** |
| **Great Falls MT** | 9.5% | **3.7%** | 19.6% | 15.1% | **5.8%** |
| **Green Bay WI** | 6.5% | **3.3%** | 12.6% | 12.1% | **4.0%** |
| **Helena MT** | 9.6% | **3.5%** | 7.6% | 6.8% | **5.1%** |
| **Jamaica Plains MA** | 11.0% | **5.5%** | 9.4% | 8.6% | **7.0%** |
| **Lincoln NE** | 10.6% | **2.8%** | 10.9% | 9.4% | **3.7%** |
| **Los Angeles CA** | 7.0% | **4.9%** | 10.7% | 10.3% | **8.2%** |
| **Milwaukee WI** | 10.8% | **3.9%** | 11.4% | 11.8% | **5.7%** |
| **Minneapolis MN** | 10.9% | **3.5%** | 14.9% | 12.4% | **4.0%** |
| **Missoula MT** | 13.7% | **4.8%** | 10.2% | 10.9% | **6.1%** |
| **New York NY** | 6.1% | **4.9%** | 15.3% | 12.7% | **8.2%** |
| **Oakland CA** | 6.4% | **3.7%** | 6.9% | 6.5% | **4.6%** |
| **Phoenix AZ** | 9.6% | **4.0%** | 10.3% | 9.7% | **4.7%** |
| **Pierre SD** | 3.1% | **1.7%** | 14.7% | 13.3% | **3.0%** |
| **Portland OR** | 8.4% | **3.9%** | 10.4% | 10.3% | **5.6%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-6. Unemployment Status of American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| Health Organization Service Area | 1990 | | 2000 | | |
|---|---|---|---|---|---|
| | AI/AN Alone | All Races | AI/AN Alone | AI/AN alone or w/ other races | All Races |
| Reno NV | 9.4% | **3.7%** | 10.1% | 9.2% | **5.0%** |
| Sacramento CA | 7.5% | **4.1%** | 10.8% | 10.6% | **6.6%** |
| Salt Lake City UT | 9.9% | **3.4%** | 9.8% | 9.8% | **4.7%** |
| San Diego CA | 6.0% | **3.8%** | 8.7% | 8.5% | **5.6%** |
| San Jose CA | 5.4% | **3.4%** | 7.9% | 7.3% | **3.9%** |
| Santa Barbara CA | 6.3% | **3.4%** | 8.4% | 7.0% | **5.7%** |
| Seattle WA | 5.5% | **3.0%** | 11.0% | 9.8% | **4.5%** |
| Spokane WA | 7.9% | **4.5%** | 13.6% | 11.7% | **7.9%** |
| Tucson AZ | 8.9% | **4.6%** | 13.8% | 12.3% | **5.3%** |
| Wichita KS | 8.0% | **3.5%** | 7.5% | 6.9% | **4.7%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-7. Percent of Households of American Indians and Alaska Natives (AI/AN) that consist of a single parent living with own children (age < 18) living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| Health Organization Service Area | 1990 | | 2000 | | |
|---|---|---|---|---|---|
| | AI/AN Alone | All Races | AI/AN Alone | AI/AN alone or w/ other races | All Races |
| US TOTAL | 36.6% | **22.8%** | 43.5% | 42.5% | **29.2%** |
| UIHO Total | 43.4% | **26.7%** | 46.1% | 44.9% | **31.0%** |
| Albuquerque NM | 42.6% | **26.4%** | 56.2% | 56.1% | **35.2%** |
| Bakersfield CA | 33.9% | **26.0%** | 38.4% | 36.6% | **31.2%** |
| Billings MT | 34.5% | **22.1%** | 45.5% | 46.7% | **30.1%** |
| Butte MT | 76.2% | **20.1%** | 40.7% | 40.5% | **28.0%** |
| Chicago IL | 34.9% | **29.3%** | 36.2% | 39.3% | **34.2%** |
| Dallas TX | 30.0% | **21.4%** | 32.8% | 33.5% | **26.9%** |
| Denver CO | 44.9% | **25.0%** | 45.2% | 42.3% | **26.1%** |
| Detroit MI | 51.9% | **35.9%** | 43.5% | 49.0% | **40.2%** |
| Flagstaff AZ | 34.9% | **24.2%** | 42.4% | 42.7% | **31.4%** |
| Fresno CA | 39.7% | **27.2%** | 40.4% | 41.5% | **31.1%** |
| Great Falls MT | 53.4% | **22.3%** | 56.4% | 51.0% | **28.8%** |
| Green Bay WI | 58.9% | **18.0%** | 58.9% | 54.8% | **24.2%** |
| Helena MT | 57.8% | **22.4%** | 46.5% | 48.7% | **25.3%** |
| Jamaica Plains MA | 64.9% | **42.3%** | 68.9% | 64.6% | **47.3%** |
| Lincoln NE | 54.7% | **22.2%** | 57.8% | 55.7% | **27.1%** |
| Los Angeles CA | 36.5% | **26.1%** | 39.4% | 40.9% | **31.5%** |
| Milwaukee WI | 47.8% | **29.2%** | 55.9% | 53.7% | **34.8%** |
| Minneapolis MN | 70.4% | **24.4%** | 62.0% | 57.9% | **28.7%** |
| Missoula MT | 61.6% | **25.4%** | 53.7% | 48.9% | **27.6%** |
| New York NY | 45.8% | **32.5%** | 48.5% | 49.3% | **37.7%** |
| Oakland CA | 36.4% | **24.2%** | 39.3% | 41.5% | **26.8%** |
| Phoenix AZ | 45.2% | **23.8%** | 52.8% | 50.0% | **28.7%** |
| Pierre SD | 58.7% | **20.0%** | 70.1% | 65.8% | **25.3%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-7. Percent of Households of American Indians and Alaska Natives (AI/AN) that consist of a single parent living with own children (age < 18) living in Urban Indian Health Organization service area counties (UIHO), 1990 and 2000**

| Health Organization Service Area | 1990 | | 2000 | | |
|---|---|---|---|---|---|
| | AI/AN Alone | All Races | AI/AN Alone | AI/AN alone or w/ other races | All Races |
| Portland OR | 48.4% | **27.9%** | 45.3% | 44.1% | **26.3%** |
| Reno NV | 46.7% | **23.5%** | 54.3% | 51.3% | **29.7%** |
| Sacramento CA | 45.6% | **29.5%** | 52.0% | 50.1% | **34.6%** |
| Salt Lake City UT | 40.5% | **16.5%** | 42.4% | 37.2% | **18.9%** |
| San Diego CA | 35.7% | **24.1%** | 41.5% | 39.4% | **28.1%** |
| San Jose CA | 34.1% | **20.1%** | 38.5% | 36.7% | **22.0%** |
| Santa Barbara CA | 31.8% | **19.3%** | 31.6% | 33.2% | **24.0%** |
| Seattle WA | 48.5% | **22.3%** | 51.0% | 46.7% | **25.6%** |
| Spokane WA | 55.0% | **25.4%** | 54.6% | 51.8% | **30.4%** |
| Tucson AZ | 57.0% | **26.9%** | 55.3% | 54.2% | **32.6%** |
| Wichita KS | 35.0% | **21.1%** | 35.2% | 38.5% | **26.8%** |

Source: 1990 and 2000 U.S. Census

**Appendix B-8. Disability Status of American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 2000**

| Health Organization Service Area | 2000 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AI/AN alone | | | | AI/AN alone or w/other races | | | | All Races | | | |
| | Ages 5 - 14 | Ages 15 - 64 | Ages 65 and Older | Total (Ages 5 and Older) | Ages 5 - 14 | Ages 15 - 64 | Ages 65 and Older | Total (Ages 5 and Older) | Ages 5 - 14 | Ages 15 - 64 | Ages 65 and Older | Total (Ages 5 and Older) |
| **US TOTAL** | 7.7% | 27.0% | 57.6% | 24.3% | 9.0% | 28.0% | 56.8% | 25.6% | **5.8%** | **18.6%** | **41.9%** | **19.3%** |
| **UIHO Total** | 7.8% | 26.7% | 54.7% | 23.9% | 8.7% | 27.0% | 53.6% | 24.5% | **5.3%** | **19.0%** | **41.8%** | **19.1%** |
| **Albuquerque NM** | 5.4% | 21.3% | 50.6% | 19.5% | 6.6% | 22.1% | 52.7% | 20.1% | **6.1%** | **18.9%** | **43.4%** | **19.7%** |
| **Bakersfield CA** | 4.9% | 29.1% | 46.9% | 24.9% | 9.2% | 32.8% | 51.1% | 28.5% | **6.1%** | **24.3%** | **47.1%** | **22.5%** |
| **Billings MT** | 7.4% | 27.6% | 63.4% | 22.8% | 8.2% | 27.7% | 57.9% | 23.0% | **6.7%** | **16.7%** | **41.2%** | **18.1%** |
| **Butte MT** | 0.0% | 29.2% | 81.8% | 25.0% | 6.3% | 22.4% | 81.8% | 20.4% | **5.1%** | **16.8%** | **40.9%** | **18.8%** |
| **Chicago IL** | 6.2% | 28.9% | 55.3% | 25.5% | 7.9% | 26.7% | 51.5% | 24.6% | **5.5%** | **19.3%** | **42.6%** | **19.7%** |
| **Dallas TX** | 9.4% | 25.1% | 52.0% | 23.5% | 9.8% | 26.1% | 52.4% | 24.4% | **5.1%** | **17.9%** | **42.4%** | **17.5%** |
| **Denver CO** | 8.7% | 25.6% | 43.6% | 23.3% | 8.0% | 26.2% | 45.6% | 23.4% | **5.2%** | **15.2%** | **38.9%** | **15.7%** |
| **Detroit MI** | 15.2% | 30.9% | 60.4% | 29.4% | 15.0% | 31.6% | 58.0% | 29.6% | **7.1%** | **20.7%** | **44.8%** | **21.0%** |
| **Flagstaff AZ** | 4.6% | 21.9% | 67.6% | 19.6% | 4.5% | 22.4% | 67.0% | 19.7% | **4.6%** | **16.6%** | **44.1%** | **16.3%** |
| **Fresno CA** | 5.5% | 26.8% | 55.9% | 23.1% | 7.1% | 30.1% | 56.6% | 26.0% | **5.2%** | **22.9%** | **46.0%** | **21.4%** |
| **Great Falls MT** | 13.3% | 31.0% | 59.2% | 28.4% | 12.6% | 29.7% | 52.1% | 26.1% | **7.3%** | **18.7%** | **39.6%** | **19.7%** |
| **Green Bay WI** | 10.7% | 23.0% | 62.0% | 22.1% | 11.1% | 25.2% | 59.4% | 23.0% | **6.2%** | **13.6%** | **36.0%** | **15.0%** |
| **Helena MT** | 0.0% | 27.6% | 50.7% | 22.8% | 0.0% | 26.6% | 42.7% | 21.1% | **4.3%** | **16.1%** | **40.0%** | **16.9%** |
| **Jamaica Plains MA** | 3.5% | 36.7% | 64.8% | 30.6% | 9.8% | 35.6% | 61.3% | 32.5% | **6.9%** | **22.0%** | **46.1%** | **22.7%** |
| **Lincoln NE** | 8.2% | 28.4% | 56.0% | 24.4% | 9.4% | 26.0% | 55.4% | 22.7% | **5.3%** | **14.5%** | **37.1%** | **15.3%** |
| **Los Angeles CA** | 7.5% | 28.2% | 51.5% | 24.9% | 7.6% | 27.3% | 53.9% | 25.0% | **4.6%** | **21.1%** | **44.8%** | **20.4%** |
| **Milwaukee WI** | 12.2% | 25.5% | 50.0% | 23.5% | 11.2% | 25.0% | 49.0% | 22.4% | **6.6%** | **16.6%** | **37.6%** | **17.5%** |
| **Minneapolis MN** | 10.1% | 23.7% | 40.1% | 20.9% | 11.0% | 24.7% | 44.2% | 21.7% | **5.6%** | **13.6%** | **35.7%** | **14.8%** |
| **Missoula MT** | 7.4% | 22.9% | 39.8% | 18.9% | 6.1% | 23.6% | 44.7% | 19.3% | **6.2%** | **14.2%** | **39.4%** | **15.6%** |
| **New York NY** | 9.9% | 34.5% | 60.2% | 30.3% | 8.8% | 32.6% | 55.0% | 29.2% | **5.8%** | **23.1%** | **42.6%** | **22.8%** |
| **Oakland CA** | 8.7% | 26.3% | 53.8% | 25.1% | 8.1% | 26.7% | 54.5% | 24.9% | **4.2%** | **17.0%** | **40.5%** | **18.0%** |
| **Phoenix AZ** | 5.9% | 24.6% | 54.3% | 20.9% | 6.8% | 25.4% | 52.0% | 21.7% | **5.2%** | **17.7%** | **38.3%** | **18.0%** |
| **Pierre SD** | 12.8% | 26.0% | 52.4% | 22.9% | 12.3% | 24.6% | 48.2% | 21.8% | **5.3%** | **14.8%** | **38.0%** | **16.0%** |

Source: 2000 U.S. Census

**Appendix B-8. Disability Status of American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 2000**

| Health Organization Service Area | 2000 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AI/AN alone | | | | AI/AN alone or w/other races | | | | All Races | | | |
| | Ages 5 - 14 | Ages 15 - 64 | Ages 65 and Older | Total (Ages 5 and Older) | Ages 5 - 14 | Ages 15 - 64 | Ages 65 and Older | Total (Ages 5 and Older) | Ages 5 - 14 | Ages 15 - 64 | Ages 65 and Older | Total (Ages 5 and Older) |
| **Portland OR** | 11.8% | 26.4% | 42.9% | 24.3% | 12.5% | 27.2% | 49.1% | 25.1% | **5.8%** | **16.0%** | **41.2%** | **17.0%** |
| **Reno NV** | 5.2% | 23.1% | 48.6% | 20.6% | 6.2% | 23.5% | 46.4% | 21.2% | **4.6%** | **18.9%** | **39.1%** | **18.9%** |
| **Sacramento CA** | 7.8% | 29.4% | 56.2% | 26.2% | 10.4% | 28.7% | 58.1% | 25.9% | **5.8%** | **20.1%** | **42.8%** | **20.0%** |
| **Salt Lake City UT** | 5.4% | 22.1% | 47.9% | 19.0% | 7.9% | 22.8% | 53.7% | 19.8% | **5.4%** | **14.7%** | **39.6%** | **14.8%** |
| **San Diego CA** | 8.7% | 24.2% | 49.4% | 22.7% | 8.6% | 24.0% | 52.3% | 22.6% | **4.7%** | **17.3%** | **40.8%** | **17.9%** |
| **San Jose CA** | 9.1% | 22.7% | 61.5% | 22.1% | 7.7% | 22.1% | 50.9% | 21.1% | **3.7%** | **16.2%** | **39.3%** | **16.4%** |
| **Santa Barbara CA** | 7.9% | 29.7% | 56.2% | 26.5% | 10.3% | 26.7% | 50.8% | 24.7% | **5.1%** | **17.3%** | **38.3%** | **17.7%** |
| **Seattle WA** | 11.8% | 26.6% | 50.0% | 25.2% | 11.1% | 25.2% | 51.6% | 23.8% | **5.2%** | **14.8%** | **39.8%** | **16.1%** |
| **Spokane WA** | 10.8% | 29.8% | 43.8% | 26.7% | 12.5% | 30.2% | 46.8% | 27.4% | **5.7%** | **17.9%** | **43.2%** | **19.1%** |
| **Tucson AZ** | 6.5% | 28.6% | 60.9% | 25.2% | 7.5% | 28.8% | 58.4% | 25.4% | **6.7%** | **18.8%** | **40.7%** | **20.1%** |
| **Wichita KS** | 11.1% | 24.6% | 54.1% | 23.3% | 8.8% | 25.6% | 49.9% | 23.1% | **5.4%** | **17.4%** | **41.3%** | **18.2%** |

Source: 2000 U.S. Census

**Appendix C-1. Births to mothers who are American Indians or Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|
| | Total Count | Rate per (95% 1,000 confidence population interval) | Rate per (95% 1,000 confidence population interval) | | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| US TOTAL | 390,606 | 15.5 (15.5-15.6) | 14.8 (14.8-14.8) | +5% | Decreasing | Decreasing |
| UIHO Total | 83,258 | 12.8 (12.7-12.8) | 16.5 (16.5-16.5) | -23% | Decreasing | Decreasing |
| Albuquerque NM | 4,028 | 17.9 (17.3-18.5) | 15.2 (15.1-15.3) | +18% | Decreasing | ns |
| Bakersfield CA | 854 | 7.1 (6.6-7.6) | 19.3 (19.2-19.4) | -63% | ns | ns |
| Billings MT | 2,825 | 25.4 (24.5-26.4) | 14.0 (13.8-14.2) | +81% | Decreasing | ns |
| Butte MT | 126 | 19.1 (15.9-22.7) | 12.2 (11.8-12.5) | +57% | ns | ns |
| Chicago IL | 1,123 | 6.2 (5.9-6.6) | 17.0 (16.9-17.0) | -63% | Decreasing | Decreasing |
| Dallas TX | 2,433 | 8.1 (7.8-8.5) | 17.4 (17.4-17.4) | -53% | Decreasing | Decreasing |
| Denver CO | 2,899 | 13.0 (12.5-13.4) | 15.2 (15.1-15.2) | -15% | Decreasing | ns |
| Detroit MI | 1,402 | 7.5 (7.1-7.9) | 16.0 (15.9-16.0) | -53% | Decreasing | Decreasing |
| Flagstaff AZ | 7,894 | 24.0 (23.4-24.5) | 16.6 (16.4-16.9) | +44% | Decreasing | ns |
| Fresno CA | 2,047 | 8.7 (8.3-9.1) | 19.9 (19.8-19.9) | -56% | Decreasing | Decreasing |
| Great Falls MT | 807 | 23.0 (21.4-24.6) | 14.7 (14.4-15.0) | +56% | Decreasing | ns |
| Green Bay WI | 1,210 | 23.5 (22.2-24.9) | 13.8 (13.6-13.9) | +71% | ns | ns |
| Helena MT | 289 | 21.7 (19.3-24.4) | 12.2 (11.9-12.5) | +78% | ns | ns |
| Jamaica Plains MA | 189 | 6.1 (5.3-7.0) | 14.7 (14.6-14.8) | -58% | Decreasing | ns |
| Lincoln NE | 1,756 | 24.2 (23.1-25.4) | 15.6 (15.5-15.6) | +56% | ns | Increasing |
| Los Angeles CA | 4,162 | 4.8 (4.7-5.0) | 18.9 (18.9-19.0) | -74% | Decreasing | Decreasing |
| Milwaukee WI | 1,494 | 16.7 (15.8-17.5) | 15.1 (15.0-15.1) | +11% | ns | ns |
| Minneapolis MN | 4,375 | 22.5 (21.8-23.2) | 14.9 (14.8-15.0) | +51% | Decreasing | Increasing |
| Missoula MT | 343 | 15.3 (13.7-17.0) | 12.1 (11.9-12.3) | +26% | ns | ns |
| New York NY | 2,276 | 4.1 (3.9-4.3) | 15.7 (15.7-15.7) | -74% | Decreasing | Decreasing |
| Oakland CA | 2,274 | 7.9 (7.5-8.2) | 14.2 (14.2-14.3) | -45% | Decreasing | Decreasing |
| Phoenix AZ | 13,083 | 23.0 (22.6-23.4) | 17.2 (17.2-17.3) | +34% | Decreasing | ns |
| Pierre SD | 1,223 | 26.0 (24.5-27.5) | 14.8 (14.6-15.0) | +76% | ns | ns |
| Portland OR | 2,317 | 13.7 (13.1-14.3) | 14.7 (14.6-14.7) | -7% | Decreasing | ns |

ns = Not statistically significant.

**Appendix C-1. Births to mothers who are American Indians or Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|
| | Total Count | Rate per (95% 1,000 confidence population interval) | Rate per (95% 1,000 confidence population interval) | | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| Reno NV | 1,545 | 16.2 (15.4-17.1) | 14.6 (14.5-14.7) | +11% | Decreasing | ns |
| Sacramento CA | 1,858 | 10.8 (10.3-11.3) | 16.0 (15.9-16.0) | -32% | Decreasing | Decreasing |
| Salt Lake City UT | 3,108 | 21.5 (20.8-22.3) | 20.7 (20.6-20.8) | +4% | Decreasing | ns |
| San Diego CA | 2,938 | 10.4 (10.0-10.8) | 17.3 (17.2-17.3) | -40% | Decreasing | Decreasing |
| San Jose CA | 1,089 | 7.9 (7.5-8.4) | 16.8 (16.7-16.8) | -53% | Decreasing | Decreasing |
| Santa Barbara CA | 1,096 | 6.5 (6.2-6.9) | 15.4 (15.3-15.5) | -58% | Decreasing | Decreasing |
| Seattle WA | 3,220 | 16.7 (16.1-17.2) | 13.5 (13.4-13.6) | +23% | Decreasing | ns |
| Spokane WA | 1,215 | 18.8 (17.8-19.9) | 13.9 (13.8-14.0) | +35% | Increasing | Increasing |
| Tucson AZ | 4,908 | 17.4 (16.9-17.9) | 14.9 (14.9-15.0) | +17% | Decreasing | ns |
| Wichita KS | 852 | 12.1 (11.3-13.0) | 16.0 (15.9-16.1) | -24% | Decreasing | ns |

ns = Not statistically significant.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **US TOTAL** | | | | | | |
| Low Birth Weight (< 2500g) | 25666 | 6.6% (6.5-6.7) | 7.4% (7.4-7.4) | -11% | Increasing | Increasing |
| Very Low Birth Weight (< 1500g) | 4422 | 1.1% (1.1-1.2) | 1.4% (1.4-1.4) | -18% | Increasing | ns |
| Mother's Age < 18 | 32203 | 8.2% (8.2-8.3) | 4.8% (4.8-4.9) | +70% | Decreasing | Decreasing |
| Mother Unmarried | 224287 | 57.4% (57.2-57.7) | 31.9% (31.9-31.9) | +80% | Increasing | ns |
| Premature (calculated gestation) | 43409 | 12.1% (12.0-12.3) | 11.1% (11.0-11.1) | +10% | Increasing | Increasing |
| Late (3rd) or No Prenatal Care | 27600 | 7.3% (7.2-7.4) | 3.0% (3.0-3.0) | +140% | Decreasing | ns |
| Maternal Smoking | 69272 | 21.1% (21.0-21.3) | 14.3% (14.3-14.3) | +48% | Decreasing | Decreasing |
| Maternal Alcohol Use | 1241 | 0.3% (0.3-0.4) | 0.3% (0.3-0.3) | ns | ns | ns |
| **UIHO Total** | | | | | | |
| Low Birth Weight (< 2500g) | 5661 | 6.8% (6.6-7.0) | 7.3% (7.2-7.3) | -6% | ns | ns |
| Very Low Birth Weight (< 1500g) | 996 | 1.2% (1.1-1.3) | 1.3% (1.3-1.3) | -10% | ns | ns |
| Mother's Age < 18 | 6844 | 8.2% (8.0-8.4) | 4.6% (4.5-4.6) | +80% | ns | Decreasing |
| Mother Unmarried | 50200 | 60.3% (59.8-60.8) | 34.8% (34.7-34.8) | +73% | Increasing | ns |
| Premature (calculated gestation) | 9161 | 12.2% (12.0-12.5) | 10.8% (10.8-10.9) | +13% | ns | ns |
| Late (3rd) or No Prenatal Care | 5941 | 7.4% (7.2-7.6) | 3.4% (3.4-3.5) | +115% | Decreasing | Decreasing |
| Maternal Smoking | 10852 | 17.2% (16.9-17.5) | 10.7% (10.7-10.7) | +61% | Decreasing | Decreasing |
| Maternal Alcohol Use | 263 | 0.3% (0.3-0.4) | 0.3% (0.3-0.3) | ns | ns | ns |
| **Albuquerque NM** | | | | | | |
| Low Birth Weight (< 2500g) | 255 | 6.4% (5.6-7.2) | 7.9% (7.7-8.1) | -19% | Increasing | ns |
| Very Low Birth Weight (< 1500g) | 33 | 0.8% (0.6-1.2) | 1.2% (1.1-1.3) | ns | Increasing | ns |
| Mother's Age < 18 | 277 | 6.9% (6.1-7.7) | 6.0% (5.8-6.2) | ns | ns | ns |
| Mother Unmarried | 2678 | 66.5% (64.0-69.1) | 38.5% (38.1-38.9) | +73% | ns | ns |
| Premature (calculated gestation) | 427 | 11.8% (10.7-13.0) | 10.3% (10.0-10.5) | +15% | Increasing | ns |
| Late (3rd) or No Prenatal Care | 329 | 8.7% (7.8-9.7) | 6.6% (6.5-6.8) | +32% | ns | Increasing |
| Maternal Smoking | 288 | 7.2% (6.4-8.1) | 11.6% (11.4-11.9) | -38% | ns | ns |
| Maternal Alcohol Use | 16 | 0.4% (0.2-0.6) | 0.4% (0.3-0.4) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area / Risk Factor | AI/AN Alone | | All Races | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|
| | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Bakersfield CA** | | | | | | |
| Low Birth Weight (< 2500g) | 68 | 8.0% (6.2-10.1) | 6.5% (6.3-6.6) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 15 | 1.8% (1.0-2.9) | 1.3% (1.2-1.3) | ns | ns | ns |
| Mother's Age < 18 | 71 | 8.3% (6.5-10.5) | 7.1% (7.0-7.3) | ns | ns | Decreasing |
| Mother Unmarried | 424 | 49.7% (45.0-54.6) | 41.1% (40.8-41.5) | +21% | ns | ns |
| Premature (calculated gestation) | 93 | 12.0% (9.7-14.7) | 11.6% (11.4-11.9) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 56 | 6.9% (5.2-8.9) | 4.6% (4.5-4.7) | +49% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.3) | ns | ns | ns |
| **Billings MT** | | | | | | |
| Low Birth Weight (< 2500g) | 183 | 6.5% (5.6-7.5) | 6.5% (6.1-6.8) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 32 | 1.1% (0.8-1.6) | 1.1% (0.9-1.2) | ns | Increasing | ns |
| Mother's Age < 18 | 266 | 9.4% (8.3-10.6) | 4.3% (4.0-4.6) | +118% | ns | ns |
| Mother Unmarried | 1815 | 64.3% (61.3-67.3) | 31.5% (30.7-32.3) | +104% | Increasing | ns |
| Premature (calculated gestation) | 276 | 10.1% (9.0-11.4) | 9.5% (9.0-9.9) | ns | Increasing | ns |
| Late (3rd) or No Prenatal Care | 292 | 10.4% (9.2-11.7) | 4.4% (4.1-4.7) | +139% | Decreasing | ns |
| Maternal Smoking | 621 | 22.1% (20.4-23.9) | 16.6% (16.0-17.2) | +33% | ns | ns |
| Maternal Alcohol Use | 13 | 0.5% (0.3-0.8) | 0.3% (0.2-0.3) | ns | ns | Decreasing |
| **Butte MT** | | | | | | |
| Low Birth Weight (< 2500g) | 13 | 10.3% (5.5-17.6) | 8.3% (7.5-9.3) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | < 10 | * * | 1.3% (1.0-1.7) | ns | ns | ns |
| Mother's Age < 18 | 18 | 14.3% (8.5-22.6) | 4.4% (3.8-5.1) | +223% | ns | ns |
| Mother Unmarried | 84 | 66.7% (53.2-82.5) | 32.0% (30.3-33.7) | +109% | ns | ns |
| Premature (calculated gestation) | 14 | 12.6% (6.9-21.1) | 10.7% (9.7-11.8) | ns | Increasing | ns |
| Late (3rd) or No Prenatal Care | 11 | 8.8% (4.4-15.7) | 3.2% (2.6-3.7) | +179% | ns | Increasing |
| Maternal Smoking | 55 | 44.0% (33.2-57.2) | 22.7% (21.3-24.2) | +94% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.3-0.7) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Chicago IL** | | | | | | |
| Low Birth Weight (< 2500g) | 88 | 7.9% (6.3-9.7) | 9.2% (9.2-9.3) | ns | Increasing | ns |
| Very Low Birth Weight (< 1500g) | 20 | 1.8% (1.1-2.8) | 1.9% (1.8-1.9) | ns | ns | Decreasing |
| Mother's Age < 18 | 65 | 5.8% (4.5-7.4) | 6.0% (5.9-6.0) | ns | ns | ns |
| Mother Unmarried | 569 | 50.7% (46.6-55.0) | 42.2% (42.1-42.3) | +20% | ns | Increasing |
| Premature (calculated gestation) | 139 | 13.1% (11.0-15.4) | 13.1% (13.0-13.2) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 60 | 5.5% (4.2-7.1) | 3.0% (3.0-3.1) | +81% | ns | ns |
| Maternal Smoking | 183 | 16.7% (14.4-19.3) | 9.8% (9.8-9.9) | +70% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.3) | ns | ns | ns |
| **Dallas TX** | | | | | | |
| Low Birth Weight (< 2500g) | 152 | 6.3% (5.3-7.3) | 7.3% (7.3-7.4) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 33 | 1.4% (0.9-1.9) | 1.3% (1.3-1.3) | ns | ns | ns |
| Mother's Age < 18 | 177 | 7.3% (6.2-8.4) | 5.4% (5.4-5.5) | +35% | Decreasing | ns |
| Mother Unmarried | 842 | 34.6% (32.3-37.0) | 26.4% (26.3-26.5) | +31% | Increasing | ns |
| Premature (calculated gestation) | 253 | 11.7% (10.3-13.3) | 11.6% (11.5-11.6) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 140 | 5.9% (5.0-7.0) | 3.6% (3.6-3.7) | +63% | ns | ns |
| Maternal Smoking | 317 | 13.3% (11.9-14.8) | 7.4% (7.3-7.4) | +80% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.3) | ns | ns | ns |
| **Denver CO** | | | | | | |
| Low Birth Weight (< 2500g) | 285 | 9.8% (8.7-11.1) | 8.6% (8.5-8.7) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 34 | 1.2% (0.8-1.6) | 1.3% (1.2-1.3) | ns | ns | ns |
| Mother's Age < 18 | 251 | 8.7% (7.6-9.8) | 4.3% (4.2-4.3) | +104% | ns | ns |
| Mother Unmarried | 1516 | 52.3% (49.7-55.0) | 24.6% (24.5-24.8) | +112% | Decreasing | ns |
| Premature (calculated gestation) | 353 | 12.8% (11.5-14.3) | 10.9% (10.8-11.0) | +18% | ns | ns |
| Late (3rd) or No Prenatal Care | 227 | 7.9% (6.9-9.1) | 3.5% (3.5-3.6) | +124% | Decreasing | ns |
| Maternal Smoking | 624 | 21.9% (20.2-23.6) | 12.1% (12.0-12.2) | +81% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.4-0.4) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Detroit MI** | | | | | | |
| Low Birth Weight (< 2500g) | 122 | 8.7% (7.3-10.4) | 9.5% (9.5-9.6) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 25 | 1.8% (1.2-2.6) | 2.0% (2.0-2.0) | ns | ns | ns |
| Mother's Age < 18 | 102 | 7.3% (5.9-8.8) | 5.7% (5.7-5.8) | +27% | ns | ns |
| Mother Unmarried | 684 | 48.8% (45.2-52.6) | 43.3% (43.2-43.5) | +13% | ns | Decreasing |
| Premature (calculated gestation) | 173 | 13.1% (11.3-15.3) | 13.0% (12.9-13.1) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 51 | 3.8% (2.8-5.0) | 2.6% (2.6-2.7) | +45% | ns | ns |
| Maternal Smoking | 408 | 29.6% (26.8-32.7) | 17.2% (17.1-17.4) | +72% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.3) | ns | ns | ns |
| **Flagstaff AZ** | | | | | | |
| Low Birth Weight (< 2500g) | 438 | 5.6% (5.1-6.1) | 7.2% (6.8-7.6) | -23% | ns | ns |
| Very Low Birth Weight (< 1500g) | 72 | 0.9% (0.7-1.2) | 1.1% (0.9-1.2) | ns | ns | ns |
| Mother's Age < 18 | 543 | 6.9% (6.3-7.5) | 5.2% (4.8-5.5) | +33% | ns | ns |
| Mother Unmarried | 5140 | 65.1% (63.4-66.9) | 43.3% (42.4-44.3) | +50% | Increasing | ns |
| Premature (calculated gestation) | 933 | 13.1% (12.2-13.9) | 12.1% (11.6-12.7) | ns | ns | Decreasing |
| Late (3rd) or No Prenatal Care | 779 | 10.0% (9.3-10.7) | 6.6% (6.2-7.0) | +52% | Decreasing | Decreasing |
| Maternal Smoking | 110 | 1.4% (1.2-1.7) | 4.3% (4.0-4.7) | -68% | ns | ns |
| Maternal Alcohol Use | 23 | 0.3% (0.2-0.4) | 0.2% (0.2-0.3) | ns | ns | ns |
| **Fresno CA** | | | | | | |
| Low Birth Weight (< 2500g) | 133 | 6.5% (5.4-7.7) | 6.2% (6.1-6.3) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 21 | 1.0% (0.6-1.6) | 1.1% (1.1-1.2) | ns | ns | ns |
| Mother's Age < 18 | 193 | 9.4% (8.2-10.9) | 7.6% (7.5-7.8) | +23% | ns | ns |
| Mother Unmarried | 1269 | 62.0% (58.6-65.5) | 39.5% (39.3-39.8) | +57% | ns | ns |
| Premature (calculated gestation) | 230 | 12.0% (10.5-13.7) | 10.5% (10.3-10.6) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 98 | 4.8% (3.9-5.9) | 3.5% (3.4-3.6) | +38% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.2-0.3) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Great Falls MT** | | | | | | |
| Low Birth Weight (< 2500g) | 59 | 7.3% (5.6-9.4) | 6.3% (5.9-6.8) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | < 10 | * * | 0.7% (0.6-0.9) | ns | ns | ns |
| Mother's Age < 18 | 102 | 12.6% (10.3-15.3) | 4.0% (3.6-4.3) | +220% | ns | Decreasing |
| Mother Unmarried | 568 | 70.4% (64.7-76.4) | 25.2% (24.3-26.1) | +180% | ns | ns |
| Premature (calculated gestation) | 107 | 13.7% (11.2-16.5) | 9.8% (9.3-10.4) | +39% | ns | ns |
| Late (3rd) or No Prenatal Care | 49 | 6.2% (4.6-8.2) | 1.9% (1.7-2.2) | +225% | Decreasing | ns |
| Maternal Smoking | 343 | 43.7% (39.2-48.6) | 18.2% (17.5-19.0) | +140% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.3-0.6) | ns | ns | ns |
| **Green Bay WI** | | | | | | |
| Low Birth Weight (< 2500g) | 68 | 5.6% (4.4-7.1) | 5.7% (5.4-6.0) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 14 | 1.2% (0.6-1.9) | 1.0% (0.9-1.1) | ns | ns | ns |
| Mother's Age < 18 | 123 | 10.2% (8.5-12.1) | 3.0% (2.9-3.2) | +235% | ns | Increasing |
| Mother Unmarried | 872 | 72.1% (67.4-77.0) | 23.6% (23.1-24.1) | +205% | ns | ns |
| Premature (calculated gestation) | 110 | 9.7% (7.9-11.6) | 9.0% (8.7-9.4) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 68 | 5.6% (4.4-7.1) | 2.1% (1.9-2.2) | +175% | ns | ns |
| Maternal Smoking | 526 | 43.6% (40.0-47.5) | 18.5% (18.0-19.0) | +136% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.3-0.4) | ns | ns | ns |
| **Helena MT** | | | | | | |
| Low Birth Weight (< 2500g) | 26 | 9.0% (5.9-13.2) | 6.2% (5.7-6.8) | ns | ns | Decreasing |
| Very Low Birth Weight (< 1500g) | < 10 | * * | 0.7% (0.5-0.9) | ns | ns | ns |
| Mother's Age < 18 | 38 | 13.2% (9.3-18.1) | 3.9% (3.4-4.3) | +242% | ns | ns |
| Mother Unmarried | 164 | 56.8% (48.4-66.1) | 23.8% (22.7-24.9) | +138% | Increasing | ns |
| Premature (calculated gestation) | 36 | 13.2% (9.3-18.3) | 9.0% (8.3-9.7) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | < 10 | * * | 1.4% (1.2-1.7) | ns | ns | ns |
| Maternal Smoking | 118 | 41.0% (33.9-49.1) | 20.1% (19.1-21.1) | +104% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.3-0.6) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Jamaica Plains MA** | | | | | | |
| Low Birth Weight (< 2500g) | < 10 | * * | 8.6% (8.4-8.8) | ns | ns | Increasing |
| Very Low Birth Weight (< 1500g) | < 10 | * * | 1.8% (1.7-1.9) | ns | ns | ns |
| Mother's Age < 18 | < 10 | * * | 4.3% (4.2-4.5) | ns | ns | ns |
| Mother Unmarried | 127 | 67.2% (56.0-79.9) | 45.7% (45.3-46.1) | +47% | ns | ns |
| Premature (calculated gestation) | 14 | 7.5% (4.1-12.6) | 11.1% (10.9-11.3) | ns | Increasing | ns |
| Late (3rd) or No Prenatal Care | < 10 | * * | 2.8% (2.7-2.9) | ns | ns | Decreasing |
| Maternal Smoking | 43 | 23.0% (16.7-31.0) | 11.2% (11.0-11.4) | +105% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.4-0.5) | ns | ns | ns |
| **Lincoln NE** | | | | | | |
| Low Birth Weight (< 2500g) | 132 | 7.5% (6.3-8.9) | 6.7% (6.5-6.8) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 27 | 1.5% (1.0-2.2) | 1.2% (1.2-1.3) | ns | ns | ns |
| Mother's Age < 18 | 196 | 11.2% (9.7-12.8) | 3.7% (3.6-3.8) | +202% | ns | ns |
| Mother Unmarried | 1205 | 68.6% (64.8-72.6) | 27.0% (26.7-27.3) | +154% | ns | ns |
| Premature (calculated gestation) | 220 | 13.4% (11.7-15.3) | 10.6% (10.5-10.8) | +26% | ns | ns |
| Late (3rd) or No Prenatal Care | 130 | 7.5% (6.3-8.9) | 2.1% (2.1-2.2) | +252% | ns | ns |
| Maternal Smoking | 648 | 37.1% (34.3-40.1) | 17.2% (17.0-17.5) | +115% | ns | Decreasing |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.3) | ns | ns | ns |
| **Los Angeles CA** | | | | | | |
| Low Birth Weight (< 2500g) | 296 | 7.1% (6.3-8.0) | 6.3% (6.3-6.4) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 57 | 1.4% (1.0-1.8) | 1.2% (1.1-1.2) | ns | ns | ns |
| Mother's Age < 18 | 263 | 6.3% (5.6-7.1) | 4.7% (4.7-4.7) | +35% | ns | ns |
| Mother Unmarried | 2095 | 50.3% (48.2-52.5) | 39.7% (39.6-39.8) | +27% | Increasing | ns |
| Premature (calculated gestation) | 487 | 12.5% (11.4-13.6) | 10.5% (10.5-10.6) | +18% | ns | ns |
| Late (3rd) or No Prenatal Care | 143 | 3.5% (2.9-4.1) | 2.9% (2.8-2.9) | +21% | Decreasing | ns |
| Maternal Alcohol Use | 14 | 0.3% (0.2-0.6) | 0.3% (0.3-0.3) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Milwaukee WI** | | | | | | |
| Low Birth Weight (< 2500g) | 99 | 6.6% (5.4-8.1) | 8.0% (7.9-8.2) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 16 | 1.1% (0.6-1.7) | 1.6% (1.5-1.7) | ns | ns | ns |
| Mother's Age < 18 | 158 | 10.6% (9.0-12.4) | 5.9% (5.8-6.0) | +79% | ns | ns |
| Mother Unmarried | 1000 | 66.9% (62.9-71.2) | 40.2% (39.9-40.4) | +67% | ns | Increasing |
| Premature (calculated gestation) | 181 | 12.8% (11.0-14.8) | 11.8% (11.6-11.9) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 84 | 5.6% (4.5-7.0) | 3.1% (3.0-3.2) | +81% | ns | ns |
| Maternal Smoking | 549 | 36.8% (33.7-40.0) | 18.1% (17.9-18.3) | +103% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.4-0.4) | ns | ns | ns |
| **Minneapolis MN** | | | | | | |
| Low Birth Weight (< 2500g) | 370 | 8.5% (7.6-9.4) | 6.4% (6.3-6.5) | +32% | ns | ns |
| Very Low Birth Weight (< 1500g) | 70 | 1.6% (1.3-2.0) | 1.2% (1.2-1.3) | ns | ns | ns |
| Mother's Age < 18 | 584 | 13.4% (12.3-14.5) | 3.8% (3.7-3.8) | +256% | ns | ns |
| Mother Unmarried | 3591 | 82.1% (79.4-84.8) | 28.7% (28.5-28.9) | +186% | Decreasing | ns |
| Premature (calculated gestation) | 474 | 13.3% (12.2-14.6) | 9.4% (9.2-9.5) | +43% | ns | ns |
| Late (3rd) or No Prenatal Care | 479 | 12.2% (11.2-13.4) | 3.7% (3.6-3.7) | +234% | Decreasing | ns |
| Maternal Smoking | 1748 | 44.5% (42.4-46.6) | 11.5% (11.3-11.6) | +288% | Decreasing | ns |
| Maternal Alcohol Use | 18 | 0.5% (0.3-0.7) | 0.3% (0.3-0.3) | ns | ns | ns |
| **Missoula MT** | | | | | | |
| Low Birth Weight (< 2500g) | 28 | 8.2% (5.4-11.8) | 6.3% (5.9-6.8) | ns | ns | Increasing |
| Very Low Birth Weight (< 1500g) | < 10 | * * | 1.2% (1.0-1.4) | ns | ns | ns |
| Mother's Age < 18 | 22 | 6.4% (4.0-9.7) | 2.7% (2.4-3.0) | +137% | ns | ns |
| Mother Unmarried | 176 | 51.3% (44.0-59.5) | 23.9% (23.0-24.8) | +115% | ns | ns |
| Premature (calculated gestation) | 38 | 12.1% (8.6-16.7) | 10.5% (9.8-11.1) | ns | ns | Increasing |
| Late (3rd) or No Prenatal Care | 19 | 5.6% (3.4-8.7) | 1.5% (1.2-1.7) | +284% | ns | ns |
| Maternal Smoking | 111 | 32.7% (27.0-39.4) | 16.8% (16.1-17.6) | +95% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.2% (0.2-0.3) | ns | Decreasing | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| Low Birth Weight (< 2500g) | 244 | 10.7% (9.4-12.2) | 8.5% (8.5-8.6) | +26% | ns | Increasing |
| Very Low Birth Weight (< 1500g) | 39 | 1.7% (1.2-2.4) | 1.7% (1.7-1.7) | ns | ns | ns |
| Mother Unmarried | 777 | 34.1% (31.8-36.6) | 42.5% (42.4-42.6) | -20% | Increasing | ns |
| Premature (calculated gestation) | 300 | 13.9% (12.3-15.5) | 11.5% (11.4-11.6) | +21% | ns | Increasing |
| Late (3rd) or No Prenatal Care | 107 | 5.2% (4.2-6.3) | 4.9% (4.8-4.9) | ns | ns | ns |
| Maternal Smoking | 52 | 7.6% (5.7-10.0) | 4.6% (4.6-4.7) | +65% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.5% (0.5-0.5) | ns | Increasing | ns |
| **Oakland CA** | | | | | | |
| Low Birth Weight (< 2500g) | 134 | 5.9% (4.9-7.0) | 6.5% (6.4-6.6) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 28 | 1.2% (0.8-1.8) | 1.1% (1.1-1.1) | ns | ns | ns |
| Mother's Age < 18 | 123 | 5.4% (4.5-6.5) | 3.1% (3.0-3.1) | +76% | ns | ns |
| Mother Unmarried | 1094 | 48.1% (45.3-51.1) | 26.6% (26.4-26.7) | +81% | ns | ns |
| Late (3rd) or No Prenatal Care | 93 | 4.2% (3.4-5.1) | 2.3% (2.3-2.4) | +79% | Decreasing | ns |
| **Phoenix AZ** | | | | | | |
| Low Birth Weight (< 2500g) | 811 | 6.2% (5.8-6.7) | 6.6% (6.6-6.7) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 153 | 1.2% (1.0-1.4) | 1.1% (1.1-1.2) | ns | ns | ns |
| Mother's Age < 18 | 1124 | 8.6% (8.1-9.1) | 5.6% (5.5-5.6) | +54% | ns | Decreasing |
| Mother Unmarried | 8837 | 67.6% (66.1-69.0) | 36.3% (36.2-36.5) | +86% | ns | ns |
| Premature (calculated gestation) | 1388 | 12.2% (11.5-12.8) | 10.5% (10.4-10.6) | +16% | ns | Increasing |
| Late (3rd) or No Prenatal Care | 1112 | 8.8% (8.3-9.3) | 4.3% (4.3-4.4) | +102% | Decreasing | Decreasing |
| Maternal Smoking | 994 | 7.7% (7.2-8.1) | 10.2% (10.1-10.3) | -25% | Decreasing | Decreasing |
| Maternal Alcohol Use | 24 | 0.2% (0.1-0.3) | 0.3% (0.3-0.3) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area / Risk Factor | AI/AN Alone | | All Races | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|
| | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Pierre SD** | | | | | | |
| Low Birth Weight (< 2500g) | 64 | 5.2% (4.0-6.7) | 5.6% (5.4-5.9) | ns | ns | ns |
| Mother's Age < 18 | 110 | 9.0% (7.4-10.8) | 2.7% (2.5-2.9) | +231% | ns | ns |
| Mother Unmarried | 849 | 69.4% (64.8-74.3) | 24.8% (24.2-25.4) | +180% | Increasing | ns |
| Premature (calculated gestation) | 124 | 10.5% (8.8-12.6) | 9.5% (9.1-9.8) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 102 | 8.4% (6.9-10.2) | 1.8% (1.6-1.9) | +376% | ns | ns |
| Maternal Smoking | 38 | 26.2% (18.6-36.0) | 16.9% (15.5-18.4) | +55% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.2% (0.2-0.3) | ns | ns | ns |
| **Portland OR** | | | | | | |
| Low Birth Weight (< 2500g) | 129 | 5.6% (4.7-6.6) | 5.5% (5.4-5.5) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 28 | 1.2% (0.8-1.8) | .9% (0.9-1.0) | ns | ns | ns |
| Mother's Age < 18 | 196 | 8.5% (7.3-9.7) | 3.7% (3.6-3.7) | +131% | ns | Decreasing |
| Mother Unmarried | 1225 | 52.9% (50.0-55.9) | 26.3% (26.1-26.5) | +101% | Increasing | ns |
| Premature (calculated gestation) | 223 | 10.2% (8.9-11.6) | 8.9% (8.8-9.0) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 115 | 5.0% (4.1-6.0) | 2.7% (2.6-2.7) | +88% | ns | ns |
| Maternal Smoking | 724 | 31.5% (29.3-33.9) | 16.3% (16.1-16.4) | +94% | ns | ns |
| Maternal Alcohol Use | 14 | .6% (0.3-1.0) | 0.5% (0.5-0.5) | ns | ns | ns |
| **Reno NV** | | | | | | |
| Low Birth Weight (< 2500g) | 93 | 6.0% (4.9-7.4) | 7.1% (6.9-7.3) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 16 | 1.0% (0.6-1.7) | 1.1% (1.0-1.2) | ns | ns | ns |
| Mother's Age < 18 | 121 | 7.8% (6.5-9.4) | 4.2% (4.1-4.4) | +86% | ns | ns |
| Mother Unmarried | 913 | 59.1% (55.3-63.1) | 32.0% (31.6-32.5) | +85% | ns | Decreasing |
| Premature (calculated gestation) | 147 | 10.4% (8.8-12.3) | 10.7% (10.4-11.0) | ns | ns | ns |
| Late (3rd) or No Prenatal Care | 88 | 5.8% (4.6-7.1) | 2.4% (2.2-2.5) | +144% | ns | ns |
| Maternal Smoking | 235 | 15.4% (13.5-17.5) | 15.3% (15.0-15.6) | ns | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.4) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area / Risk Factor | AI/AN Alone | | All Races | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|
| | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Sacramento CA** | | | | | | |
| Low Birth Weight (< 2500g) | 123 | 6.6% (5.5-7.9) | 6.5% (6.4-6.6) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 15 | 0.8% (0.5-1.3) | 1.2% (1.1-1.2) | ns | ns | ns |
| Mother's Age < 18 | 124 | 6.7% (5.6-8.0) | 4.9% (4.8-5.0) | +38% | ns | Decreasing |
| Mother Unmarried | 1038 | 55.9% (52.5-59.4) | 34.0% (33.7-34.3) | +64% | Increasing | Increasing |
| Premature (calculated gestation) | 215 | 12.2% (10.6-13.9) | 9.8% (9.6-9.9) | +25% | ns | ns |
| Late (3rd) or No Prenatal Care | 127 | 6.9% (5.8-8.2) | 4.0% (3.9-4.1) | +72% | ns | Decreasing |
| Maternal Alcohol Use | 14 | 0.8% (0.4-1.3) | 0.4% (0.4-0.4) | ns | ns | ns |
| **Salt Lake City UT** | | | | | | |
| Low Birth Weight (< 2500g) | 227 | 7.3% (6.4-8.3) | 6.4% (6.3-6.5) | ns | Increasing | ns |
| Very Low Birth Weight (< 1500g) | 54 | 1.7% (1.3-2.3) | 1.0% (1.0-1.0) | +76% | ns | ns |
| Mother's Age < 18 | 229 | 7.4% (6.5-8.4) | 3.4% (3.4-3.5) | +115% | ns | ns |
| Mother Unmarried | 1651 | 53.1% (50.6-55.8) | 16.5% (16.3-16.6) | +223% | ns | Decreasing |
| Premature (calculated gestation) | 337 | 12.4% (11.1-13.8) | 9.3% (9.2-9.4) | +33% | ns | ns |
| Late (3rd) or No Prenatal Care | 309 | 10.3% (9.2-11.5) | 3.0% (2.9-3.1) | +244% | ns | ns |
| Maternal Smoking | 394 | 12.7% (11.5-14.0) | 9.1% (9.0-9.2) | +40% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.4-0.4) | ns | ns | ns |
| **San Diego CA** | | | | | | |
| Low Birth Weight (< 2500g) | 176 | 6.0% (5.1-6.9) | 5.8% (5.8-5.9) | ns | Decreasing | ns |
| Very Low Birth Weight (< 1500g) | 33 | 1.1% (0.8-1.6) | 1.0% (1.0-1.1) | ns | ns | ns |
| Mother's Age < 18 | 171 | 5.8% (5.0-6.8) | 3.8% (3.8-3.9) | +52% | ns | ns |
| Mother Unmarried | 1309 | 44.6% (42.2-47.0) | 29.1% (28.9-29.2) | +53% | Increasing | ns |
| Premature (calculated gestation) | 307 | 11.5% (10.2-12.8) | 9.8% (9.7-9.9) | +17% | ns | ns |
| Late (3rd) or No Prenatal Care | 124 | 4.3% (3.6-5.1) | 4.1% (4.1-4.2) | ns | ns | ns |
| Maternal Alcohol Use | 11 | 0.4% (0.2-0.7) | 0.2% (0.2-0.3) | ns | ns | Decreasing |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **San Jose CA** | | | | | | |
| Low Birth Weight (< 2500g) | 86 | 7.9% (6.3-9.8) | 5.8% (5.7-5.9) | +36% | ns | ns |
| Very Low Birth Weight (< 1500g) | 16 | 1.5% (0.8-2.4) | 1.0% (0.9-1.0) | ns | Increasing | ns |
| Mother's Age < 18 | 86 | 7.9% (6.3-9.8) | 3.2% (3.1-3.3) | +146% | ns | ns |
| Mother Unmarried | 522 | 47.9% (43.9-52.2) | 24.3% (24.1-24.5) | +97% | ns | ns |
| Premature (calculated gestation) | 133 | 13.2% (11.1-15.7) | 8.6% (8.5-8.7) | +54% | ns | ns |
| Late (3rd) or No Prenatal Care | 53 | 4.9% (3.7-6.5) | 3.1% (3.0-3.1) | +61% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.4) | ns | ns | ns |
| **Santa Barbara CA** | | | | | | |
| Low Birth Weight (< 2500g) | 52 | 4.8% (3.6-6.2) | 5.5% (5.4-5.6) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | < 10 | * * | 0.9% (0.9-1.0) | ns | ns | ns |
| Mother's Age < 18 | 73 | 6.7% (5.2-8.4) | 4.1% (4.0-4.2) | +63% | ns | ns |
| Mother Unmarried | 473 | 43.2% (39.4-47.2) | 23.9% (23.7-24.1) | +81% | ns | Increasing |
| Premature (calculated gestation) | 122 | 12.0% (10.0-14.3) | 9.5% (9.3-9.6) | +26% | ns | ns |
| Late (3rd) or No Prenatal Care | 34 | 3.1% (2.2-4.3) | 3.0% (2.9-3.0) | ns | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.4) | ns | ns | ns |
| **Seattle WA** | | | | | | |
| Low Birth Weight (< 2500g) | 222 | 6.9% (6.1-7.9) | 5.7% (5.6-5.8) | +22% | ns | ns |
| Very Low Birth Weight (< 1500g) | 33 | 1.0% (0.7-1.5) | .9% (0.9-1.0) | ns | ns | ns |
| Mother's Age < 18 | 267 | 8.3% (7.3-9.4) | 2.5% (2.4-2.5) | +237% | ns | Decreasing |
| Mother Unmarried | 1818 | 56.5% (53.9-59.1) | 22.7% (22.5-22.9) | +149% | ns | ns |
| Premature (calculated gestation) | 296 | 12.8% (11.4-14.3) | 8.8% (8.7-9.0) | +45% | Decreasing | ns |
| Late (3rd) or No Prenatal Care | 162 | 6.1% (5.2-7.1) | 2.5% (2.4-2.5) | +145% | Decreasing | ns |
| Maternal Smoking | 750 | 25.8% (24.0-27.7) | 11.7% (11.6-11.9) | +120% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.3% (0.3-0.3) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-2. Risk factors for poor infant health among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties, 1991-2000.**

| Health Organization Service Area | AI/AN Alone | | All Races | | Trends over Time | |
|---|---|---|---|---|---|---|
| Risk Factor | Total Count | (95% Percent of confidence live births interval) | (95% Percent of confidence live births interval) | AI/AN compared to All Races | AI/AN 10-year trend (1991-2000) | AI/AN 6-year trend (1995-2000) |
| **Spokane WA** | | | | | | |
| Low Birth Weight (< 2500g) | 82 | 6.8% (5.4-8.4) | 5.7% (5.5-5.9) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 12 | 1.0% (0.5-1.7) | .9% (0.9-1.0) | ns | ns | ns |
| Mother's Age < 18 | 112 | 9.2% (7.6-11.1) | 3.9% (3.7-4.0) | +139% | ns | ns |
| Mother Unmarried | 761 | 62.6% (58.3-67.3) | 28.5% (28.1-29.0) | +120% | ns | Decreasing |
| Premature (calculated gestation) | 110 | 11.4% (9.3-13.7) | 8.4% (8.1-8.6) | +35% | ns | ns |
| Late (3rd) or No Prenatal Care | 42 | 3.7% (2.7-5.0) | 1.6% (1.5-1.7) | +134% | ns | ns |
| Maternal Smoking | 451 | 38.1% (34.6-41.7) | 21.4% (21.0-21.8) | +78% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.2% (0.2-0.2) | +244% | Decreasing | ns |
| **Tucson AZ** | | | | | | |
| Low Birth Weight (< 2500g) | 329 | 6.7% (6.0-7.5) | 7.2% (7.0-7.3) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 46 | 0.9% (0.7-1.3) | 1.1% (1.1-1.2) | ns | ns | ns |
| Mother's Age < 18 | 528 | 10.8% (9.9-11.7) | 5.7% (5.6-5.8) | +89% | ns | ns |
| Mother Unmarried | 3687 | 75.1% (72.7-77.6) | 38.5% (38.2-38.9) | +95% | ns | ns |
| Premature (calculated gestation) | 580 | 13.7% (12.6-14.8) | 11.3% (11.1-11.5) | +21% | ns | ns |
| Late (3rd) or No Prenatal Care | 399 | 8.2% (7.4-9.0) | 6.6% (6.4-6.7) | +24% | ns | ns |
| Maternal Smoking | 325 | 6.6% (5.9-7.4) | 10.0% (9.8-10.2) | -34% | Decreasing | ns |
| Maternal Alcohol Use | < 10 | * * | 0.2% (0.2-0.3) | ns | ns | ns |
| **Wichita KS** | | | | | | |
| Low Birth Weight (< 2500g) | 65 | 7.6% (5.9-9.7) | 7.2% (7.0-7.3) | ns | ns | ns |
| Very Low Birth Weight (< 1500g) | 14 | 1.6% (0.9-2.8) | 1.4% (1.3-1.5) | ns | ns | ns |
| Mother's Age < 18 | 62 | 7.3% (5.6-9.3) | 4.7% (4.6-4.9) | +54% | ns | ns |
| Mother Unmarried | 427 | 50.1% (45.5-55.1) | 29.3% (28.9-29.6) | +71% | Decreasing | ns |
| Premature (calculated gestation) | 105 | 13.1% (10.7-15.9) | 10.3% (10.1-10.6) | +27% | ns | ns |
| Late (3rd) or No Prenatal Care | 42 | 5.0% (3.6-6.7) | 1.9% (1.8-2.0) | +166% | ns | ns |
| Maternal Smoking | 190 | 22.4% (19.3-25.8) | 14.3% (14.1-14.6) | +57% | ns | ns |
| Maternal Alcohol Use | < 10 | * * | 0.4% (0.3-0.4) | ns | ns | ns |

*Risk factors with less than 10 occurrences in an area are not reported.
ns = Not statistically significant.
Source: U.S. Centers for Health Statistics.

**Appendix C-3. Leading causes of infant deaths among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties with populations greater than 250,000**, 1995-2000. (See end of table for applicable notes)**

| Health Organization Service Area / Risk Factor | AI/AN Alone Rank | AI/AN Alone Total Deaths | AI/AN Alone Rate per 1,000 live births (95% confidence interval) | All Races Rank | All Races Rate per 1,000 live births (95% confidence interval) | AI/AN compared to All Races | AI/AN 6-year trend (1995-2000) |
|---|---|---|---|---|---|---|---|
| **US TOTAL** | | | | | | | |
| All Causes | | 2,093 | 8.9 (8.5-9.3) | | 7.1 (7.0-7.1) | +26% | ns |
| Sudden infant death syndrome | 1 | 387 | 1.6 (1.5-1.8) | 3 | 0.8 (.7-.8) | +119% | Decreasing |
| Congenital malformations, deformations and chromosomal abnormalities | 2 | 357 | 1.5 (1.4-1.7) | 1 | 1.4 (1.4-1.4) | ns | ns |
| Disorders related to short gestation and low birth weight, not elsewhere classified | 3 | 220 | 0.9 (.8-1.1) | 2 | 1.1 (1.1-1.1) | -14% | ns |
| Accidents | 4 | 96 | 0.4 (.3-.5) | 6 | 0.2 (.2-.2) | +122% | ns |
| Newborn affected by complications of placenta, cord and membranes | 5 | 69 | 0.3 (.2-.4) | 5 | 0.3 (.2-.3) | ns | ns |
| Newborn affected by maternal complications of pregnancy | 6 | 61 | 0.3 (.2-.3) | 4 | 0.3 (.3-.3) | ns | ns |
| Diseases of the circulatory system | 7 | 43 | 0.2 (.1-.2) | 8 | 0.2 (.2-.2) | ns | ns |
| Intrauterine hypoxia and birth asphyxia | 8 | 41 | 0.2 (.1-.2) | 9 | 0.2 (.2-.2) | ns | ns |
| Bacterial sepsis of newborn | 9 | 40 | 0.2 (.1-.2) | 7 | 0.2 (.2-.2) | ns | ns |
| Necrotizing enterocolitis of newborn | 10 | 34 | 0.1 (.1-.2) | 12 | 0.1 (.1-.1) | ns | ns |
| **UIHO Total (Partial)** | | | | | | | |
| All Causes | | 340 | 8.8 (7.9-9.8) | | 6.6 (6.5-6.7) | +33% | ns |
| Sudden infant death syndrome | 1 | 68 | 1.8 (1.4-2.2) | 2 | 0.7 (.7-.7) | +157% | ns |
| Disorders related to short gestation and low birth weight, not elsewhere classified | 2 | 46 | 1.2 (.9-1.6) | 1 | 1.0 (1.0-1.0) | ns | Increasing |
| Accidents | 3 | 12 | 0.3 (.2-.6) | 3 | 0.1 (.1-.2) | +121% | ns |
| **Albuquerque NM** | | | | | | | |
| All Causes | | 21 | 8.7 (5.4-13.2) | | 5.8 (5.1-6.5) | ns | ns |
| **Bakersfield CA** | | | | | | | |
| All Causes | | < 10 | * * | | 8.0 (7.4-8.7) | ns | ns |

**Appendix C-3. Leading causes of infant deaths among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties with populations greater than 250,000**, 1995-2000. (See end of table for applicable notes)**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | AI/AN 6-year trend (1995-2000) |
|---|---|---|---|---|---|---|---|
| Risk Factor | Rank | Total Deaths | Rate per 1,000 live births (95% confidence interval) | Rank | Rate per 1,000 live births (95% confidence interval) | | |
| **Chicago IL** | | | | | | | |
| All Causes | | 14 | 21.5 (11.8-36.1 | | 10.0 (9.8-10.3) | +115% | ns |
| **Dallas TX (Partial)** | | | | | | | |
| All Causes | | < 10 | * * | | 5.9 (5.7-6.1) | ns | ns |
| **Denver CO (Partial)** | | | | | | | |
| All Causes | | 14 | 8.5 (4.6-14.2) | | 6.7 (6.3-7.1) | ns | Increasing |
| **Detroit MI** | | | | | | | |
| All Causes | | < 10 | * * | | 10.1 (9.7-10.4) | ns | ns |
| **Fresno CA (Partial)** | | | | | | | |
| All Causes | | 14 | 12.5 (6.9-20.9) | | 6.7 (6.3-7.2) | ns | ns |
| **Jamaica Plains MA** | | | | | | | |
| All Causes | | < 10 | * * | | 6.2 (5.5-6.9) | ns | ns |
| **Lincoln NE (Partial)** | | | | | | | |
| All Causes | | < 10 | * * | | 7.9 (7.0-8.7) | ns | ns |
| **Los Angeles CA** | | | | | | | |
| All Causes | | 18 | 7.2 (4.3-11.3) | | 5.3 (5.2-5.5) | ns | ns |
| **Milwaukee WI** | | | | | | | |
| All Causes | | 13 | 14.4 (7.7-24.5) | | 9.0 (8.4-9.5) | ns | ns |
| **Minneapolis MN** | | | | | | | |
| All Causes | | 37 | 15.8 (11.2-21.8 | | 7.1 (6.7-7.6) | +122% | Decreasing |
| **New York NY (Partial)** | | | | | | | |
| All Causes | | < 10 | * * | | 6.6 (6.5-6.8) | ** | ns |
| **Oakland CA (Partial)** | | | | | | | |
| All Causes | | 10 | 7.6 (3.7-14.0) | | 5.0 (4.7-5.2) | ns | ns |

**Appendix C-3. Leading causes of infant deaths among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties with populations greater than 250,000**, 1995-2000. (See end of table for applicable notes)**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | AI/AN 6-year trend (1995-2000) |
|---|---|---|---|---|---|---|---|
| Risk Factor | Rank | Total Deaths | Rate per 1,000 live births (95% confidence interval) | Rank | Rate per 1,000 live births (95% confidence interval) | | |
| **Phoenix AZ** | | | | | | | |
| All Causes | | 71 | 8.5 (6.7-10.8) | | 7.1 (6.8-7.4) | ns | ns |
| Congenital malformations, deformations and chromosomal abnormalities | 1 | 16 | 2.0 (1.1-3.2) | 1 | 1.6 (1.5-1.8) | ns | ns |
| **Portland OR** | | | | | | | |
| All Causes | | < 10 | * * | | 5.0 (4.6-5.4) | ns | ns |
| **Reno NV (Partial)** | | | | | | | |
| All Causes | | < 10 | * * | | 6.3 (5.4-7.3) | ns | ns |
| **Sacramento CA** | | | | | | | |
| All Causes | | < 10 | * * | | 6.3 (5.9-6.8) | ns | ns |
| **Salt Lake City UT (Partial)** | | | | | | | |
| All Causes | | < 10 | * * | | 5.4 (5.0-5.7) | ns | ns |
| **San Diego CA** | | | | | | | |
| All Causes | | 16 | 8.9 (5.1-14.4) | | 5.2 (4.9-5.4) | ns | ns |
| **San Jose CA** | | | | | | | |
| All Causes | | < 10 | * * | | 4.9 (4.5-5.2) | ns | ns |
| **Santa Barbara CA (Partial)** | | | | | | | |
| All Causes | | < 10 | * * | | 5.3 (4.9-5.8) | ns | ns |
| **Seattle WA** | | | | | | | |
| All Causes | | 19 | 10.0 (6.0-15.6) | | 5.0 (4.7-5.4) | +99% | ns |
| **Spokane WA** | | | | | | | |
| All Causes | | < 10 | * * | | 5.5 (4.8-6.4) | ns | ns |
| **Tucson AZ** | | | | | | | |
| All Causes | | 25 | 8.3 (5.4-12.3) | | 6.3 (5.7-6.9) | ns | ns |

**Appendix C-3. Leading causes of infant deaths among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties with populations greater than 250,000**, 1995-2000. (See end of table for applicable notes)**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | AI/AN 6-year trend (1995-2000) |
|---|---|---|---|---|---|---|---|
| Risk Factor | Rank | Total Deaths | Rate per 1,000 live births (95% confidence interval) | Rank | Rate per 1,000 live births (95% confidence interval) | | |
| **Witchita KS (Partial)** | | | | | | | |
| All Causes | | < 10 | * * | | (7.2-8.9) | ns | ns |

**Notes:**

**AI/AN infant mortality rates may in some or all locations be significantly underreported and should be interpreted with caution.**

***Rates of infant mortality are limited to areas with totals of 10 or more deaths from 1995 to 2000.**

****Significantly less than rate for area total, but percentage suppressed due to the number of deaths being less than 10.**

**"Partial" refers to service areas that only include counties with populations greater than 250,000 based on the 1990 U.S. Census.**

**Source of mortality and birth vital statistics data: U.S. Centers for Health Statistics.**

**Appendix C-4. Risk Factors* associated with infant deaths among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties with populations greater than 250,000**, 1995-2000. (See end of table for applicable notes).**

| Health Organization Service Area / Risk Factor | AI/AN Alone | | All Races | AI/AN compared to All Races | AI/AN 6-year trend (1995-2000) |
|---|---|---|---|---|---|
| | Total Count | (95% Percent of confidence deaths interval) | (95% Percent of confidence deaths interval) | | |
| **US TOTAL** | | | | | |
| Low Birth Weight (< 2500g) | 1022 | 49.7% (46.7-52.8) | 65.2% (64.8-65.6) | -24% | Increasing |
| Very Low Birth Weight (< 1500g) | 721 | 35.1% (32.5-37.7) | 50.8% (50.5-51.2) | -31% | Increasing |
| Mother's Age < 18 | 213 | 10.2% (8.9-11.6) | 7.6% (7.4-7.7) | 35% | ns |
| Mother Unmarried | 1372 | 65.6% (62.1-69.1) | 47.2% (46.9-47.5) | 39% | ns |
| Premature (calculated gestation) | 873 | 50.1% (46.9-53.6) | 64.5% (64.1-64.9) | -22% | ns |
| Late (3rd) or No Prenatal Care | 136 | 7.1% (5.9-8.4) | 2.7% (2.6-2.7) | 167% | ns |
| Maternal Smoking | 503 | 29.8% (27.3-32.5) | 19.5% (19.3-19.7) | 53% | ns |
| Maternal Alcohol Use | 126 | 7.4% (6.2-8.9) | 2.3% (2.2-2.4) | 225% | ns |
| **UIHO Total (Partial**)** | | | | | |
| Low Birth Weight (< 2500g) | 182 | 54.2% (46.6-62.6) | 65.5% (64.7-66.3) | -17% | ns |
| Very Low Birth Weight (< 1500g) | 130 | 38.7% (32.3-45.9) | 51.2% (50.5-51.9) | -24% | Increasing |
| Mother's Age < 18 | 38 | 11.2% (7.9-15.4) | 7.0% (6.8-7.3) | 59% | ns |
| Mother Unmarried | 238 | 70.0% (61.4-79.5) | 49.5% (48.8-50.2) | 41% | ns |
| Premature (calculated gestation) | 154 | 53.7% (45.5-62.8) | 64.5% (63.7-65.4) | -17% | ns |
| Late (3rd) or No Prenatal Care | 23 | 7.4% (4.7-11.1) | 3.0% (2.8-3.2) | 146% | ns |
| Maternal Smoking | 63 | 25.2% (19.4-32.2) | 15.5% (15.0-16.0) | 62% | ns |
| Maternal Alcohol Use | 22 | 9.2% (5.8-13.9) | 2.2% (2.0-2.4) | 319% | ns |
| **Albuquerque NM** | | | | | |
| Low Birth Weight (< 2500g) | 13 | 61.9% (33.0-105.6) | 61.9% (52.9-72.0) | ns | ns |
| Mother Unmarried | 16 | 76.2% (43.6-123.5) | 47.9% (40.2-56.7) | ns | ns |
| Premature (calculated gestation) | 11 | 57.9% (28.9-103.2) | 65.0% (55.5-75.6) | ns | ns |
| **Denver CO (Partial**)** | | | | | |
| Mother Unmarried | 12 | 85.7% (44.4-149.2) | 40.4% (36.7-44.3) | 112% | ns |
| **Los Angeles CA** | | | | | |
| Low Birth Weight (< 2500g) | 12 | 66.7% (34.5-116.1) | 64.2% (62.1-66.4) | ns | ns |

**Appendix C-4. Risk Factors* associated with infant deaths among American Indians and Alaska Natives living in Urban Indian Health Organization (UIHO) service area counties with populations greater than 250,000**, 1995-2000. (See end of table for applicable notes).**

| Health Organization Service Area / Risk Factor | AI/AN Alone | | All Races | AI/AN compared to All Races | AI/AN 6-year trend (1995-2000) |
|---|---|---|---|---|---|
| | Total Count | Percent of deaths (95% confidence interval) | Percent of deaths (95% confidence interval) | | |
| **Milwaukee WI** | | | | | |
| Mother Unmarried | 12 | 92.3% (47.8-160.7) | 63.3% (58.6-68.4) | ns | ns |
| **Minneapolis MN** | | | | | |
| Low Birth Weight (< 2500g) | 19 | 52.8% (31.8-82.3) | 60.2% (55.4-65.3) | ns | ns |
| Very Low Birth Weight (< 1500g) | 13 | 36.1% (19.3-61.6) | 46.9% (42.7-51.4) | ns | ns |
| Mother Unmarried | 32 | 86.5% (59.2-122.1) | 47.3% (43.1-51.8) | 83% | ns |
| Premature (calculated gestation) | 16 | 47.1% (26.9-76.3) | 59.5% (54.6-64.8) | ns | ns |
| Maternal Smoking | 16 | 50.0% (28.6-81.1) | 17.5% (14.8-20.5) | 186% | ns |
| **Phoenix AZ** | | | | | |
| Low Birth Weight (< 2500g) | 36 | 50.7% (35.6-70.2) | 61.5% (58.1-65.0) | ns | ns |
| Very Low Birth Weight (< 1500g) | 27 | 38.0% (25.1-55.3) | 45.1% (42.2-48.1) | ns | ns |
| Mother's Age < 18 | 11 | 15.5% (7.8-27.6) | 9.0% (7.7-10.3) | ns | ns |
| Mother Unmarried | 57 | 80.3% (60.9-103.9) | 47.9% (44.9-50.9) | 68% | ns |
| **Phoenix AZ** | | | | | |
| Premature (calculated gestation) | 30 | 55.6% (37.5-79.3) | 62.2% (58.4-66.1) | ns | ns |
| **Seattle WA** | | | | | |
| Mother Unmarried | 13 | 68.4% (36.5-116.7) | 40.0% (35.3-45.1) | ns | ns |
| **Tucson AZ** | | | | | |
| Mother Unmarried | 20 | 80.0% (48.9-123.5) | 48.1% (41.8-55.0) | ns | ns |

**Notes: AI/AN infant mortality rates may in some or all locations be significantly underreported and should be interpreted with caution.**
***Risk factors are limited to factors associated with 10 or more deaths from 1995 to 2000.**
****"Partial" refers to service areas that only include counties with populations greater than 250,000 based on the 1990 U.S. Census. All UIHO service areas with counties less than 250,000 are excluded to protect patient confidentiality.**
**Source of mortality and birth vital statistics data: U.S. Centers for Health Statistics.**

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **US TOTAL** | | | | | | | | |
| All Causes | | 97,926 | 769.0 (763.7-774.4) | | 902.1 (901.7-902.4) | -15% | Increasing | Increasing |
| Diseases of the heart | 1 | 21,712 | 206.0 (203.0-208.9) | 1 | 289.0 (288.8-289.2) | -29% | Decreasing | Decreasing |
| Malignant neoplasms | 2 | 16,147 | 137.3 (135.0-139.6) | 2 | 210.0 (209.9-210.2) | -35% | ns | ns |
| Lung Cancer | | 4,240 | 36.1 (34.9-37.2) | | 57.3 (57.2-57.4) | -37% | Increasing | ns |
| Accidents | 3 | 12,693 | 60.4 (59.2-61.6) | 5 | 35.5 (35.4-35.5) | +70% | Decreasing | Decreasing |
| Diabetes mellitus | 4 | 5,193 | 44.7 (43.4-46.0) | 7 | 22.9 (22.8-22.9) | +96% | Increasing | Increasing |
| Cerebrovascular diseases | 5 | 4,809 | 48.8 (47.4-50.3) | 3 | 65.4 (65.3-65.5) | -25% | ns | Decreasing |
| Chronic liver disease and cirrhosis | 6 | 4,334 | 25.5 (24.7-26.3) | 12 | 10.4 (10.3-10.4) | +146% | ns | ns |
| Chronic lower respiratory diseases | 7 | 3,061 | 30.0 (28.9-31.1) | 4 | 42.1 (42.0-42.2) | -29% | Increasing | Increasing |
| Intentional self-harm (suicide) | 8 | 2,703 | 10.9 (10.5-11.4) | 9 | 11.6 (11.6-11.7) | -6% | ns | ns |
| Influenza and pneumonia | 9 | 2,473 | 25.1 (24.0-26.2) | 6 | 23.8 (23.7-23.8) | +6% | ns | ns |
| Assault (homicide) | 10 | 2,367 | 9.5 (9.1-9.9) | 14 | 8.2 (8.2-8.2) | +16% | Decreasing | ns |
| Alcohol-related deaths | | 4,883 | 26.6 (25.8-27.4) | | 7.3 (7.3-7.4) | +262% | Decreasing | Decreasing |
| Injury by firearms | | 2,624 | 10.5 (10.1-10.9) | | 12.9 (12.9-13.0) | -19% | Decreasing | Decreasing |
| Drug-related deaths | | 1,348 | 6.0 (5.7-6.3) | | 6.2 (6.2-6.2) | ns | Increasing | ns |
| **UIHO Total** | | | | | | | | |
| All Causes | | 18,141 | 573.9 (564.4-583.7) | | 883.2 (882.4-884.0) | -35% | Decreasing | Decreasing |
| Diseases of the heart | 1 | 3,555 | 145.0 (139.8-150.3) | 1 | 290.0 (289.6-290.5) | -50% | Decreasing | ns |
| Malignant neoplasms | 2 | 2,711 | 98.0 (94.0-102.2) | 2 | 201.8 (201.5-202.2) | -51% | ns | ns |
| Lung Cancer | | 663 | 24.9 (22.9-27.0) | | 51.2 (51.0-51.4) | -51% | Increasing | ns |
| Accidents | 3 | 2,313 | 42.7 (40.7-44.9) | 5 | 30.9 (30.8-31.1) | +38% | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 1,192 | 27.5 (25.9-29.3) | 11 | 12.2 (12.1-12.3) | +126% | ns | ns |
| Diabetes mellitus | 5 | 894 | 32.0 (29.7-34.4) | 8 | 20.8 (20.7-20.9) | +54% | Increasing | ns |
| Cerebrovascular diseases | 6 | 806 | 34.5 (32.0-37.2) | 3 | 61.2 (61.0-61.5) | -44% | ns | ns |
| Assault (homicide) | 7 | 622 | 9.0 (8.3-9.9) | 9 | 11.4 (11.3-11.5) | -21% | Decreasing | ns |
| Intentional self-harm (suicide) | 8 | 519 | 8.1 (7.3-8.9) | 10 | 11.2 (11.1-11.3) | -28% | ns | Decreasing |
| Chronic lower respiratory diseases | 9 | 515 | 21.8 (19.9-24.0) | 4 | 39.8 (39.7-40.0) | -45% | ns | ns |
| Influenza and pneumonia | 10 | 493 | 20.6 (18.6-22.8) | 6 | 26.5 (26.3-26.6) | -22% | ns | ns |
| Alcohol-related deaths | | 1,278 | 28.1 (26.5-29.9) | | 10.1 (10.0-10.2) | +178% | Decreasing | Decreasing |
| Drug-related deaths | | 540 | 9.0 (8.2-9.9) | | 9.4 (9.4-9.5) | ns | Increasing | ns |
| Injury by firearms | | 539 | 8.0 (7.2-8.8) | | 14.0 (13.9-14.1) | -43% | Decreasing | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Albuquerque NM** | | | | | | | | |
| All Causes | | 711 | 683.9 (627.3-745.0) | | 832.6 (824.1-841.2) | -18% | Increasing | ns |
| Malignant neoplasms | 1 | 103 | 117.0 (94.0-144.6) | 2 | 183.8 (179.9-187.8) | -36% | ns | ns |
| Accidents | 1 | 103 | 54.4 (42.3-70.3) | 3 | 49.0 (47.1-51.0) | ns | ns | ns |
| Lung Cancer | | 16 | 17.2 (9.5-29.8) | | 40.8 (38.9-42.7) | -58% | ns | ns |
| Diseases of the heart | 3 | 94 | 126.8 (101.3-157.3) | 1 | 211.5 (207.1-216.0) | -40% | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 52 | 38.6 (28.0-53.3) | 8 | 14.8 (13.7-16.0) | +160% | ns | ns |
| Diabetes mellitus | 5 | 39 | 43.4 (30.1-61.4) | 5 | 23.6 (22.2-25.1) | +84% | ns | Decreasing |
| Cerebrovascular diseases | 6 | 35 | 50.2 (34.2-71.6) | 4 | 58.4 (56.1-60.8) | ns | ns | ns |
| Intentional self-harm (suicide) | 7 | 33 | 15.6 (10.5-24.8) | 6 | 18.5 (17.3-19.7) | ns | ns | ns |
| Assault (homicide) | 8 | 28 | 13.3 (8.4-22.3) | 9 | 10.7 (9.9-11.7) | ns | ns | ns |
| Influenza and pneumonia | 9 | 25 | 31.0 (19.0-48.4) | 7 | 21.5 (20.1-23.0) | ns | ns | ns |
| Congenital malformations, deformations a | 10 | 14 | 4.3 (2.2-11.4) | 10 | 4.6 (4.0-5.2) | ns | ns | ns |
| Alcohol-related deaths | | 63 | 43.2 (32.3-58.2) | | 14.1 (13.1-15.2) | +207% | ns | ns |
| Injury by firearms | | 33 | 16.6 (11.0-26.4) | | 17.1 (16.0-18.2) | ns | ns | ns |
| Drug-related deaths | | 12 | 6.1 (3.0-13.8) | | 19.3 (18.2-20.6) | -69% | ns | ns |
| **Bakersfield CA** | | | | | | | | |
| All Causes | | 147 | 242.8 (200.9-292.5) | | 972.1 (962.8-981.5) | -75% | ns | ns |
| Diseases of the heart | 1 | 39 | 75.9 (51.9-108.6) | 1 | 337.5 (331.8-343.2) | -78% | ns | ns |
| Malignant neoplasms | 2 | 23 | 39.3 (24.3-62.6) | 2 | 205.0 (200.8-209.2) | -81% | ns | Increasing |
| Accidents | 3 | 20 | 23.0 (13.0-41.1) | 3 | 47.5 (45.6-49.4) | -52% | ns | ns |
| Alcohol-related deaths | | 10 | 9.7 (4.5-23.4) | | 13.6 (12.6-14.7) | ns | ns | Decreasing |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Billings MT** | | | | | | | | |
| All Causes | | 616 | 1332.8 (1208.8-1469.0) | | 852.7 (836.8-868.9) | +56% | ns | ns |
| Accidents | 1 | 121 | 138.7 (110.0-178.5) | 5 | 42.1 (38.7-45.8) | +229% | ns | ns |
| Malignant neoplasms | 2 | 119 | 295.2 (239.2-363.8) | 1 | 205.3 (197.6-213.3) | +44% | ns | ns |
| Lung Cancer | | 39 | 102.2 (70.5-147.2) | | 52.8 (48.9-56.9) | +94% | Increasing | ns |
| Diseases of the heart | 3 | 92 | 257.2 (201.7-326.2) | 2 | 203.3 (195.5-211.3) | ns | ns | ns |
| Diabetes mellitus | 4 | 36 | 105.0 (71.2-152.7) | 7 | 19.2 (16.9-21.8) | +447% | ns | ns |
| Cerebrovascular diseases | 5 | 28 | 79.0 (48.9-123.7) | 3 | 76.0 (71.2-80.9) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 6 | 27 | 37.9 (24.3-64.2) | 9 | 10.6 (8.9-12.5) | +258% | ns | ns |
| Chronic lower respiratory diseases | 7 | 19 | 60.4 (33.9-102.3) | 4 | 63.2 (59.0-67.7) | ns | Increasing | ns |
| Intentional self-harm (suicide) | 8 | 17 | 18.7 (9.0-42.9) | 6 | 20.3 (17.9-22.9) | ns | ns | ns |
| Influenza and pneumonia | 9 | 16 | 46.4 (23.4-85.0) | 8 | 17.1 (14.9-19.5) | +172% | ns | Decreasing |
| Assault (homicide) | 10 | 13 | 9.9 (5.3-30.3) | 11 | 5.6 (4.5-7.1) | ns | ns | ns |
| Alcohol-related deaths | | 37 | 48.8 (33.7-76.1) | | 9.1 (7.5-10.9) | +438% | ns | ns |
| Injury by firearms | | 19 | 18.1 (8.9-41.7) | | 15.7 (13.7-18.0) | ns | ns | ns |
| **Butte MT** | | | | | | | | |
| All Causes | | 28 | 704.7 (444.8-1115.8) | | 995.0 (964.8-1026.0) | ns | ns | ns |
| **Chicago IL** | | | | | | | | |
| All Causes | | 351 | 379.6 (335.8-428.7) | | 988.2 (985.4-991.0) | -62% | Decreasing | ns |
| Diseases of the heart | 1 | 93 | 119.6 (94.6-150.3) | 1 | 325.8 (324.2-327.5) | -63% | ns | ns |
| Malignant neoplasms | 2 | 45 | 53.5 (38.1-74.3) | 2 | 229.3 (227.9-230.6) | -77% | ns | ns |
| Lung Cancer | | 14 | 17.6 (9.1-32.1) | | 58.4 (57.7-59.1) | -70% | ns | ns |
| Chronic liver disease and cirrhosis | 3 | 26 | 21.0 (13.5-33.7) | 10 | 14.4 (14.1-14.8) | ns | Decreasing | ns |
| Accidents | 4 | 24 | 15.8 (9.6-27.3) | 4 | 31.9 (31.4-32.4) | -51% | Decreasing | ns |
| Assault (homicide) | 5 | 15 | 7.9 (4.3-17.3) | 6 | 17.7 (17.4-18.1) | -55% | Decreasing | ns |
| Septicemia | 6 | 13 | 19.4 (9.7-35.7) | 9 | 17.8 (17.4-18.2) | ns | ns | ns |
| Cerebrovascular diseases | 6 | 13 | 15.3 (7.2-29.8) | 3 | 64.8 (64.1-65.6) | -76% | ns | ns |
| Diabetes mellitus | 8 | 12 | 16.2 (7.8-30.9) | 5 | 25.8 (25.3-26.3) | ns | ns | ns |
| Human immunodeficiency virus (HIV) | 9 | 11 | 7.3 (3.5-17.0) | 8 | 16.6 (16.2-16.9) | ns | ns | ns |
| Nephritis, nephrotic syndrome and nephro | 10 | 10 | 15.2 (6.5-30.8) | 7 | 18.2 (17.8-18.6) | ns | ns | ns |
| Alcohol-related deaths | | 24 | 19.8 (12.5-32.3) | | 9.3 (9.0-9.5) | +114% | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Dallas TX** | | | | | | | | |
| All Causes | | 272 | 186.7 (160.5-217.1) | | 920.2 (916.7-923.7) | -80% | ns | ns |
| Diseases of the heart | 1 | 55 | 45.7 (32.6-63.3) | 1 | 292.6 (290.6-294.6) | -84% | ns | ns |
| Malignant neoplasms | 2 | 48 | 38.4 (26.7-54.6) | 2 | 211.9 (210.2-213.5) | -82% | ns | ns |
| Lung Cancer | | 13 | 11.1 (5.5-21.6) | | 62.0 (61.1-62.9) | -82% | ns | ns |
| Accidents | 3 | 39 | 15.2 (10.4-24.0) | 3 | 33.7 (33.1-34.3) | -55% | ns | ns |
| Diabetes mellitus | 4 | 21 | 17.3 (9.9-29.5) | 4 | 26.1 (25.5-26.7) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 5 | 15 | 7.5 (3.7-16.0) | 7 | 10.0 (9.7-10.3) | ns | ns | ns |
| Assault (homicide) | 6 | 14 | 4.4 (2.4-11.2) | 6 | 11.4 (11.1-11.7) | ns | ns | Increasing |
| Human immunodeficiency virus (HIV) | 7 | 11 | 3.6 (1.8-10.4) | 5 | 13.5 (13.2-13.9) | -74% | ns | ns |
| Alcohol-related deaths | | 13 | 5.0 (2.6-12.2) | | 6.0 (5.8-6.3) | ns | ns | ns |
| Injury by firearms | | 12 | 3.6 (1.8-10.3) | | 16.9 (16.5-17.3) | -79% | ns | ns |
| **Denver CO** | | | | | | | | |
| All Causes | | 509 | 511.9 (457.4-572.4) | | 828.2 (823.6-832.8) | -38% | ns | ns |
| Diseases of the heart | 1 | 88 | 129.6 (100.5-165.7) | 1 | 219.7 (217.3-222.1) | -41% | ns | ns |
| Malignant neoplasms | 2 | 75 | 97.8 (73.9-128.3) | 2 | 183.6 (181.5-185.8) | -47% | ns | ns |
| Lung Cancer | | 20 | 27.0 (15.5-45.6) | | 42.8 (41.8-43.8) | ns | ns | ns |
| Accidents | 3 | 59 | 32.2 (23.2-46.9) | 5 | 34.6 (33.7-35.4) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 37 | 25.7 (16.7-41.0) | 9 | 10.0 (9.6-10.5) | +157% | ns | Decreasing |
| Intentional self-harm (suicide) | 5 | 20 | 8.4 (5.1-18.8) | 7 | 16.0 (15.5-16.6) | ns | ns | ns |
| Assault (homicide) | 5 | 20 | 8.0 (4.8-18.3) | 10 | 5.6 (5.3-5.9) | ns | ns | ns |
| Cerebrovascular diseases | 7 | 18 | 31.2 (17.5-52.5) | 4 | 57.4 (56.2-58.7) | -46% | ns | ns |
| Human immunodeficiency virus (HIV) | 8 | 16 | 7.5 (4.2-18.0) | 8 | 11.1 (10.6-11.5) | ns | ns | ns |
| Influenza and pneumonia | 8 | 16 | 19.7 (9.4-37.8) | 6 | 23.5 (22.7-24.3) | ns | ns | ns |
| Chronic lower respiratory diseases | 10 | 10 | 13.1 (5.6-28.2) | 3 | 56.4 (55.2-57.7) | -77% | ns | ns |
| Certain conditions originating in the perina | 10 | 10 | 3.5 (1.7-13.5) | 11 | 4.5 (4.2-4.8) | ns | ns | ns |
| Alcohol-related deaths | | 63 | 38.4 (28.4-54.2) | | 10.8 (10.3-11.3) | +255% | ns | Decreasing |
| Injury by firearms | | 18 | 7.0 (4.1-17.1) | | 12.2 (11.7-12.7) | ns | ns | ns |
| Drug-related deaths | | 15 | 7.0 (3.8-17.3) | | 7.8 (7.4-8.2) | ns | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Detroit MI** | | | | | | | | |
| All Causes | | 941 | 1011.9 (940.7-1088.1) | | 1016.1 (1012.5-1019.7 | ns | Decreasing | ns |
| Diseases of the heart | 1 | 267 | 331.4 (289.4-378.6) | 1 | 350.9 (348.7-353.1) | ns | ns | ns |
| Malignant neoplasms | 2 | 196 | 210.0 (179.2-245.6) | 2 | 226.2 (224.5-227.9) | ns | ns | ns |
| Lung Cancer | | 73 | 72.8 (56.1-94.6) | | 62.1 (61.2-63.0) | ns | ns | ns |
| Chronic lower respiratory diseases | 3 | 58 | 73.4 (54.7-97.5) | 4 | 39.4 (38.7-40.2) | +86% | ns | ns |
| Accidents | 4 | 57 | 36.4 (26.5-51.0) | 5 | 31.8 (31.2-32.4) | ns | ns | ns |
| Cerebrovascular diseases | 5 | 42 | 54.8 (38.4-77.0) | 3 | 66.7 (65.7-67.6) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 6 | 38 | 30.1 (20.6-44.5) | 9 | 15.1 (14.7-15.6) | +99% | ns | ns |
| Diabetes mellitus | 7 | 29 | 29.4 (18.9-45.3) | 6 | 27.5 (26.9-28.1) | ns | ns | ns |
| Intentional self-harm (suicide) | 8 | 24 | 13.3 (8.3-23.5) | 11 | 10.6 (10.2-10.9) | ns | ns | ns |
| Assault (homicide) | 8 | 24 | 12.6 (7.9-22.5) | 8 | 19.9 (19.4-20.4) | ns | Decreasing | ns |
| Influenza and pneumonia | 10 | 22 | 29.9 (17.8-48.0) | 7 | 25.2 (24.6-25.7) | ns | ns | ns |
| Alcohol-related deaths | | 40 | 27.6 (19.5-40.6) | | 10.1 (9.7-10.4) | +174% | ns | ns |
| Injury by firearms | | 25 | 13.5 (8.4-23.7) | | 20.5 (20.0-21.0) | ns | ns | ns |
| Drug-related deaths | | 20 | 11.4 (6.9-21.1) | | 9.4 (9.0-9.7) | ns | ns | ns |
| **Flagstaff AZ** | | | | | | | | |
| All Causes | | 1,424 | 781.4 (737.1-828.0) | | 763.7 (740.2-787.9) | ns | ns | ns |
| Accidents | 1 | 365 | 139.7 (123.9-157.7) | 3 | 64.0 (58.7-69.8) | +118% | ns | ns |
| Diseases of the heart | 2 | 216 | 151.1 (130.8-174.0) | 1 | 186.1 (174.1-198.7) | -19% | ns | ns |
| Malignant neoplasms | 3 | 169 | 110.5 (93.7-129.9) | 2 | 164.3 (153.6-175.6) | -33% | ns | ns |
| Female breast cancer | | 12 | 13.5 (6.7-25.1) | | 26.3 (21.0-32.7) | ns | ns | ns |
| Influenza and pneumonia | 4 | 66 | 46.5 (35.4-60.3) | 7 | 30.5 (25.5-36.3) | ns | ns | ns |
| Cerebrovascular diseases | 5 | 50 | 38.4 (28.3-51.3) | 4 | 62.5 (55.3-70.4) | -38% | ns | ns |
| Chronic liver disease and cirrhosis | 6 | 49 | 22.9 (16.6-31.6) | 9 | 11.7 (9.4-14.5) | +97% | ns | ns |
| Intentional self-harm (suicide) | 7 | 46 | 15.0 (10.6-21.6) | 5 | 19.3 (16.5-22.5) | ns | ns | ns |
| Diabetes mellitus | 8 | 43 | 28.6 (20.5-39.4) | 8 | 19.2 (15.7-23.4) | ns | ns | ns |
| Assault (homicide) | 9 | 40 | 12.9 (9.0-19.0) | 10 | 6.5 (5.0-8.5) | +99% | ns | ns |
| Septicemia | 10 | 33 | 22.2 (14.9-32.3) | 12 | 10.2 (7.6-13.4) | +118% | ns | ns |
| Alcohol-related deaths | | 74 | 32.0 (24.8-41.4) | | 12.5 (10.2-15.3) | +156% | ns | ns |
| Injury by firearms | | 31 | 9.5 (6.2-15.2) | | 15.4 (12.9-18.4) | ns | ns | ns |
| Drug-related deaths | | 12 | 3.2 (1.6-7.4) | | 5.7 (4.2-7.7) | ns | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Fresno CA** | | | | | | | | |
| All Causes | | 343 | 305.5 (270.9-344.1) | | 898.4 (892.3-904.5) | -66% | ns | ns |
| Diseases of the heart | 1 | 93 | 97.1 (77.4-121.0) | 1 | 280.3 (276.9-283.8) | -65% | ns | ns |
| Malignant neoplasms | 2 | 53 | 52.6 (38.7-70.6) | 2 | 188.2 (185.5-191.0) | -72% | ns | ns |
| Lung Cancer | | 14 | 13.6 (7.2-24.4) | | 50.1 (48.7-51.6) | -73% | Increasing | ns |
| Accidents | 3 | 36 | 17.4 (11.6-26.7) | 4 | 49.5 (48.2-50.8) | -65% | ns | ns |
| Cerebrovascular diseases | 4 | 18 | 20.3 (11.6-33.5) | 3 | 69.2 (67.5-71.0) | -71% | Increasing | ns |
| Chronic liver disease and cirrhosis | 4 | 18 | 11.5 (6.7-20.1) | 6 | 15.4 (14.6-16.2) | ns | ns | ns |
| Diabetes mellitus | 6 | 16 | 13.9 (7.7-24.3) | 5 | 25.6 (24.6-26.7) | -46% | ns | ns |
| Assault (homicide) | 7 | 14 | 6.2 (3.3-13.1) | 7 | 11.3 (10.7-11.9) | ns | Decreasing | Decreasing |
| Alcohol-related deaths | | 18 | 10.8 (6.3-19.3) | | 12.3 (11.6-13.0) | ns | ns | ns |
| Injury by firearms | | 12 | 4.7 (2.4-11.1) | | 14.8 (14.1-15.6) | -69% | ns | ns |
| **Great Falls MT** | | | | | | | | |
| All Causes | | 174 | 1035.9 (847.9-1268.6) | | 872.1 (851.7-892.8) | ns | ns | ns |
| Malignant neoplasms | 1 | 30 | 191.1 (116.2-316.8) | 2 | 208.9 (199.0-219.1) | ns | ns | ns |
| Lung Cancer | | 13 | 103.2 (48.7-213.4) | | 57.3 (52.2-62.8) | ns | ns | ns |
| Diseases of the heart | 2 | 28 | 188.1 (113.1-314.2) | 1 | 226.9 (216.5-237.6) | ns | ns | ns |
| Accidents | 3 | 13 | 41.9 (21.7-120.2) | 3 | 40.2 (35.9-44.9) | ns | ns | ns |
| Alcohol-related deaths | | 10 | 40.2 (18.8-120.0) | | 9.3 (7.3-11.7) | +333% | ns | ns |
| **Green Bay WI** | | | | | | | | |
| All Causes | | 257 | 1125.6 (973.8-1298.2) | | 812.2 (800.3-824.2) | +39% | ns | ns |
| Diseases of the heart | 1 | 71 | 385.4 (295.1-498.1) | 1 | 259.6 (252.9-266.5) | +48% | ns | ns |
| Malignant neoplasms | 2 | 46 | 221.7 (157.6-308.0) | 2 | 190.5 (184.7-196.4) | ns | ns | ns |
| Lung Cancer | | 15 | 74.6 (40.5-132.0) | | 43.3 (40.6-46.2) | ns | ns | ns |
| Accidents | 3 | 32 | 63.2 (38.4-108.7) | 4 | 29.8 (27.7-32.2) | +112% | ns | Increasing |
| Cerebrovascular diseases | 4 | 19 | 96.6 (55.7-160.9) | 3 | 75.5 (71.9-79.3) | ns | ns | ns |
| Diabetes mellitus | 5 | 13 | 63.0 (32.0-117.9) | 5 | 16.6 (14.9-18.4) | +280% | ns | Increasing |
| Intentional self-harm (suicide) | 5 | 13 | 22.9 (11.9-57.2) | 6 | 12.9 (11.5-14.4) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 7 | 12 | 68.5 (33.7-128.4) | 7 | 7.0 (5.9-8.2) | +886% | ns | ns |
| Alcohol-related deaths | | 11 | 50.7 (22.3-104.2) | | 5.4 (4.5-6.5) | +837% | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Helena MT** | | | | | | | | |
| All Causes | | 82 | 1387.6 (1074.2-1775.3) | | 880.4 (855.4-905.9) | +58% | ns | ns |
| Malignant neoplasms | 1 | 25 | 517.0 (321.0-796.4) | 2 | 205.6 (193.8-218.0) | +151% | ns | ns |
| Diseases of the heart | 2 | 13 | 197.5 (99.4-373.5) | 1 | 221.5 (209.0-234.6) | ns | ns | ns |
| **Jamaica Plains MA** | | | | | | | | |
| All Causes | | 43 | 240.9 (170.7-334.4) | | 972.3 (964.4-980.2) | -75% | ns | ns |
| **Lincoln NE** | | | | | | | | |
| All Causes | | 329 | 1130.4 (978.7-1305.9) | | 860.8 (854.2-867.4) | +31% | Increasing | ns |
| Diseases of the heart | 1 | 59 | 279.9 (203.1-383.5) | 1 | 267.8 (264.1-271.5) | ns | ns | ns |
| Malignant neoplasms | 2 | 43 | 188.4 (128.2-275.5) | 2 | 204.8 (201.6-208.0) | ns | ns | ns |
| Lung Cancer | | 12 | 57.1 (25.0-120.2) | | 57.2 (55.6-59.0) | ns | ns | ns |
| Accidents | 3 | 40 | 70.4 (43.5-123.7) | 5 | 27.5 (26.4-28.7) | +156% | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 28 | 66.3 (41.5-117.4) | 7 | 7.8 (7.1-8.4) | +755% | ns | ns |
| Assault (homicide) | 5 | 19 | 23.3 (13.5-64.1) | 8 | 4.3 (3.9-4.8) | +441% | ns | ns |
| Diabetes mellitus | 6 | 16 | 73.6 (37.5-139.5) | 6 | 18.8 (17.9-19.8) | +291% | Increasing | ns |
| Cerebrovascular diseases | 7 | 15 | 73.3 (38.0-138.0) | 3 | 62.9 (61.2-64.8) | ns | ns | ns |
| Chronic lower respiratory diseases | 8 | 10 | 53.6 (21.4-118.3) | 4 | 49.3 (47.7-50.9) | ns | ns | ns |
| Alcohol-related deaths | | 34 | 71.3 (47.3-120.9) | | 5.8 (5.2-6.3) | +1,129% | ns | ns |
| **Los Angeles CA** | | | | | | | | |
| All Causes | | 1,067 | 278.3 (260.1-297.6) | | 866.1 (863.9-868.3) | -68% | ns | Decreasing |
| Diseases of the heart | 1 | 294 | 97.9 (86.4-110.5) | 1 | 302.8 (301.5-304.1) | -68% | ns | ns |
| Malignant neoplasms | 2 | 195 | 53.4 (45.7-62.2) | 2 | 192.8 (191.7-193.8) | -72% | ns | ns |
| Lung Cancer | | 50 | 15.4 (11.3-20.8) | | 46.8 (46.3-47.3) | -67% | ns | ns |
| Accidents | 3 | 86 | 12.2 (9.4-15.8) | 5 | 27.6 (27.2-28.0) | -56% | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 75 | 12.9 (10.0-16.8) | 10 | 15.0 (14.7-15.3) | ns | ns | ns |
| Cerebrovascular diseases | 5 | 65 | 18.7 (14.2-24.5) | 3 | 65.9 (65.3-66.5) | -72% | ns | ns |
| Diabetes mellitus | 6 | 50 | 13.4 (9.7-18.1) | 9 | 20.5 (20.2-20.9) | -35% | ns | ns |
| Human immunodeficiency virus (HIV) | 7 | 40 | 4.9 (3.5-7.4) | 7 | 21.1 (20.8-21.4) | -77% | Decreasing | Decreasing |
| Chronic lower respiratory diseases | 8 | 33 | 10.3 (6.9-14.9) | 4 | 40.4 (39.9-40.8) | -75% | ns | ns |
| Assault (homicide) | 9 | 32 | 3.8 (2.5-6.1) | 8 | 16.0 (15.8-16.3) | -76% | ns | ns |
| Influenza and pneumonia | 10 | 26 | 9.9 (6.3-14.7) | 6 | 31.2 (30.8-31.7) | -68% | ns | ns |
| Alcohol-related deaths | | 76 | 12.5 (9.7-16.3) | | 13.4 (13.2-13.7) | ns | ns | ns |
| Drug-related deaths | | 61 | 7.5 (5.7-10.3) | | 10.1 (9.9-10.3) | ns | ns | ns |
| Injury by firearms | | 30 | 3.2 (2.1-5.3) | | 18.1 (17.8-18.4) | -82% | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Milwaukee WI** | | | | | | | | |
| All Causes | | 283 | 780.5 (669.2-911.4) | | 892.2 (887.0-897.4) | ns | ns | ns |
| Diseases of the heart | 1 | 67 | 244.0 (179.3-330.7) | 1 | 279.1 (276.2-282.0) | ns | ns | Decreasing |
| Malignant neoplasms | 2 | 48 | 149.2 (102.7-217.5) | 2 | 216.5 (213.9-219.1) | ns | ns | ns |
| Lung Cancer | | 13 | 35.4 (17.9-76.8) | | 53.0 (51.8-54.3) | ns | ns | ns |
| Accidents | 3 | 22 | 34.6 (18.3-74.4) | 4 | 30.5 (29.5-31.5) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 18 | 31.7 (16.9-70.1) | 6 | 9.0 (8.5-9.6) | +250% | ns | ns |
| Cerebrovascular diseases | 5 | 16 | 53.5 (28.7-101.6) | 3 | 71.2 (69.8-72.7) | ns | ns | ns |
| Assault (homicide) | 6 | 10 | 9.2 (4.3-42.7) | 5 | 11.2 (10.6-11.8) | ns | ns | ns |
| Alcohol-related deaths | | 19 | 27.6 (16.4-62.9) | | 9.1 (8.6-9.7) | +203% | ns | Increasing |
| Drug-related deaths | | 12 | 21.5 (8.7-59.7) | | 6.5 (6.0-6.9) | +233% | ns | ns |
| **Minneapolis MN** | | | | | | | | |
| All Causes | | 1,035 | 1246.1 (1146.5-1354.2) | | 821.0 (816.3-825.6) | +52% | ns | Decreasing |
| Diseases of the heart | 1 | 167 | 278.7 (229.0-338.0) | 1 | 196.8 (194.5-199.0) | +42% | ns | ns |
| Malignant neoplasms | 2 | 140 | 201.0 (162.9-248.0) | 2 | 201.1 (198.7-203.4) | ns | ns | ns |
| Lung Cancer | | 45 | 67.5 (47.0-97.1) | | 50.4 (49.2-51.6) | ns | ns | ns |
| Accidents | 3 | 113 | 81.7 (62.8-108.7) | 5 | 32.1 (31.2-33.0) | +155% | ns | ns |
| Assault (homicide) | 4 | 71 | 34.0 (26.1-50.6) | 12 | 5.7 (5.3-6.1) | +496% | Decreasing | ns |
| Chronic liver disease and cirrhosis | 5 | 67 | 59.2 (42.6-84.5) | 11 | 8.9 (8.4-9.4) | +567% | ns | ns |
| Diabetes mellitus | 6 | 44 | 69.1 (46.6-101.3) | 7 | 21.5 (20.7-22.2) | +222% | ns | ns |
| Intentional self-harm (suicide) | 7 | 35 | 15.8 (10.9-30.6) | 8 | 11.0 (10.5-11.5) | ns | Decreasing | ns |
| Cerebrovascular diseases | 8 | 32 | 61.1 (37.7-95.3) | 3 | 65.0 (63.7-66.3) | ns | ns | ns |
| Chronic lower respiratory diseases | 9 | 30 | 56.3 (35.2-87.7) | 4 | 41.9 (40.9-43.0) | ns | ns | ns |
| Certain conditions originating in the perinatal period | 10 | 27 | 7.9 (5.2-22.0) | 14 | 5.0 (4.7-5.4) | ns | ns | ns |
| Alcohol-related deaths | | 93 | 70.1 (54.9-93.2) | | 8.8 (8.3-9.3) | +697% | ns | Decreasing |
| Injury by firearms | | 42 | 18.2 (13.0-33.2) | | 7.9 (7.5-8.4) | +129% | ns | Decreasing |
| Drug-related deaths | | 20 | 11.9 (7.1-27.0) | | 4.4 (4.1-4.8) | +169% | ns | ns |
| **Missoula MT** | | | | | | | | |
| All Causes | | 80 | 929.6 (704.3-1213.4) | | 813.3 (792.5-834.5) | ns | ns | ns |
| Malignant neoplasms | 1 | 18 | 258.9 (145.4-436.1) | 2 | 193.8 (183.7-204.3) | ns | ns | ns |
| Diseases of the heart | 1 | 18 | 271.5 (150.8-458.0) | 1 | 202.7 (192.3-213.6) | ns | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **New York NY** | | | | | | | | |
| All Causes | | 357 | 120.1 (107.0-134.7) | | 916.0 (914.1-917.9) | -87% | Decreasing | ns |
| Diseases of the heart | 1 | 135 | 54.7 (45.5-65.4) | 1 | 368.3 (367.0-369.5) | -85% | Decreasing | ns |
| Malignant neoplasms | 2 | 54 | 20.0 (14.8-26.7) | 2 | 201.2 (200.3-202.1) | -90% | ns | ns |
| Accidents | 3 | 27 | 5.6 (3.5-8.9) | 5 | 26.0 (25.7-26.3) | -79% | ns | ns |
| Human immunodeficiency virus (HIV) disease | 4 | 13 | 2.3 (1.2-4.8) | 3 | 54.5 (54.0-55.0) | -96% | ns | ns |
| Cerebrovascular diseases | 4 | 13 | 5.1 (2.6-9.3) | 4 | 37.4 (37.0-37.8) | -86% | ns | ns |
| Assault (homicide) | 6 | 12 | 2.3 (1.2-4.9) | 7 | 14.5 (14.3-14.8) | -84% | Decreasing | ns |
| Diabetes mellitus | 7 | 11 | 3.7 (1.8-7.1) | 6 | 19.2 (18.9-19.5) | -81% | ns | ns |
| Chronic liver disease and cirrhosis | 7 | 11 | 2.9 (1.4-5.8) | 8 | 11.3 (11.1-11.5) | -75% | ns | ns |
| Alcohol-related deaths | | 13 | 3.1 (1.6-6.1) | | 11.5 (11.3-11.7) | -73% | ns | ns |
| Injury by firearms | | 12 | 2.5 (1.2-5.1) | | 12.2 (12.0-12.4) | -80% | Decreasing | ns |
| **Oakland CA** | | | | | | | | |
| All Causes | | 648 | 413.3 (377.2-452.5) | | 842.8 (839.8-845.8) | -51% | ns | Decreasing |
| Diseases of the heart | 1 | 142 | 114.5 (94.6-137.8) | 1 | 243.6 (242.0-245.3) | -53% | Increasing | ns |
| Malignant neoplasms | 2 | 113 | 76.1 (61.4-93.9) | 2 | 198.3 (196.9-199.8) | -62% | ns | ns |
| Lung Cancer | | 38 | 25.3 (17.3-36.7) | | 50.3 (49.6-51.1) | -50% | ns | ns |
| Accidents | 3 | 59 | 25.0 (18.1-34.9) | 6 | 28.5 (28.0-29.1) | ns | ns | ns |
| Human immunodeficiency virus (HIV) disease | 4 | 51 | 15.6 (11.5-22.5) | 4 | 34.5 (34.0-35.1) | -55% | Decreasing | Decreasing |
| Chronic liver disease and cirrhosis | 5 | 43 | 19.1 (13.2-28.2) | 9 | 13.2 (12.8-13.5) | ns | Decreasing | ns |
| Cerebrovascular diseases | 6 | 39 | 33.3 (22.7-47.7) | 3 | 74.3 (73.4-75.2) | -55% | ns | ns |
| Diabetes mellitus | 7 | 21 | 16.0 (9.4-26.2) | 8 | 16.0 (15.6-16.4) | ns | ns | ns |
| Intentional self-harm (suicide) | 7 | 21 | 6.7 (4.1-12.6) | 10 | 11.7 (11.4-12.1) | ns | ns | Decreasing |
| Assault (homicide) | 7 | 21 | 6.6 (4.0-12.5) | 11 | 9.3 (9.0-9.6) | ns | ns | ns |
| Chronic lower respiratory diseases | 10 | 20 | 18.6 (11.0-30.1) | 5 | 38.5 (37.8-39.1) | -52% | ns | ns |
| Alcohol-related deaths | | 40 | 17.3 (11.8-25.7) | | 10.1 (9.8-10.4) | +71% | ns | ns |
| Drug-related deaths | | 29 | 10.7 (6.8-17.8) | | 12.2 (11.9-12.6) | ns | ns | ns |
| Injury by firearms | | 19 | 6.0 (3.6-11.9) | | 11.8 (11.4-12.1) | ns | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Phoenix AZ** | | | | | | | | |
| All Causes | | 2,323 | 994.9 (945.5-1046.7) | | 816.4 (812.7-820.1) | +22% | Decreasing | ns |
| Accidents | 1 | 366 | 84.5 (73.7-97.5) | 5 | 38.2 (37.4-39.0) | +121% | ns | ns |
| Diseases of the heart | 2 | 332 | 197.4 (174.1-223.3) | 1 | 239.1 (237.1-241.1) | -17% | ns | ns |
| Malignant neoplasms | 3 | 221 | 123.8 (106.1-144.1) | 2 | 188.6 (186.8-190.3) | -34% | Decreasing | ns |
| Lung Cancer | | 35 | 22.5 (15.1-32.8) | | 51.2 (50.3-52.1) | -56% | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 212 | 70.1 (60.1-82.4) | 10 | 11.8 (11.3-12.2) | +496% | ns | ns |
| Diabetes mellitus | 5 | 182 | 105.3 (89.3-123.9) | 7 | 18.4 (17.9-19.0) | +471% | ns | ns |
| Assault (homicide) | 6 | 105 | 18.3 (14.3-24.5) | 11 | 9.5 (9.2-9.9) | +92% | ns | ns |
| Cerebrovascular diseases | 7 | 81 | 50.6 (38.9-65.1) | 3 | 57.4 (56.4-58.4) | ns | ns | ns |
| Influenza and pneumonia | 8 | 66 | 35.3 (25.8-47.8) | 6 | 21.8 (21.2-22.4) | +62% | ns | ns |
| Intentional self-harm (suicide) | 9 | 64 | 11.6 (8.6-17.0) | 8 | 15.5 (15.0-16.0) | ns | Decreasing | ns |
| Chronic lower respiratory diseases | 10 | 47 | 33.7 (24.1-46.3) | 4 | 49.3 (48.4-50.2) | -32% | ns | ns |
| Alcohol-related deaths | | 200 | 62.3 (53.2-73.5) | | 8.4 (8.0-8.8) | +643% | ns | ns |
| Injury by firearms | | 96 | 17.2 (13.5-23.1) | | 18.0 (17.4-18.5) | ns | ns | ns |
| Drug-related deaths | | 71 | 13.6 (10.3-19.2) | | 9.6 (9.2-10.0) | +41% | ns | ns |
| **Pierre SD** | | | | | | | | |
| All Causes | | 169 | 1031.3 (840.0-1268.0) | | 797.1 (784.2-810.1) | +29% | ns | ns |
| Diseases of the heart | 1 | 30 | 245.0 (157.7-382.3) | 1 | 248.9 (241.8-256.3) | ns | ns | ns |
| Malignant neoplasms | 2 | 23 | 210.7 (125.8-348.3) | 2 | 202.6 (196.0-209.3) | ns | ns | ns |
| Accidents | 3 | 17 | 40.3 (21.9-117.3) | 4 | 29.2 (26.8-31.8) | ns | ns | ns |
| Cerebrovascular diseases | 4 | 12 | 129.8 (56.7-264.2) | 3 | 63.9 (60.3-67.6) | ns | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Portland OR** | | | | | | | | |
| All Causes | | 549 | 686.7 (618.9-761.8) | | 870.6 (865.8-875.5) | -21% | ns | ns |
| Malignant neoplasms | 1 | 104 | 147.0 (116.1-185.7) | 2 | 208.5 (206.1-210.9) | -30% | ns | ns |
| Lung Cancer | | 35 | 53.3 (35.1-79.8) | | 59.4 (58.1-60.7) | ns | ns | ns |
| Diseases of the heart | 2 | 76 | 127.5 (96.7-166.6) | 1 | 233.0 (230.5-235.6) | -45% | ns | Decreasing |
| Accidents | 3 | 68 | 44.4 (32.4-63.5) | 5 | 35.4 (34.5-36.4) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 35 | 31.8 (20.9-50.5) | 9 | 9.5 (9.0-10.0) | +236% | ns | ns |
| Cerebrovascular diseases | 5 | 33 | 60.3 (39.6-89.7) | 3 | 76.1 (74.6-77.5) | ns | ns | ns |
| Diabetes mellitus | 6 | 26 | 35.8 (21.8-58.3) | 6 | 21.9 (21.1-22.7) | ns | Increasing | ns |
| Chronic lower respiratory diseases | 7 | 22 | 39.9 (23.9-64.9) | 4 | 47.3 (46.2-48.5) | ns | ns | ns |
| Intentional self-harm (suicide) | 8 | 17 | 11.2 (5.6-25.6) | 7 | 14.0 (13.4-14.6) | ns | ns | ns |
| Assault (homicide) | 9 | 13 | 6.0 (3.2-18.4) | 10 | 4.5 (4.2-4.9) | ns | Decreasing | ns |
| Human immunodeficiency virus (HIV) | 10 | 11 | 6.7 (3.2-19.5) | 8 | 9.4 (8.9-9.9) | ns | ns | ns |
| Alcohol-related deaths | | 52 | 46.8 (33.8-67.1) | | 10.3 (9.8-10.8) | +354% | ns | ns |
| Drug-related deaths | | 49 | 27.0 (19.8-41.6) | | 10.6 (10.2-11.2) | +153% | ns | ns |
| Injury by firearms | | 12 | 7.9 (3.1-22.0) | | 10.9 (10.4-11.4) | ns | ns | ns |
| **Reno NV** | | | | | | | | |
| All Causes | | 444 | 899.6 (806.4-1002.6) | | 937.9 (927.3-948.5) | ns | ns | ns |
| Diseases of the heart | 1 | 118 | 283.7 (229.8-348.3) | 1 | 299.3 (293.2-305.5) | ns | ns | ns |
| Malignant neoplasms | 2 | 76 | 176.5 (135.2-228.5) | 2 | 212.5 (207.7-217.4) | ns | ns | ns |
| Lung Cancer | | 18 | 45.6 (25.6-77.4) | | 62.7 (60.1-65.3) | ns | ns | ns |
| Accidents | 3 | 45 | 50.0 (36.0-73.2) | 5 | 36.7 (34.8-38.7) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 28 | 38.0 (24.8-61.1) | 7 | 16.7 (15.5-18.1) | +127% | ns | ns |
| Intentional self-harm (suicide) | 5 | 19 | 19.5 (10.9-38.9) | 6 | 23.5 (22.0-25.1) | ns | ns | ns |
| Diabetes mellitus | 6 | 17 | 31.1 (17.3-55.9) | 8 | 15.0 (13.8-16.4) | +107% | ns | ns |
| Cerebrovascular diseases | 6 | 17 | 35.6 (19.7-62.6) | 4 | 61.1 (58.3-64.0) | ns | ns | ns |
| Chronic lower respiratory diseases | 8 | 13 | 33.7 (17.6-61.5) | 3 | 68.6 (65.7-71.5) | -51% | ns | ns |
| Nephritis, nephrotic syndrome and nephro | 9 | 11 | 24.7 (11.3-50.2) | 9 | 11.8 (10.6-13.1) | ns | ns | ns |
| Assault (homicide) | 10 | 10 | 8.4 (4.0-24.8) | 10 | 6.2 (5.4-7.0) | ns | ns | ns |
| Alcohol-related deaths | | 35 | 47.0 (32.3-71.2) | | 18.5 (17.2-19.9) | +154% | ns | ns |
| Injury by firearms | | 16 | 16.4 (8.4-35.3) | | 18.8 (17.5-20.3) | ns | ns | ns |
| Drug-related deaths | | 12 | 13.7 (6.9-31.8) | | 10.5 (9.6-11.6) | ns | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Sacramento CA** | | | | | | | | |
| All Causes | | 355 | 444.2 (392.1-502.8) | | 878.6 (872.6-884.7) | -49% | ns | ns |
| Diseases of the heart | 1 | 80 | 124.6 (96.1-160.1) | 1 | 262.9 (259.5-266.3) | -53% | ns | ns |
| Malignant neoplasms | 2 | 61 | 85.2 (63.2-114.0) | 2 | 203.9 (201.0-206.8) | -58% | ns | ns |
| Lung Cancer | | 12 | 20.1 (9.7-38.3) | | 57.9 (56.4-59.5) | -65% | ns | ns |
| Accidents | 3 | 29 | 21.2 (13.1-35.9) | 5 | 31.1 (30.0-32.2) | ns | ns | ns |
| Chronic lower respiratory diseases | 4 | 22 | 37.1 (22.2-59.8) | 4 | 52.1 (50.7-53.6) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 22 | 18.0 (11.0-31.6) | 8 | 12.2 (11.5-12.9) | ns | ns | ns |
| Cerebrovascular diseases | 6 | 17 | 26.3 (14.0-46.3) | 3 | 69.4 (67.7-71.2) | -62% | ns | ns |
| Human immunodeficiency virus (HIV) | 7 | 14 | 7.6 (4.1-18.5) | 7 | 13.2 (12.6-13.9) | ns | ns | ns |
| Diabetes mellitus | 8 | 11 | 15.5 (7.0-31.6) | 6 | 18.2 (17.4-19.1) | ns | ns | ns |
| Assault (homicide) | 9 | 10 | 5.3 (2.5-15.9) | 9 | 8.8 (8.3-9.4) | ns | ns | ns |
| Alcohol-related deaths | | 24 | 21.6 (13.4-36.5) | | 12.0 (11.3-12.7) | +81% | ns | ns |
| Drug-related deaths | | 19 | 11.1 (6.6-22.6) | | 9.1 (8.5-9.7) | ns | ns | ns |
| Injury by firearms | | 10 | 5.5 (2.6-16.2) | | 13.9 (13.2-14.6) | ns | ns | ns |
| **Salt Lake City UT** | | | | | | | | |
| All Causes | | 319 | 819.6 (659.8-1018.5) | | 794.4 (788.8-800.0) | ns | ns | ns |
| Accidents | 1 | 55 | 55.2 (35.2-121.2) | 4 | 33.1 (32.1-34.2) | +66% | ns | ns |
| Diseases of the heart | 2 | 39 | 174.1 (100.6-293.7) | 1 | 219.3 (216.3-222.4) | ns | ns | ns |
| Malignant neoplasms | 3 | 36 | 131.6 (75.2-232.1) | 2 | 156.0 (153.6-158.5) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 25 | 31.4 (18.5-95.0) | 8 | 7.7 (7.2-8.2) | +308% | ns | ns |
| Diabetes mellitus | 5 | 19 | 51.0 (24.8-124.0) | 5 | 30.3 (29.2-31.4) | ns | ns | ns |
| Intentional self-harm (suicide) | 6 | 15 | 7.7 (4.2-72.2) | 7 | 15.4 (14.7-16.1) | ns | ns | ns |
| Cerebrovascular diseases | 7 | 14 | 87.1 (32.9-194.9) | 3 | 65.3 (63.7-67.0) | ns | ns | ns |
| Assault (homicide) | 8 | 13 | 9.4 (4.4-73.8) | 9 | 3.1 (2.9-3.4) | +199% | ns | ns |
| Influenza and pneumonia | 9 | 11 | 76.4 (23.0-188.0) | 6 | 26.2 (25.1-27.2) | ns | ns | ns |
| Alcohol-related deaths | | 36 | 61.1 (28.2-140.9) | | 7.0 (6.5-7.5) | +773% | ns | ns |
| Injury by firearms | | 13 | 7.2 (3.7-71.9) | | 10.7 (10.1-11.3) | ns | ns | ns |
| Drug-related deaths | | 10 | 6.4 (3.0-71.4) | | 9.5 (9.0-10.1) | ns | Increasing | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **San Diego CA** | | | | | | | | |
| All Causes | | 695 | 507.4 (466.5-551.4) | | 823.3 (819.5-827.1) | -38% | ns | ns |
| Diseases of the heart | 1 | 191 | 167.0 (142.7-194.6) | 1 | 250.4 (248.3-252.6) | -33% | ns | ns |
| Malignant neoplasms | 2 | 110 | 84.6 (68.6-103.9) | 2 | 197.6 (195.7-199.5) | -57% | ns | ns |
| Lung Cancer | | 30 | 22.3 (14.6-33.3) | | 51.0 (50.1-52.0) | -56% | ns | ns |
| Accidents | 3 | 66 | 22.0 (16.8-29.8) | 5 | 27.4 (26.7-28.0) | ns | ns | ns |
| Diabetes mellitus | 4 | 38 | 30.9 (21.5-43.7) | 9 | 14.4 (13.9-14.9) | +115% | Increasing | ns |
| Chronic liver disease and cirrhosis | 5 | 37 | 21.4 (14.7-31.1) | 10 | 11.6 (11.2-12.1) | +84% | ns | ns |
| Chronic lower respiratory diseases | 6 | 28 | 25.4 (16.5-37.7) | 4 | 46.1 (45.2-47.0) | -45% | ns | ns |
| Cerebrovascular diseases | 7 | 23 | 20.4 (12.5-31.9) | 3 | 66.5 (65.4-67.6) | -69% | ns | ns |
| Human immunodeficiency virus (HIV) | 8 | 21 | 8.6 (5.2-15.0) | 7 | 17.2 (16.7-17.8) | -50% | ns | ns |
| Influenza and pneumonia | 9 | 17 | 16.5 (9.3-27.3) | 6 | 27.4 (26.7-28.1) | ns | ns | ns |
| Assault (homicide) | 10 | 15 | 4.7 (2.6-10.1) | 11 | 6.6 (6.3-6.9) | ns | ns | ns |
| Alcohol-related deaths | | 38 | 18.9 (13.2-27.5) | | 9.9 (9.5-10.3) | +91% | ns | ns |
| Drug-related deaths | | 26 | 10.0 (6.4-16.5) | | 10.9 (10.5-11.3) | ns | ns | ns |
| Injury by firearms | | 12 | 4.8 (2.1-10.8) | | 10.7 (10.3-11.1) | ns | ns | ns |
| **San Jose CA** | | | | | | | | |
| All Causes | | 188 | 333.3 (280.6-394.7) | | 752.1 (747.1-757.3) | -56% | ns | ns |
| Malignant neoplasms | 1 | 44 | 75.5 (52.9-107.0) | 2 | 177.2 (174.8-179.6) | -57% | ns | ns |
| Lung Cancer | | 10 | 19.6 (8.7-40.8) | | 42.6 (41.4-43.8) | -54% | ns | ns |
| Diseases of the heart | 2 | 42 | 86.3 (59.7-122.5) | 1 | 234.0 (231.1-237.0) | -63% | ns | ns |
| Accidents | 3 | 15 | 15.4 (7.7-32.6) | 4 | 21.8 (21.0-22.6) | ns | ns | ns |
| Diabetes mellitus | 4 | 10 | 19.7 (8.4-41.6) | 5 | 17.7 (16.9-18.5) | ns | ns | ns |
| Cerebrovascular diseases | 4 | 10 | 24.9 (10.9-49.9) | 3 | 65.4 (63.9-67.0) | -62% | ns | ns |
| Alcohol-related deaths | | 13 | 17.4 (8.4-36.1) | | 7.3 (6.9-7.8) | +137% | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Santa Barbara CA** | | | | | | | | |
| All Causes | | 188 | 240.1 (203.7-281.9) | | 767.2 (762.2-772.3) | -69% | Increasing | ns |
| Diseases of the heart | 1 | 45 | 64.7 (46.1-89.3) | 1 | 232.8 (230.0-235.6) | -72% | ns | ns |
| Malignant neoplasms | 2 | 40 | 51.5 (35.7-72.9) | 2 | 183.9 (181.4-186.4) | -72% | ns | ns |
| Lung Cancer | | 14 | 17.1 (9.0-31.3) | | 48.1 (46.9-49.4) | -64% | ns | ns |
| Cerebrovascular diseases | 3 | 17 | 27.0 (15.1-45.4) | 3 | 66.1 (64.6-67.6) | -59% | ns | ns |
| Accidents | 4 | 15 | 10.8 (5.8-21.4) | 4 | 31.4 (30.5-32.4) | -66% | ns | ns |
| Alcohol-related deaths | | 11 | 9.9 (4.6-21.2) | | 10.1 (9.6-10.7) | ns | ns | ns |
| **Seattle WA** | | | | | | | | |
| All Causes | | 905 | 927.9 (854.6-1007.6) | | 803.0 (798.3-807.7) | +16% | ns | ns |
| Diseases of the heart | 1 | 181 | 249.0 (208.4-296.8) | 1 | 218.6 (216.1-221.1) | ns | ns | ns |
| Malignant neoplasms | 2 | 164 | 183.4 (152.5-220.9) | 2 | 197.9 (195.6-200.3) | ns | ns | ns |
| Lung Cancer | | 47 | 55.8 (39.2-79.5) | | 52.8 (51.6-54.0) | ns | ns | ns |
| Accidents | 3 | 86 | 48.8 (37.3-66.5) | 5 | 29.1 (28.2-30.0) | +68% | ns | ns |
| Chronic liver disease and cirrhosis | 4 | 58 | 38.1 (28.0-54.8) | 10 | 8.8 (8.4-9.3) | +332% | ns | ns |
| Cerebrovascular diseases | 5 | 42 | 67.5 (46.4-96.5) | 3 | 68.6 (67.2-70.0) | ns | ns | ns |
| Human immunodeficiency virus (HIV) | 6 | 33 | 14.9 (10.1-27.1) | 8 | 14.8 (14.2-15.4) | ns | ns | Decreasing |
| Assault (homicide) | 7 | 29 | 12.9 (8.5-24.7) | 12 | 5.0 (4.7-5.4) | +156% | ns | ns |
| Diabetes mellitus | 8 | 28 | 33.1 (20.8-52.9) | 7 | 19.7 (19.0-20.5) | +68% | ns | ns |
| Chronic lower respiratory diseases | 9 | 26 | 34.8 (21.2-56.2) | 4 | 41.4 (40.4-42.5) | ns | ns | ns |
| Intentional self-harm (suicide) | 10 | 25 | 12.4 (7.9-24.4) | 9 | 12.2 (11.7-12.8) | ns | ns | ns |
| Alcohol-related deaths | | 60 | 38.1 (28.6-54.0) | | 7.1 (6.7-7.6) | +435% | ns | ns |
| Drug-related deaths | | 52 | 25.6 (18.9-39.0) | | 10.3 (9.9-10.8) | +148% | Increasing | ns |
| Injury by firearms | | 21 | 9.6 (5.9-21.3) | | 9.2 (8.7-9.7) | ns | ns | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Spokane WA** | | | | | | | | |
| All Causes | | 256 | 891.5 (761.0-1044.2) | | 861.2 (852.0-870.5) | ns | ns | ns |
| Malignant neoplasms | 1 | 50 | 202.6 (144.0-284.9) | 2 | 205.6 (201.1-210.2) | ns | ns | ns |
| Lung Cancer | | 13 | 51.7 (25.3-104.7) | | 58.6 (56.2-61.1) | ns | ns | ns |
| Diseases of the heart | 2 | 44 | 203.6 (139.1-293.7) | 1 | 244.3 (239.4-249.3) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 3 | 26 | 63.1 (39.4-110.9) | 5 | 12.9 (11.8-14.1) | +389% | ns | ns |
| Accidents | 3 | 26 | 42.3 (26.7-83.0) | 4 | 32.7 (30.9-34.5) | ns | ns | ns |
| Cerebrovascular diseases | 5 | 20 | 86.8 (48.5-151.4) | 3 | 69.7 (67.1-72.4) | ns | ns | ns |
| Assault (homicide) | 6 | 10 | 14.0 (6.6-51.4) | 6 | 4.6 (4.0-5.3) | +205% | Decreasing | ns |
| Alcohol-related deaths | | 25 | 62.2 (38.6-109.9) | | 10.6 (9.6-11.7) | +487% | ns | ns |
| Drug-related deaths | | 10 | 16.5 (7.9-54.3) | | 5.8 (5.0-6.6) | +186% | ns | ns |
| **Tucson AZ** | | | | | | | | |
| All Causes | | 1773 | 1196.6 (1135.0-1261.1) | | 859.5 (852.9-866.2) | +39% | ns | ns |
| Diseases of the heart | 1 | 276 | 244.8 (215.1-278.0) | 1 | 250.1 (246.5-253.7) | ns | ns | ns |
| Accidents | 2 | 269 | 123.7 (107.7-142.3) | 5 | 42.8 (41.3-44.3) | +189% | ns | ns |
| Malignant neoplasms | 3 | 172 | 135.6 (114.7-159.7) | 2 | 192.0 (188.9-195.2) | -29% | ns | ns |
| Lung Cancer | | 18 | 14.8 (8.5-24.7) | | 51.0 (49.4-52.6) | -71% | Increasing | ns |
| Chronic liver disease and cirrhosis | 4 | 163 | 82.3 (69.8-97.4) | 10 | 14.8 (14.0-15.8) | +455% | ns | ns |
| Diabetes mellitus | 5 | 138 | 100.5 (83.6-120.6) | 8 | 17.3 (16.4-18.3) | +480% | ns | ns |
| Cerebrovascular diseases | 6 | 68 | 61.4 (46.9-79.4) | 3 | 57.8 (56.0-59.5) | ns | ns | ns |
| Intentional self-harm (suicide) | 7 | 61 | 20.7 (15.6-28.4) | 7 | 17.9 (17.0-18.9) | ns | ns | ns |
| Influenza and pneumonia | 8 | 59 | 49.3 (36.5-65.7) | 6 | 24.5 (23.4-25.7) | +101% | ns | ns |
| Assault (homicide) | 9 | 54 | 18.4 (13.6-26.0) | 12 | 8.3 (7.7-9.0) | +121% | ns | ns |
| Nephritis, nephrotic syndrome and nephro | 10 | 46 | 36.9 (26.5-50.8) | 11 | 11.7 (10.9-12.5) | +216% | Increasing | ns |
| Alcohol-related deaths | | 119 | 61.6 (50.5-75.4) | | 9.3 (8.6-10.0) | +564% | ns | ns |
| Injury by firearms | | 52 | 17.1 (12.6-24.4) | | 17.5 (16.5-18.4) | ns | ns | ns |
| Drug-related deaths | | 49 | 21.2 (15.3-29.9) | | 13.3 (12.5-14.2) | +59% | Increasing | ns |

**Appendix D-1. Leading causes of death* among American Indians and Alaska Natives (AI/AN) living in Urban Indian Health Organization service area counties (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **Wichita KS** | | | | | | | | |
| All Causes | | 280 | 970.6 (843.2-1115.5) | | 872.4 (864.6-880.3) | ns | ns | ns |
| Diseases of the heart | 1 | 68 | 273.9 (206.6-359.9) | 1 | 263.0 (258.7-267.3) | ns | ns | ns |
| Malignant neoplasms | 2 | 52 | 158.9 (114.2-221.1) | 2 | 201.4 (197.6-205.2) | ns | ns | ns |
| Lung Cancer | | 17 | 54.4 (30.6-97.2) | | 57.8 (55.8-59.8) | ns | ns | ns |
| Chronic lower respiratory diseases | 3 | 20 | 72.9 (41.6-124.1) | 4 | 46.9 (45.1-48.7) | ns | ns | ns |
| Accidents | 3 | 20 | 37.0 (19.3-73.9) | 5 | 37.5 (35.9-39.1) | ns | ns | ns |
| Cerebrovascular diseases | 5 | 17 | 67.9 (36.4-120.1) | 3 | 66.7 (64.5-68.9) | ns | ns | ns |
| Diabetes mellitus | 6 | 15 | 55.7 (27.4-105.1) | 6 | 22.8 (21.5-24.1) | +144% | ns | ns |
| Chronic liver disease and cirrhosis | 7 | 10 | 28.2 (12.8-63.8) | 7 | 7.8 (7.1-8.6) | +262% | ns | ns |

**Notes:**

**AI/AN mortality rates may in some or all locations be significantly underreported and should be interpreted with caution.**

***Causes of death are limited to causes with totals of 10 or more deaths from 1990 to 1999 and are based on ICD-10 disease classifications.**

****Rates are age-adjusted to the 2000 stadard U.S. population. AI/AN and All Race total populations are based on July 1st intercensal estimates produced by U.S. National Center for Health Statistics (http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm). Source of data: U.S. Centers for Health Statistics.**

**"ns"=not statistically significant.**

**Appendix D-2. Age-specific causes of death* among American Indians and Alaska Natives (AI/AN) living in the United States and in all Urban Indian Health Organization service area counties combined (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **US TOTAL** | | | | | | | | |
| **Age 1 to 14** | | | | | | | | |
| All Causes | | 2241 | 32.7 (31.3-34.0) | | 27.1 (27.0-27.3) | +20% | Decreasing | Decreasing |
| Accidents | 1 | 1156 | 16.8 (15.9-17.8) | 1 | 10.9 (10.8-11.0) | +55% | Decreasing | Decreasing |
| Assault (homicide) | 2 | 164 | 2.4 (2.0-2.8) | 4 | 1.8 (1.7-1.8) | +36% | ns | ns |
| Malignant neoplasms | 3 | 125 | 1.8 (1.5-2.2) | 2 | 2.9 (2.8-2.9) | -36% | ns | ns |
| Congenital malformations, deformations and chromosomal abnormalities | 4 | 110 | 1.6 (1.3-1.9) | 3 | 1.9 (1.8-1.9) | ns | Decreasing | ns |
| Intentional self-harm (suicide) | 5 | 64 | 0.90 (0.7-1.2) | 6 | 0.6 (0.5-0.6) | +66% | ns | ns |
| Diseases of the heart | 6 | 63 | 0.9 (0.7-1.2) | 5 | 1.0 (1.0-1.1) | ns | ns | ns |
| Influenza and pneumonia | 7 | 40 | 0.6 (0.4-0.8) | 9 | 0.4 (0.4-0.4) | ns | ns | ns |
| Septicemia | 8 | 23 | 0.3 (0.2-0.5) | 11 | 0.3 (0.3-0.3) | ns | ns | ns |
| Certain conditions originating in the perinatal period | 9 | 19 | 0.3 (0.2-0.4) | 12 | 0.3 (0.2-0.3) | ns | ns | ns |
| Chronic lower respiratory diseases | 10 | 18 | 0.3 (0.2-0.4) | 10 | 0.4 (0.3-0.4) | ns | ns | ns |
| Injury by firearms | | 125 | 1.8 (1.5-2.2) | | 1.4 (1.3-1.4) | +34% | ns | Decreasing |
| Drug-related deaths | | 15 | 0.2 (0.1-0.4) | | 0.1 (0.1-0.2) | ns | ns | ns |
| **US TOTAL** | | | | | | | | |
| **Age 15 to 24** | | | | | | | | |
| All Causes | | 4981 | 118.1 (114.9-121.4) | | 90.3 (90.0-90.6) | +31% | Decreasing | Decreasing |
| Accidents | 1 | 2650 | 62.8 (60.5-65.3) | 1 | 38.6 (38.4-38.8) | +63% | Decreasing | Decreasing |
| Intentional self-harm (suicide) | 2 | 915 | 21.7 (20.3-23.2) | 3 | 12.1 (12.0-12.2) | +79% | Decreasing | ns |
| Assault (homicide) | 3 | 620 | 14.7 (13.6-15.9) | 2 | 18.6 (18.5-18.8) | -21% | Decreasing | Decreasing |
| Malignant neoplasms | 4 | 133 | 3.2 (2.6-3.7) | 4 | 4.6 (4.6-4.7) | -32% | ns | ns |
| Diseases of the heart | 5 | 87 | 2.1 (1.7-2.5) | 5 | 2.7 (2.6-2.7) | -23% | ns | ns |
| Congenital malformations, deformations and chromosomal abnormalities | 6 | 37 | 0.9 (0.6-1.2) | 7 | 1.0 (1.0-1.1) | ns | ns | ns |
| Cerebrovascular diseases | 7 | 24 | 0.6 (0.4-0.9) | 9 | 0.5 (0.5-0.6) | ns | ns | ns |
| Influenza and pneumonia | 8 | 23 | 0.6 (0.4-0.8) | 10 | 0.4 (0.4-0.5) | ns | ns | Increasing |
| Legal intervention | 9 | 21 | 0.5 (0.3-0.8) | 13 | 0.2 (0.2-0.2) | +138% | ns | ns |
| Chronic liver disease and cirrhosis | 10 | 18 | 0.4 (0.3-0.7) | 14 | 0.1 (0.1-0.1) | +425% | ns | ns |
| Injury by firearms | | 936 | 22.2 (20.8-23.7) | | 24.4 (24.3-24.6) | -9% | Decreasing | ns |
| Drug-related deaths | | 120 | 2.8 (2.4-3.4) | | 2.9 (2.8-2.9) | ns | ns | ns |
| Alcohol-related deaths | | 98 | 2.3 (1.9-2.8) | | 0.3 (0.2-0.3) | +796% | Decreasing | ns |

**Appendix D-2. Age-specific causes of death* among American Indians and Alaska Natives (AI/AN) living in the United States and in all Urban Indian Health Organization service area counties combined (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **US TOTAL** | | | | | | | | |
| **Age 25 to 44** | | | | | | | | |
| All Causes | | 15984 | 209.6 (206.4-212.9) | | 173.6 (173.3-173.9) | +21% | Decreasing | Decreasing |
| Accidents | 1 | 5127 | 67.2 (65.4-69.1) | 1 | 32.8 (32.7-32.9) | +105% | Decreasing | Decreasing |
| Chronic liver disease and cirrhosis | 2 | 1535 | 20.1 (19.1-21.2) | 7 | 5.2 (5.2-5.3) | +286% | ns | Decreasing |
| Intentional self-harm (suicide) | 3 | 1322 | 17.3 (16.4-18.3) | 5 | 14.6 (14.6-14.7) | +18% | ns | ns |
| Diseases of the heart | 4 | 1230 | 16.1 (15.3-17.1) | 4 | 19.3 (19.2-19.4) | -16% | ns | ns |
| Assault (homicide) | 5 | 1153 | 15.1 (14.3-16.0) | 6 | 12.1 (12.0-12.1) | +25% | Decreasing | ns |
| Malignant neoplasms | 6 | 1133 | 14.9 (14.0-15.8) | 3 | 26.0 (25.9-26.1) | -43% | ns | ns |
| Female breast cancer | | 149 | 3.9 (3.3-4.6) | | 8.9 (8.8-8.9) | -56% | ns | ns |
| Human immunodeficiency virus (HIV) | 7 | 736 | 9.7 (9.0-10.4) | 2 | 27.6 (27.5-27.7) | -65% | Decreasing | Decreasing |
| Cerebrovascular diseases | 8 | 294 | 3.9 (3.4-4.3) | 8 | 4.2 (4.2-4.3) | ns | ns | ns |
| Diabetes mellitus | 9 | 279 | 3.7 (3.2-4.1) | 9 | 2.9 (2.8-2.9) | +28% | Increasing | ns |
| Influenza and pneumonia | 10 | 222 | 2.9 (2.5-3.3) | 10 | 1.7 (1.7-1.8) | +68% | ns | ns |
| Alcohol-related deaths | | 2058 | 27.0 (25.8-28.2) | | 5.5 (5.4-5.5) | +392% | Decreasing | Decreasing |
| Injury by firearms | | 1184 | 15.5 (14.7-16.4) | | 16.5 (16.4-16.6) | ns | Decreasing | Decreasing |
| Drug-related deaths | | 902 | 11.8 (11.1-12.6) | | 12.0 (11.9-12.1) | ns | Increasing | ns |
| **US TOTAL** | | | | | | | | |
| **Age 45 to 64** | | | | | | | | |
| All Causes | | 25265 | 668.6 (660.4-676.9) | | 716.2 (715.5-716.9) | -7% | Decreasing | Decreasing |
| Diseases of the heart | 1 | 6036 | 159.7 (155.7-163.8) | 2 | 193.7 (193.4-194.1) | -18% | Decreasing | Decreasing |
| Malignant neoplasms | 2 | 5491 | 145.3 (141.5-149.2) | 1 | 255.2 (254.7-255.6) | -43% | Decreasing | Decreasing |
| Female breast cancer | | 497 | 25.4 (23.2-27.7) | | 52.4 (52.2-52.7) | -52% | ns | ns |
| Accidents | 3 | 2237 | 59.2 (56.8-61.7) | 3 | 30.2 (30.0-30.3) | +96% | Decreasing | ns |
| Chronic liver disease and cirrhosis | 4 | 2085 | 55.2 (52.8-57.6) | 7 | 21.2 (21.1-21.3) | +160% | ns | ns |
| Diabetes mellitus | 5 | 1877 | 49.7 (47.5-52.0) | 6 | 22.5 (22.3-22.6) | +121% | ns | ns |
| Cerebrovascular diseases | 6 | 976 | 25.8 (24.2-27.5) | 4 | 30.1 (29.9-30.2) | -14% | ns | Decreasing |
| Chronic lower respiratory diseases | 7 | 657 | 17.4 (16.1-18.8) | 5 | 25.8 (25.6-25.9) | -33% | ns | ns |
| Influenza and pneumonia | 8 | 393 | 10.4 (9.4-11.5) | 10 | 7.6 (7.5-7.6) | +38% | ns | ns |
| Nephritis, nephrotic syndrome and nephrosis | 9 | 381 | 10.1 (9.1-11.1) | 12 | 6.2 (6.1-6.3) | +62% | ns | ns |
| Septicemia | 10 | 341 | 9.0 (8.1-10.0) | 11 | 6.4 (6.3-6.4) | +41% | ns | ns |
| Alcohol-related deaths | | 2203 | 58.3 (55.9-60.8) | | 17.6 (17.5-17.7) | +231% | Decreasing | Decreasing |
| Injury by firearms | | 290 | 7.7 (6.8-8.6) | | 11.8 (11.7-11.8) | -35% | ns | ns |
| Drug-related deaths | | 269 | 7.1 (6.3-8.0) | | 7.4 (7.3-7.4) | ns | Increasing | ns |

**Appendix D-2. Age-specific causes of death* among American Indians and Alaska Natives (AI/AN) living in the United States and in all Urban Indian Health Organization service area counties combined (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **US TOTAL** | | | | | | | | |
| **Age 65 and older** | | | | | | | | |
| All Causes | | 45849 | 3594.5 (3561.6-3627.5) | | 5005.0 (5002.6-5007.4 | -28% | Increasing | Increasing |
| Diseases of the heart | 1 | 14208 | 1113.9 (1095.6-1132.3) | 1 | 1796.0 (1794.6-1797.5 | -38% | ns | ns |
| Malignant neoplasms | 2 | 9255 | 725.6 (710.9-740.5) | 2 | 1126.1 (1124.9-1127.2 | -36% | Increasing | ns |
| Colorectal cancer | | 940 | 73.7 (69.0-78.5) | | 130.5 (130.2-130.9) | -44% | Increasing | ns |
| Cerebrovascular diseases | 3 | 3487 | 273.3 (264.3-282.6) | 3 | 424.9 (424.2-425.6) | -36% | ns | ns |
| Diabetes mellitus | 4 | 3028 | 237.4 (229.0-246.0) | 6 | 130.3 (130.0-130.7) | +82% | Increasing | Increasing |
| Chronic lower respiratory diseases | 5 | 2282 | 178.9 (171.6-186.4) | 4 | 275.4 (274.8-275.9) | -35% | Increasing | Increasing |
| Influenza and pneumonia | 6 | 1700 | 133.3 (127.0-139.8) | 5 | 156.1 (155.7-156.5) | -15% | ns | ns |
| Accidents | 7 | 1349 | 105.8 (100.2-111.6) | 8 | 84.3 (84.0-84.6) | +26% | ns | Increasing |
| Nephritis, nephrotic syndrome and nephrosis | 8 | 1057 | 82.8 (77.9-88.0) | 9 | 75.1 (74.8-75.4) | +10% | ns | ns |
| Septicemia | 9 | 700 | 54.9 (50.9-59.1) | 10 | 61.8 (61.5-62.0) | -11% | ns | ns |
| Chronic liver disease and cirrhosis | 10 | 695 | 54.5 (50.5-58.7) | 14 | 32.0 (31.8-32.2) | +70% | ns | ns |
| Alcohol-related deaths | | 522 | 40.9 (37.5-44.6) | | 13.7 (13.6-13.8) | +199% | ns | ns |
| Injury by firearms | | 88 | 6.9 (5.5-8.5) | | 14.0 (13.9-14.1) | -51% | ns | ns |
| Drug-related deaths | | 40 | 3.1 (2.3-4.3) | | 3.5 (3.5-3.6) | ns | ns | ns |
| **UIHO Total** | | | | | | | | |
| **Age 1 to 14** | | | | | | | | |
| All Causes | | 426 | 24.8 (22.5-27.2) | | 25.7 (25.5-26.0) | ns | ns | ns |
| Accidents | 1 | 180 | 10.5 (9.0-12.1) | 1 | 8.5 (8.4-8.7) | +23% | ns | ns |
| Assault (homicide) | 2 | 53 | 3.1 (2.3-4.0) | 3 | 2.4 (2.3-2.5) | ns | ns | ns |
| Malignant neoplasms | 3 | 29 | 1.7 (1.1-2.4) | 2 | 3.0 (2.9-3.1) | -43% | ns | ns |
| Congenital malformations, deformations and chromosomal abnormalities | 4 | 22 | 1.3 (0.8-2.0) | 4 | 2.0 (1.9-2.1) | ns | ns | ns |
| Intentional self-harm (suicide) | 5 | 15 | 0.9 (0.5-1.4) | 6 | 0.5 (0.4-0.5) | ns | ns | ns |
| Diseases of the heart | 6 | 14 | 0.8 (0.4-1.4) | 5 | 0.9 (0.9-1.0) | ns | ns | ns |
| Injury by firearms | | 30 | 1.7 (1.2-2.5) | | 1.5 (1.4-1.5) | ns | ns | ns |

**Appendix D-2. Age-specific causes of death* among American Indians and Alaska Natives (AI/AN) living in the United States and in all Urban Indian Health Organization service area counties combined (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **UIHO Total** | | | | | | | | |
| **Age 15 to 24** | | | | | | | | |
| All Causes | | 924 | 83.2 (77.9-88.8) | | 91.1 (90.5-91.8) | -9% | Decreasing | Decreasing |
| Accidents | 1 | 424 | 38.2 (34.7-42.0) | 2 | 28.3 (28.0-28.7) | +35% | ns | ns |
| Assault (homicide) | 2 | 180 | 16.2 (13.9-18.7) | 1 | 30.1 (29.7-30.4) | -46% | Decreasing | Decreasing |
| Intentional self-harm (suicide) | 3 | 158 | 14.2 (12.1-16.6) | 3 | 11.2 (11.0-11.4) | +27% | Decreasing | Decreasing |
| Malignant neoplasms | 4 | 21 | 1.9 (1.2-2.9) | 4 | 4.8 (4.6-4.9) | -60% | ns | ns |
| Diseases of the heart | 5 | 12 | 1.1 (0.6-1.9) | 5 | 2.6 (2.5-2.7) | -58% | ns | ns |
| Injury by firearms | | 199 | 17.9 (15.5-20.6) | | 33.2 (32.9-33.6) | -46% | ns | Decreasing |
| Drug-related deaths | | 35 | 3.2 (2.2-4.4) | | 3.8 (3.7-3.9) | ns | ns | ns |
| Alcohol-related deaths | | 16 | 1.4 (0.8-2.3) | | 0.3 (0.3-0.3) | +383% | ns | ns |
| **UIHO Total** | | | | | | | | |
| **Age 25 to 44** | | | | | | | | |
| All Causes | | 3760 | 178.7 (173.0-184.5) | | 188.1 (187.5-188.7) | -5% | Decreasing | Decreasing |
| Accidents | 1 | 1049 | 49.9 (46.9-53.0) | 2 | 30.4 (30.2-30.7) | +64% | Decreasing | Decreasing |
| Chronic liver disease and cirrhosis | 2 | 484 | 23.0 (21.0-25.1) | 7 | 6.7 (6.6-6.8) | +244% | ns | ns |
| Assault (homicide) | 3 | 294 | 14.0 (12.4-15.6) | 5 | 16.1 (15.9-16.2) | -13% | Decreasing | ns |
| Human immunodeficiency virus (HIV) | 4 | 278 | 13.2 (11.7-14.9) | 1 | 43.9 (43.7-44.2) | -70% | Decreasing | Decreasing |
| Intentional self-harm (suicide) | 5 | 268 | 12.7 (11.3-14.4) | 6 | 13.7 (13.6-13.9) | ns | ns | ns |
| Diseases of the heart | 6 | 248 | 11.8 (10.4-13.3) | 4 | 17.2 (17.0-17.4) | -31% | ns | ns |
| Malignant neoplasms | 7 | 228 | 10.8 (9.5-12.3) | 3 | 24.4 (24.2-24.6) | -56% | ns | ns |
| Female breast cancer | | 28 | 2.7 (1.8-3.8) | | 8.2 (8.0-8.4) | -68% | ns | ns |
| Diabetes mellitus | 8 | 69 | 3.3 (2.5-4.1) | 9 | 2.7 (2.6-2.7) | ns | ns | ns |
| Cerebrovascular diseases | 9 | 67 | 3.2 (2.5-4.1) | 8 | 4.1 (4.0-4.2) | ns | ns | ns |
| Influenza and pneumonia | 10 | 61 | 2.9 (2.2-3.7) | 10 | 2.0 (2.0-2.1) | +43% | ns | ns |
| Alcohol-related deaths | | 570 | 27.1 (24.9-29.4) | | 7.4 (7.3-7.5) | +267% | Decreasing | Decreasing |
| Drug-related deaths | | 383 | 18.2 (16.4-20.1) | | 17.6 (17.5-17.8) | ns | Increasing | ns |
| Injury by firearms | | 247 | 11.8 (10.3-13.3) | | 17.7 (17.5-17.9) | -34% | ns | ns |

**Appendix D-2. Age-specific causes of death* among American Indians and Alaska Natives (AI/AN) living in the United States and in all Urban Indian Health Organization service area counties combined (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **UIHO Total** | | | | | | | | |
| **Age 45 to 64** | | | | | | | | |
| All Causes | | 5160 | 561.0 (545.8-576.6) | | 698.7 (697.2-700.2) | -20% | Decreasing | Decreasing |
| Diseases of the heart | 1 | 1092 | 118.7 (111.8-126.0) | 2 | 181.0 (180.2-181.7) | -34% | Decreasing | Decreasing |
| Malignant neoplasms | 2 | 1028 | 111.8 (105.1-118.8) | 1 | 238.8 (237.9-239.6) | -53% | Decreasing | ns |
| Female breast cancer | | 93 | 19.2 (15.5-23.5) | | 52.8 (52.2-53.4) | -64% | ns | ns |
| Chronic liver disease and cirrhosis | 3 | 559 | 60.8 (55.9-66.0) | 6 | 25.9 (25.6-26.2) | +135% | ns | ns |
| Accidents | 4 | 427 | 46.4 (42.1-51.0) | 5 | 29.1 (28.8-29.4) | +60% | ns | ns |
| Diabetes mellitus | 5 | 368 | 40.0 (36.0-44.3) | 8 | 20.7 (20.5-21.0) | +93% | ns | ns |
| Cerebrovascular diseases | 6 | 196 | 21.3 (18.4-24.5) | 4 | 29.3 (29.0-29.6) | -27% | ns | ns |
| Chronic lower respiratory diseases | 7 | 124 | 13.5 (11.2-16.1) | 7 | 22.9 (22.6-23.1) | -41% | ns | ns |
| Influenza and pneumonia | 8 | 100 | 10.9 (8.9-13.3) | 10 | 8.5 (8.3-8.6) | +29% | ns | ns |
| Nephritis, nephrotic syndrome and nephrosis | 9 | 89 | 9.6 (7.7-11.8) | 12 | 5.7 (5.6-5.9) | +68% | ns | Increasing |
| Septicemia | 10 | 84 | 9.1 (7.3-11.3) | 13 | 5.2 (5.0-5.3) | +77% | ns | ns |
| Alcohol-related deaths | | 567 | 61.7 (56.7-67.0) | | 24.2 (23.9-24.5) | +155% | ns | ns |
| Drug-related deaths | | 104 | 11.3 (9.3-13.7) | | 12.7 (12.5-12.9) | ns | Increasing | ns |
| Injury by firearms | | 52 | 5.6 (4.2-7.4) | | 10.9 (10.7-11.1) | -48% | ns | ns |

**Appendix D-2. Age-specific causes of death* among American Indians and Alaska Natives (AI/AN) living in the United States and in all Urban Indian Health Organization service area counties combined (UIHO), 1990-1999. (See end of table for applicable notes).**

| Health Organization Service Area | AI/AN Alone | | | All Races | | AI/AN compared to All Races | Trends over Time | |
|---|---|---|---|---|---|---|---|---|
| Cause of death | Rank | Total Deaths | Rate** (95% per confidence 100,000 interval) | Rank | Rate** (95% per confidence 100,000 interval) | | AI/AN 10-year trend (1990-99) | AI/AN 5-year trend (1995-99) |
| **UIHO Total** | | | | | | | | |
| **Age 65 and older** | | | | | | | | |
| All Causes | | 7120 | 2541.7 (2483.0-2601.4) | | 4839.2 (4833.9-4844.4 | -47% | ns | ns |
| Diseases of the heart | 1 | 2173 | 775.8 (743.6-809.1) | 1 | 1823.3 (1820.1-1826.5 | -57% | ns | ns |
| Malignant neoplasms | 2 | 1403 | 500.9 (475.1-527.9) | 2 | 1086.3 (1083.8-1088.8 | -54% | ns | ns |
| Colorectal cancer | | 138 | 49.3 (41.4-58.2) | | 126.8 (126.0-127.7) | -61% | ns | Decreasing |
| Cerebrovascular diseases | 3 | 533 | 190.2 (174.4-207.1) | 3 | 395.2 (393.7-396.7) | -52% | Increasing | ns |
| Diabetes mellitus | 4 | 455 | 162.5 (147.9-178.1) | 6 | 117.5 (116.7-118.3) | +38% | Increasing | ns |
| Chronic lower respiratory diseases | 5 | 364 | 130.1 (117.1-144.1) | 4 | 260.4 (259.2-261.6) | -50% | ns | ns |
| Influenza and pneumonia | 6 | 291 | 103.9 (92.3-116.5) | 5 | 173.9 (172.9-174.9) | -40% | ns | ns |
| Accidents | 7 | 195 | 69.6 (60.2-80.1) | 8 | 71 (70.4-71.7) | ns | ns | ns |
| Nephritis, nephrotic syndrome and nephrosis | 8 | 146 | 52.0 (43.9-61.2) | 9 | 59.2 (58.6-59.8) | ns | ns | ns |
| Chronic liver disease and cirrhosis | 9 | 145 | 51.6 (43.5-60.7) | 14 | 33.6 (33.2-34.0) | +53% | ns | ns |
| Septicemia | 10 | 125 | 44.7 (37.3-53.3) | 11 | 44 (43.5-44.5) | ns | ns | ns |
| Alcohol-related deaths | | 125 | 44.8 (37.3-53.3) | | 18.6 (18.2-18.9) | +141% | ns | ns |
| Drug-related deaths | | 12 | 4.3 (2.2-7.5) | | 4.4 (4.2-4.5) | ns | ns | ns |
| Injury by firearms | | 11 | 3.9 (2.0-7.0) | | 11.7 (11.4-11.9) | -66% | ns | ns |

**Notes:**

**AI/AN mortality rates may in some or all locations be significantly underreported and should be interpreted with caution.**

***Causes of death are limited to causes with totals of 25 or more deaths from 1995 to 1999 and are based on ICD-10 disease classifications.**

****Rates are age-adjusted to the 2000 stadard U.S. population. AI/AN and All Race total populations are based on July 1st intercensal estimates produced by U.S. National Center for Health Statistics (http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm). Source of data: U.S. Centers for Health Statistics.**

**"ns"=not statistically significant.**

# Seattle Indian Health Board

**MEMORANDUM**

| | |
|---|---|
| TO: | The Honorable Byron L. Dorgan, Vice Chairman<br>Senate Committee on Indian Affairs |
| FROM: | **Ralph Forquera, Executive Director** |
| RE: | Response to questions from Senator Maria Cantwell |
| DATE: | August 4, 2005 |

Enclosed, please find my response to questions submitted by Senator Maria Cantwell with regard to the joint hearing of the U. S. Senate Committee on Health, Education, Labor, and Pensions and the Committee on Indian Affairs regarding S. 1057, a bill to reauthorize the Indian Health Care Improvement Act. If there are additional questions or the need for further clarification, I will be happy to provide any assistance requested.

Thank you again for the opportunity to testify at the July 14 hearing. I am hopeful that this legislation will be enacted this year.

RESPONSE TO QUESTIONS
FROM SENATOR MARIA CANTWELL
in regard to the Joint Hearing
on the Reauthorization of the Indian Health Care Improvement Act
held July 14, 2005

QUESTION 1: Importance of Preventive Healthcare and Its Impact on Reducing Mortality Rates.

* *Can you share with us some of your efforts to address chronic health conditions and disease through preventive efforts?*

The urban Indian health programs are all grantees under the Special Diabetes Program for Indians initiative established in 1997. Our efforts around diabetes offers significant opportunities to strengthen prevention efforts that address a broad range of chronic health conditions. Specifically, all urban programs now provide at a minimum diabetes education services and manage diabetes registries that allow us to capture primary and secondary prevention information for case management and early intervention purposes. The creation of a diabetes registry as a tool for disease management has been extended to other chronic conditions such as heart disease, arthritis, asthma, etc. at some locations Thus, the funding from this initiative has provided for the development of tools to help us identify and manage chronic disease more effectively.

Findings from data we have collected through the Urban Indian Health Institute (UIHI) at the SIHB show that diabetics served by urban Indian health organizations are more likely to be receiving routine diabetes care, improved access to services like podiatry and vision screening, statistically-significant improvements in laboratory results like Hemoglobin A-1c levels, blood pressure control, cholesterol maintenance, improved dietary practices, weight loss, exercise and effective medication use. Many of these practices and biological measures influence a broader range of chronic conditions beyond diabetes. Many of the strategies used to maintain and control diabetes have broad effects on the health of the individual perhaps helping reduce the risk of other chronic disorders. The key in getting buy-in by the patient and on-going involvement in the disease management process.

Urban programs also receive small grants from the Indian Health Service to implement health promotion and disease prevention activities. These funds are used for outreach, health fairs, community screenings, and a variety of programs designed to promote better health and recommend changes in risky behaviors. We also have grants to improve childhood immunizations and to implement drug and alcohol education and prevention activities. Several programs participate in programs that help with asthma supplies for homes, infant safety seats for vehicles, health education materials, and support for getting Indian people to resources like housing, job training, food banks, and other essential

needs. Funding from other non-Indian sources are also used to support prevention efforts, generally around a defined topic.

We here at the Seattle Indian Health Board are managing a state-wide urban Indian youth tobacco coalition aimed at offering activities in the major urban centers of Washington state such as Spokane, Olympia, Tacoma, Everett, Vancouver, as well as King County. Coalition members have provided a variety of prevention strategies designed to educate Indian youth about both the dangers of tobacco use, but also to understand the nature of the use of tobacco in a cultural sense. This latter role is an important recognition of the traditional and spiritual place tobacco holds in native cultures and how that differs from contemporary smoking behavior.

Prevention is a integral part of our work. Given that we can offer only primary medical and dental services through our organizations, prevention and early intervention are essential strategies to achieving improvements in the health status of urban Indians.

* *What are some barriers to providing preventive care to Indian populations?*

There are numerous barriers to providing preventive care to Indian populations. First, there is a general lack of involvement by many Americans in preventive health care overall. Indians are no exception. In fact, building "trust" among Indian people that encourages them to participate in preventive activities is one of our greatest challenges.

All too many of our clients have had bad experiences dealing with government agencies and even community-based organizations. Intrusive eligibility requirements, disrespectful treatment, and inadequate assistance has made all too many of our clients hesitant to become involved with planned activities. As mentioned in my oral testimony, there continues to be an enormous reluctance on the part of Indian people to "trust" institutions offering them help. Reluctance on the part of Indian people to participate in preventive or even curative health activities limits our capacity to engage and retain Indians in preventive services. This is especially true of younger members of the community who may not currently be experiencing the ill effects of poor health practices.

Money, of course, is also a barrier. While we offer our direct care services on a sliding fee basis, these modest charges have been noted as a barrier for some Indian clients to get care at recommended intervals. Many of our preventive activities are free. However, when we do identify health problems among prevention participants, a very frequent situation, they are referred for direct care that may cost them money. If we send someone outside of our agency for specialty services, our clients almost always receive bills from these providers. Our clients do not easily discriminate between the services we provide and those received from referral sources. Thus, they may blame us for the debt they have incurred at our request and this may result in their failing to seek additional help, both preventive and curative.

There is also a misconception among some urban Indians that agencies like the Seattle Indian Health Board are a direct part of the Indian Health Service or a tribal clinic that

provides services for free. There is a belief by some Indians that health services are a right and that they should be offered for free because the government "owes" them health care. However, when Title V was created in the 1970s, the Congress clearly stipulated that the urban Indian health program was not an extension of the federal obligation to Indians but was a special contract program designed to help urban Indian communities organize to improve access to care. Those of us who have succeeded in actually developing direct health care have mostly used non-Indian resources to build these services. In most cases, a requirement of getting public assistance grants to serve low income residents requires a sliding-fee payment system and to provide care to anyone seeking assistance. This misconception has, on occasion, been a barrier.

Although a sizeable portion of our clients are eligible for public financed health insurance like Medicaid, efforts to enroll Indians have been generally unsuccessful. The burden of eligibility and the frequent lack of adequate documentation to meet eligibility guidelines has left many Indians without coverage here in cities. In addition, there are a number of urban Indians who choose not to seek Medicaid coverage due to feelings of being poorly treated at government offices. Furthermore, changes in registration rules and the frequency of having to "prove you are poor" to remain eligible for these programs is seen as disrespectful and humiliating by some. Unfortunately, Indian people would rather go without care than suffer the continuing indignity of feeling mistreated or like second class citizens as has been their history and experience.

There is a significant portion of urban Indian people who live highly mobile lifestyles making prevention efforts difficult. In a recent telephone survey we conducted among our clients regarding pharmacy services, 60% of those called in this study had disconnected or non-working telephones. Frequently clients seeking services, when asked to update their residence, have a different address than at their previous clinical visit, even when that visit was just weeks earlier.

The high mobility of the population makes offering preventive services a major challenge. We may see our truly indigent clients only for an acute problem – an infection, injury, or illness. Few may be able to participate in preventive interventions due to their life circumstances.

Limitations of funding make outreach and case finding to address the mobility issue difficult to maintain. Even now, changes proposed for Medicaid will further reduce our capacity to provide outreach activities as the Medicaid Administrative match program that supports access services is targeted for revisions that will reduce our capacity to reach Indian clients. With a sizeable and growing homeless Indian population in Seattle/King County, the ability to reach people to advise them of preventive services has become a daunting task.

Prevention services, particularly primary prevention activities, are seldom directly paid for by public or private grants and contracts. As public grants to support the indigent and uninsured remain insufficient for demand, most community health organizations are forced to divert funds away from prevention services to cover the rising cost of direct

health care. Increasingly, public grants too are prioritizing treatment services over prevention activities in their funding solicitations further limiting our capacity to budget for preventive care.

One advantage of having an organization devoted specifically to targeting urban Indians is that we are in a position to assure that prevention activities are conducted in a truly culturally-appropriate manner. This is essential if we are to be effective in engaging the urban Indian community in health improvement activities. For example, we sponsor community events and activities that allow us to engage Indian people outside of a purely health care context. We sponsor events that promote cultural pride and encourage community involvement. These activities improve our relationship with the community and offer a level of emotional and psychological recognition that has a powerful healing effect. Over time, community members see us as a place that respects their cultural and traditional views. As time and experience grow, the likelihood that reluctant Indian clients will become involved in preventive health care grows as well.

Screenings and other educational programs at these events provide important opportunities to raise awareness about health conditions and the need for both preventive and curative services. Health literacy has become an obvious shortcoming of our current health care system. Our use of support groups, outreach at local events, use of community partners to promote services, etc., helps to change the perception of community members so that those reluctant to seek help begin to see us as a "community resource" rather than just another health care organization. By providing cultural experiences not directly linked to health, we expand our involvement with Indian people and increase the likelihood of their acceptance and participation in both preventive and treatment options offered through our organizations.

* *Do you believe this bill provides an enhanced ability to provide such care in line with established best practices? Does it go far enough?*

In my personal opinion, the proposed Senate bill (S. 1057) generally extends existing authorities crafted for the original legislation in the mid 1970s. The health care world has changed considerably since that time. However, the original bill was artfully crafted to provide broad authorities that certainly could permit the incorporation of both best practices and quality assurance initiatives that are driving today's health policy. However, whatever the level of authority offered through the bill, if financial resources are not adequately available to implement these practices, then little will change.

It is well recognized that the Indian Health Service is grossly under funded. The urban Indian program that represents only 1% of the IHS budget, is woefully inadequate to address growing direct care needs. It is also well known that health care costs are rising at near double digit inflationary levels, more than three times general inflation. Each year, the pinching of pennies is quickly reaching a point were services are being lost.

There is a growing crisis in the incidence of chronic disease that will consume a greater share of available resources. There are emerging infectious diseases that may further

stress our capacity to adequately respond to both realities. Indian health communities, both on reservation and in cities, are not immune from these facts.

The use of best practices must also be viewed cautiously when dealing with underserved populations. Strategies determined as "best practices" often come from mainstream institutions that may have financial rather than service outcomes as their measurement. These findings may differ from priorities of agencies trying to improve the health status of a population or dealing with health disparities. A certain level of inefficiency is necessary to reach underserved and disadvantaged populations. If Indians could get adequate and culturally-appropriate care from mainstream providers, there would not be much use for us. But unfortunately, this has never been the case.

Here at the Seattle Indian Health Board, like most of the Indian Health Service, we attempt to implement best practices into our work when they make sense. Often, implementation of best practices involves greater administrative time and bureaucratic costs than we have available. In some instances, such as the Special Diabetes Program for Indians initiative, resources are directed exclusively for implementing best practices. In this instance, the benefits have been quite good. But today, this is more the exception than the rule.

QUESTION 2: The transition from infectious diseases and chronic disease as the leading causes of death, the possible causes and implications.

* *What do you attribute the rise in chronic conditions and diseases among the Indian population?*

The advent of both antibiotics and immunizations have greatly reduced deaths due to infectious disease that were the major causes of death for Indian people through the 1960s. The formalization of the Indian health system through the Indian Health Care Improvement Act not only brought greater access to medical care, but it also fostered improvements in sanitation and positive environmental changes. This combination of factors not only reduced early mortality, it also prolonged the life of Indians sufficiently to allow for more chronic illnesses to develop.

Lifestyle changes have obviously influenced increases in chronic disease. We know, for example, that dietary and lifestyle changes have directly influenced the epidemic of diabetes among Indians. Obesity now afflicts a large portion of Indian youth and adults increasing the risk of several different chronic conditions. Unfortunately, these changes are now also being felt in the broader mainstream society as well.

Our obsession with chronic disease must not overpower our need to recognize that infectious disease is still a serious threat. Recently, we have seen an increase in tuberculosis cases in this country, especially among the homeless. In Seattle, a large segment of a local cohort of TB cases were natives. SARS and the avian flu are potentially devastating conditions that, if not adequately addressed, could cause epidemics the like we have not seen in the United States in decades. Urban and

reservation Indians are at risk for these infections since their health status is already compromised.

Antibiotic resistant infections are also on the rise. The over-prescribing of antibiotics for minor infections in years past is now coming back to haunt us. We are seeing an upswing in vaccine preventable diseases like pertussis (whooping cough), measles, and others. Our focus on medicine has detracted from our need to assure that public health interventions are not overlooked. Unsubstantiated claims like the flap over solutions used in vaccines and a link to autism that make media headlines prompts fear among the public who then chose not to vaccinate their children.

Misconceptions about the benefits and detriments of childhood vaccines is an enormous public health problem that is not getting proper attention. While we are seeing remarkable achievements in vaccine preventable diseases in other nations, our focus on chronic illness may be exposing another generation of American children to preventable risk through immunization.

By all indications, there is a significant chronic disease problem in America. My personal view is that social changes and the capacity to rescue individual with serious life threatening illnesses through improvements in health care helps prolong lives. The extension of life shares some responsibility for our higher incidence of chronic disease and associated costs. This is not a negative assessment, but a consideration that cannot be ignored as we try and find ways of coping with these changes.

Some factors that have been sited as contributing to the rise in chronic disease are dietary changes, inactivity, and stress. Among Indian people, one should not overlook the influence history has had over the lives of Indian people and the psychological effects of these experiences on their well-being.

Like many aboriginal cultures, history is told through stories and oral traditions. Facts about Indian people found in history texts tell a one sided story of Indian people that seldom matches traditional understandings. Negative experiences resulting from government policies (relocation, boarding schools, broken promises) reinforce feelings of inferiority that may influence health. A common diagnosis in Indian Country is depression. Indians tend to be diagnosed with anxiety disorders. Suicide, as is seen all to frequently in Indian Country, may be a outcome of unresolved feels associated with their personal or cultural experience. Alcohol and drug abuse and its effects: violence, domestic abuse, neglect, etc., may too be expressions of this history. The fact that the Nation fails to honor its responsibility to Indian people even today by refusing to adequately finance schools, health care, housing, and other resources on reservations, certainly has an influence over health and behavior.

* *What role does the shift from cultural diets and activities play in the health outcomes?*

Clearly the shift in traditional diets and inactivity play into the increase in chronic disease among Indians. To what extent is a much larger question.

Some Indian health professionals believe that a return to a traditional diet is an important step in reversing the trend toward chronic disease. However, traditional diets cannot be isolated from other lifestyle factors that may or may not have contributed to the health of native people in generations past.

I personally feel that inactivity plays a far more important role in our health than diet. Our bodies were built for motion. Only a few generations ago, people were far more active then they are today. The American society has been built on a foundation that does not support physical activity. We use automobiles far too much. Parks and opportunities for recreation are increasingly scarce. Indians too have been effected by these societal changes. However, the Special Diabetes Program for Indians has raised the issue of inactivity to a higher level of consciousness in Indian Country. I am hopeful that this initiative will get more Indians up and moving.

* *How has your facility dealt with the transition from infectious disease to chronic disease?*

Like most community health centers, we are struggling with the shift from acute to chronic disease. Caring for people with chronic conditions is more expensive and time consuming on a per capita basis. In addition, there is the need for greater technical skills to care for individuals with complicated chronic problems. Prescription medications alone place new burdens on our organization in both cost and volume of medications distributed. Few chronic patients suffer from a single disorder. Thus, our providers are often treating multiple problems and managing multiple medications in the care plan. It is not uncommon for clients with chronic conditions to be receiving 10 or more medications.

The need for more extensive office visit time to understand and manage chronic illnesses challenges productivity standards and disrupts business models needed as justification to secure government financing for indigent care. Health care providers are being asked to treat people with multiple system problems in an environment that is not set up to manage such patients.

Chronic disease requires assistance from multiple professionals using a team approach to care. For effective management of chronic conditions, improvements in treatment coordination, communication across team members, follow up, extensive case management, and family and community support are essential. In most instances, agencies like the Seattle Indian Health Board are better prepared to meet this challenge as our approach to care has mostly relied on a team approach including the use of traditional native healing.

Access to specialty care for consultation and guidance for diagnosed chronic illnesses has become increasingly difficult to obtain for uninsured patients. Significant provider and

administrative time and expense is now being used to try and get very sick patients to appropriate levels of care. For those who are uninsured or even those on public insurance programs like Medicare and Medicaid, referrals to specialists are not always attainable. Even when consultation is offered, getting needed procedures like stress tests for heart patients or endoscopies for patients with gastrointestinal problems may not be available.

Our success in getting patients to the proper level of care for their diagnosed condition can no longer be assured. We more frequently are forced to resort to sending patients to the emergency room as an access point for specialty care when direct referrals can not be achieved. As you know, this is an expensive and inefficient alternative. In addition, clients sent to emergency rooms often receive sizeable bills for the care they receive adding emotional stress to the patient and their family when they cannot afford the charges. In many cases, this experience may influence decision about further treatment that is generally needed for patients with chronic illnesses.

As mentioned earlier, the demands of caring for a chronic disease population changes priorities within an agency forcing us to divert resources that could normally be used for prevention to cover the cost of treatment. Since most of health care financing focuses on the treatment of illness and not paying for preventive care, the lack of resources devoted to prevention and declining revenues from treatment payment sources means that less preventive care can be offered.

QUESTION 3: Federal Tort Claims Coverage

* *How would the expansion of FTCA impact the operations of urban Indian health centers?*

As I mentioned in my oral testimony, community health centers that offer a broader array of direct health care services than those offered by urban Indian health agencies already enjoy the protection of Federal Tort Claims Act coverage. This protection has saved CHCs a lot of grant money that has been turned into new or expanded services. Allowing urban Indian health program to receive FTCA protection will have a similar benefit and give these organizations more money to devote to services.

There is a secondary benefit that might be derived from extending FTCA protection to urban Indian health programs. Recently, at a diabetes training we offered, several urban programs expressed frustration at not being able to offer direct diabetes care because they could not afford liability insurance. The inability for these programs to offer direct diabetes care limits our overall capacity to assure that Indians are getting needed diabetes services. These programs are forced to refer Indian clients to non-Indian clinics for care. Factors mentioned above may prevent Indian diabetics from getting services at referral sites, and even if services are rendered, confidentiality rules may prevent the sharing of clinical information needed to track the health of these individuals diminishing our capacity to influence the health status of these Indian people.

Giving urban Indian health programs FTCA protection may reduce the financial barrier for these urban programs so that they can offer diabetes care directly. By offering care for diabetics directly in these agencies, we can assure that Indians are getting the care that they need to prevent unnecessary and costly complications of this devastating disease.

It seems to me that the liability risk to the Federal government is less for urban Indian health programs then it would be for community health centers or even tribal clinics that offer a broader array of services that may hold greater liability risk. Like community health centers, urban Indian health programs can only offer services by licensed health care professionals. Therefore, extending FTCA coverage to urban Indian health organizations only adds to the network of safety net providers and helps to advance the goal of addressing health disparities.

# Critique of an ADA-Sponsored Proposal Opposing the Dental Health Aide Therapist

by
Jay W. Friedman, DDS, MPH

The American Dental Association and the Alaska Dental Society oppose the utilization of Dental Health Aide Therapists by the Alaska Native Tribal Health Consortium to provide treatment to Native Americans. Trained for two years in the New Zealand Dental Therapist school, the Native American dental therapists provide routine dental care, including fillings and simple extractions. They work under the supervision of dentists participating in the ANTHC programs who can then provide higher levels of care. The ability of dental therapists to provide first rate dental care is well established, as evidenced by their acceptance in Australia, Canada, England, New Zealand and many other countries worldwide.[1,2]

Opposition of the ADA and the Alaska Dental Society has nothing to do with the quality or safety of the care provided by Dental Therapists. Many studies of Dental Therapists have affirmed the quality of their work as equal to that of dentists. Rather than support a program that would alleviate the severe shortage of dentists in Alaska, the ADA proposes an unrealistic recruitment of volunteer dentists from the Lower States to help out, despite the complete failure of such efforts in the past.

The ADAs opposition to dental therapists is historic and unrelenting.[3] Every attempt to introduce dental therapists in the United States to provide basic care to children suffering extensive dental disease has been resisted by organized dentistry—in the 1950s, in the 1970s, and now in year 2005. Its method is simple: (1) hire dentists to do an "independent" study that has a predictable negative outcome; (2) appropriate funds for lobbying and legal actions to prevent implementation of dental therapists.

The most recent examples are: (1) the unpublished ADA-sponsored study, "Integrated Dental Health Program for Alaska Native Populations" (hereinafter referred to as the Report)[4], which cleverly supports ANTHC's "general plan" for dental aides while substituting a lesser-trained "community oral health provider (COHP)" that cannot provide the fillings and simple extractions that the Native children in rural communities need so desperately to eliminate toothaches and infections; and (2) the Alaska Dental Society and the ADA appealing to the Alaska State Board of Dental Examiners to condemn DHATs as the illegal practice of dentistry.

Why is organized dentistry in the United States so afraid of dental therapists? They do not represent a threat to dentists, no more than physician assistants or nurse practitioners diminish the role or income of physicians. Sooner or later the American dental profession must *give up the ghost* that only a dentist can drill and fill a tooth, when it is well known that dental therapists are just as capable. If the ADA and the Alaska Dental Society really wanted to improve the oral health of Alaska Natives, and that of other neglected populations, it would stand up and be counted in support of the entire ANTHC program, including the dental therapists, as advocated by the Alaska Daily News in its June 2, 2005 editorial.[5]

Contrary to the ADA, the authors of the Report do not contend that DHATs are practicing dentistry illegally or that the quality of their work is not satisfactory. Instead, it presents the typical ADA argument that there is an adequate supply of licensed dentists and the Aides should concentrate on prevention rather than treatment. But the Report contradicts itself, admitting that "the current dental care system has not been able to effectively prevent and treat oral diseases in this population," and then concluding, "Overall, the system appears adequately funded and has sufficient numbers of licensed dentist positions to provide care...." Considering that 50 percent of the population, or about 60,000 Native Americans, lives in remote villages not accessible by roads and that 15 dentist-positions are currently vacant, to say there is not a shortage of dentists is misleading. Quite the contrary, the shortage is chronic and severe. According to the Alaska Native Health Board, "Alaska Tribal Health Programs experience a 25% vacancy rate among dentists and a 30% average turnover rate."[6]

The Report cites the accomplishments of the Southcentral Foundation (SCF) Alaska Native Medical Center's dental practice as a model of efficiency and effectiveness. Referring to dentists in the Other Tribal programs, the Report states that "The productivity of dentists is low," compared to SCF's. The only comparative data is the number of patient visits and patients treated in a year. The 26 SCF dentists saw an average of 817 patients and 1900 visits per dentist, compared to the 21 Other dentists who averaged 1267 patients and 2952 visits. On this basis, the dentists in the Other Tribal programs are more productive than SCF's.

This comparison is not intended to diminish the accomplishments of SCF's dental department. Rather, it is illustrative of the failure of the Report to substantiate its claims with objective data, which leads to erroneous conclusions. Further, the demographics of the area served by Southcentral Foundation differ significantly from the other service regions. Based in Anchorage, it has access to hospitals, the university, and other treatment, training and research facilities, and therefore has many advantages in attracting and retaining professional personnel. Southcentral Foundation is a suitable model for Anchorage and the other metropolitan areas in Alaska. It can assist but it cannot serve as a model for the rural Native Tribal health programs.

Instead of supporting development and deployment of DHATs in rural Alaska who can treat dental emergencies such as toothaches and abscesses, the Report would substitute lesser trained aides with whom the Tribal dentists located elsewhere "should be in frequent communication ...and [the dentists] should have an on-call schedule to deal with emergencies." Considering the shortage of staff dentists, the distances to travel, the availability of airplanes, and the cooperation of the weather, the logistics of timely treatment of emergencies recommended in the Report appears illogical. How does one "have an on-call schedule" for emergencies when the very nature of an emergency is that it is not scheduled? By opposing the DHAT and proposing a lesser trained auxiliary, the authors of the Report are perpetuating a problem that the DHAT was developed to alleviate.

The Report contends that substitution of COHPs for DHATs would be more economic. Although the COHPs would be less expensive to train, they could not provide definitive care such as fillings and simple extractions that the Native populations in rural Alaska want and need. COHPs are not cheaper to employ. Their salaries would be about the same as DHATs. The higher cost of

training a DHAT is outweighed by the greater care provided. And when training costs are amortized over a few years, the difference between the two would be insignificant.

The Report admits that the "COHPs will have insufficient skills to permanently restore a large percentage of carious teeth." Dentists obviously have the skills, but their shortage in Alaska leads to the same conclusion. A 1991 dental manpower study in Alaska estimated that "If the IHS/Tribal health system doubled the number of dentists, it would take 10 years to eliminate the unmet need for dental services."[6] If anything, unmet dental needs of the Alaska Native population are greater today. With or without COHPs, there is still an enormous need for DHATs. The ANTHC adopted the Dental Health Aide Therapist as the only logical and practical solution to a dental health crisis that dentists alone cannot alleviate.

In conclusion, the Report sponsored by the American Dental Association is part of a concerted effort by the ADA to subvert ANTHC's Dental Health Aide Therapist program. It bases its recommendations on inadequate and misleading data and assumptions. It would deny the right of Native Americans to decide for themselves how to obtain dental health care that the dental profession has failed to provide in the past.

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# Developing and Deploying a New Member of the Dental Team: A Pediatric Oral Health Therapist

**David A. Nash, DMD, MS, EdD**

**Abstract**

*There are inadequate numbers of dentists able and willing to treat America's children, specifically children from low income and minority populations. This has led to the well-publicized disparities in oral health among children. In the early part of the 20th century New Zealand faced a significant problem with oral disease among its children and introduced a School Dental Service, staffed by allied dental professionals with two years' training in caring for the teeth of children, "school dental nurses." A significant number of countries have adopted the model. This article reviews the history of attempts to develop such an approach in the United States. It advocates for the development and deployment of pediatric oral health therapists as a means of addressing the disparities problem that exists in America with such individuals being trained in children's dentistry in a two-year academic program. The article asserts that adding a pediatric oral health therapist to the dental team is one way in which the profession of dentistry can fulfill its moral obligation to care for the oral health of America's children and ensure that all children are treated justly. Recently, the American Association of Public Health Dentistry promulgated a strategic plan that endorsed such an approach.*

*Key Words: oral health disparities, access, pediatric oral health therapist, dental therapist, dental team*

*"Children may be the victims of fate—they must never be the victims of neglect."*
John F. Kennedy

## Introduction

In the January 2004 issue of the *Journal of Dental Education*, I published an article entitled, "Developing a Pediatric Oral Health Therapist to Help Address Oral Health Disparities Among Children" (1). The article called for the development of a new member of the dental team, a pediatric oral health therapist, as a means of helping address the significant disparities in oral health that exist among children in the United States. It is not necessarily the "*bold, new* solution" to the access problem for low income and minority children called for in a 2002 National Council of State Legislatures' (NCSL) report entitled: "Access to Oral Health Services for Low Income People" (2). Rather, it is an *old* solution that was *boldly* undertaken by the New Zealand Dental Association when, in 1921, they led in the development of the now internationally famous New Zealand school dental nurse, the progenitor of the pediatric oral health therapist for which I continue to advocate in this article (3,4,5).

**Disparities and Access.** The disparities that exist in oral health among America's children, and the lack of access to oral health care, have been played out in the theatre of *Oral Health in America: A Report of the Surgeon General* (6), and the *National Call to Action to Promote Oral Health* (7), under the leadership of the Office of the Surgeon General. The details are so well known and acknowledged they require no rehearsing.

While numerous barriers to access have been identified (2,6,8,9), the most significant one, in my judgment, are the numbers, distribution, education, and attitudes of dentists.

We face a real decline in the actual number of dentists practicing in the United States, in the face of an expanding population (6,10,11). Compounding the problem is the mal-distribution and the ethnicity of dentists. The number of federally designated shortage areas has increased from 792 in 1993 to 1,895 in 2002 (8). While approximately 12% of the population is African-American, only 2.2% of dentists are; and individuals of Hispanic ethnicity make up another 10.7% of the population, yet only 2.8% of dentists are Hispanic (12).

There is a general lack of instruction and experience that graduating dentists have had in treating children that "affect competency achievement, and adversely affect training and practice" (13). Furthermore, the number of pediatric dentists is not helpful in addressing the issue of access for children. While there has been a significant increase in the number of specialists in pediatric dentistry over the past thirty years, there are only 4,337 such specialists practicing in the United States (14) compared with the 57,000 pediatricians who care for the general health of the nation's children (15).

The attitude of dentists is an additional access problem for low-income children. Dentists generally do not want to treat publicly insured children when they are covered by Medicaid or the State Children's Insurance Program (S-CHIP). A 1996 study indicated that only 10% of America's dentists participated the Medicaid program (16). A more recent study indi-

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cates that in the year 2000, approximately 25% of dentists received some payment from public insurance; however, only 9.5% received more than $10,000 (17). Additionally, most dentists are as busy as they care to be, as they manage the increasing numbers of baby-boomers and others who require implants, esthetic dentistry, and other complex services in high demand.

**The New Zealand School Dental Nurse-Now Therapist.** In 1921, a group of 30 young women entered a two-year training program at Wellington, New Zealand to study to become "school dental nurses," and in so doing transformed the oral health of the children of a country and laid the basis for what was to become an international movement (3). New Zealand's School Dental Service continues to this day, and has developed an enviable record in caring for the oral health of all children in New Zealand. There have been changes in the School Dental Service through the years, as well as in the training program for school nurses. However, the basic education and service strategies of over 80 years ago remain intact, having stood the test of time.

In 1998, there were 569 school dental therapists in the School Dental Service (18). (The name change occurred in 1988 by a vote of the dental nurses.) They care for 497,000 school children in over 2,000 schools (19). Two training programs currently exist, one at the national dental school at the University of Otago, in Dunedin, on the South Island, and one at the Auckland University of Technology on the North Island. The two educational programs each enroll approximately 20 new students/year (20).

New Zealand's record of oral health for children is enviable. All children, from age six months through age 13, are eligible to participate in the School Dental Service and receive comprehensive preventive and restorative care, without fee, at their local school clinic, by the school dental therapist. Children, 14-18, and those requiring root canal therapy, management of dental trauma, or extraction of permanent teeth, are referred to private practitioners who serve under contract to the government. While enrollment is not compulsory, 97% of all school-aged children participate in the School Dental Service (21). The School Dental Service is revered as a New Zealand "icon" (22). As one colleague expressed it, "the School Dental Service has become an integral component of the New Zealand culture. To Kiwis it is like motherhood and apple pie" (23). And, it is highly valued, not only by the public, but by dentists as well (19).

While the number of decayed, missing, and filled primary and permanent teeth (deft and DMFT) of the children of New Zealand and the United States is roughly comparable, of particular interest are the differences in the components of these epidemiological indices. A May, 2003, report indicates that 53% of New Zealand's five year olds are caries-free, with a mean eft of 1.8 (24). At age 12-13, 42% of children are caries-free with a mean MFT of 1.6. What is surprising and fascinating about these data is that the decayed (d/D) components are not included. The University of Otago School of Dentistry's epidemiologist indicated that these data represent children enrolled in the School Dental Service and are collected at the end of each school year (23). At that time all decayed teeth have either been restored, extracted, or have exfoliated. This means that (essentially) all of the school children in New Zealand are caries free at the end of an academic year.

In 1968, at the Centennial Conference on Oral Health held at the Harvard School of Dental Medicine, Dean John Walsh, of the University of Otago School of Dentistry, presented a paper entitled, *"International Patterns of Oral Health Care—The Example of New Zealand"* (25,26). He suggested the utilization of a *Care Index*, with such an index being calculated by developing a ratio of the filled teeth component (the f/F) of the deft or the DMFT to the overall deft or DMFT. In 1968, the *Care Index* in New Zealand was 72%; meaning 72% of all teeth of children affected by caries had been restored. In the United States, the figure was 23%. Dean Walsh made the claim that the *Care Index* provides a convenient measure of the effectiveness of a country in treating dental caries. Today, the *Care Index* for New Zealand children is (essentially) 100% (24). In the United States, while significantly improved from 1968, it is 63.3% for primary teeth and 74.0% for permanent teeth through age 14 (27). Of note is that the *Care Index* drops significantly for U.S. children when adjusted for family income. For primary teeth it is 72.3% for children at 300% of the federal poverty level (FPL), but only 48.7% for children at 100% of the FPL. For permanent teeth it is 93.2% for children at 300% of the FPL, and only 72.3% for children at the 100% of the FPL (27). Such disparities help underscore the access to care issue for poor children.

**Training Dental Therapists in New Zealand.** Admission to one of the two dental therapy training programs in New Zealand is based on graduation from high school. The curriculum is offered over two academic years, each of approximately 32 weeks' duration; total curriculum clock hours are 2,400. Approximately 760 hours of the curriculum is spent in the clinic treating children. Upon graduation, individuals entering the School Dental Service must serve for one year with another school dental therapist.

The New Zealand school dental nurse/therapist has served as a prototype for adding such a member to the dental team in many countries throughout the world, although the specific approach, including practice environments and restrictions, vary from country to country. The World Health Organization documents 42 countries with some variant of a dental therapist including: Australia, China (Hong Kong), Singapore, Thailand, Malaysia, Great Britain, and Canada (28). The typical justification for developing and deploying dental therapists in these countries has been an inadequacy of the dental workforce which adversely affects access to oral health care (29).

**The Canadian Experience.** The Canadian experience is relevant as it is apparently the only country in the Western Hemisphere to have a train-

ing program for dental therapists. The National School of Dental Therapy for Canada exists as a component of the First Nations University of Canada, in Prince Albert, Saskatchewan. The School began in 1972 at Fort Smith, in the Northwest Territories, and was modeled after New Zealand's program (30). The mission was to train dental nurses, in a two-year program, to provide care to the remote First Nation (aboriginal Indians) and Inuit (Eskimo) villagers of the Canadian North, where dental care was virtually inaccessible. In 1984, the School was moved to Prince Albert, Saskatchewan, due to an inadequate supply of patients in the Fort Smith area. The School continues to prepare dental therapists today, with an emphasis on training aboriginal people to care for aboriginal people, specifically those on First Nation reserves and in the North (31). The curriculum is similar to the one in New Zealand.

Dental therapists are able to work for Health Canada (Canada's ministry of health) on federal First Nation reserves throughout Canada, with the exception of the provinces of Ontario and Quebec. There are 88 dental therapists so employed today (32). Recent legislation (2001) enables therapists to also work in private dental offices in the Province of Saskatchewan, under the indirect supervision of a dentist (33). Currently, there are 208 registered dental therapists in Saskatchewan, with 184 holding active registrations to practice (34).

Double blind studies of the work of the Canadian dental therapists, in comparison to federal dentists, have been conducted (31,35). The results indicated that the quality of restorations placed by dental therapists were equal to those placed by dentists. Trueblood has documented the cost-benefit effectiveness of the federal dental therapists in a doctoral dissertation published in 1992 (36).

**The United States Experience.** In 1949, the Massachusetts legislature passed legislation authorizing the acceptance of funding by Forsyth Dental Infirmary for Children from the Children's Bureau to institute a research project to train individuals, in a two year program, to prepare and restore cavities in children's teeth (37,38). The program was to be conducted under the supervision of the Department of Health and the Board of Dental Examiners. The passage of this legislation provided for the establishment of an experimental dental care program for children similar to the school dental nurse of New Zealand.

The reaction and response of organized dentistry was swift and strong. The ADA House of Delegates passed resolutions "deploring" the program; expressing the view that any such program concerning the development of "sub-level" personnel, whether for experimental purposes or otherwise, be planned and developed only with the knowledge, consent, and cooperation of organized dentistry; and stating that a teaching program designed to equip and train personnel to treat children's teeth cannot be given in a less rigorous course, or in a shorter time, than that approved for the education of dentists (37). Faced with increasing pressure from organized dentistry, the Massachusetts governor signed a bill in July, 1950, rescinding the enabling legislation (39).

In 1970, under the leadership of Dr. John Hein and Dr. Ralph Lobene, the Forsyth Dental Center initiated what was subsequently designated, and described in a book by the same title, *The Forsyth Experiment* (40). The House of Delegates of the Massachusetts Dental Association had recently passed a resolution favoring research on expanded function dental auxiliaries. Forsyth communicated to both the Massachusetts Board of Dental Examiners and to the Massachusetts Dental Society its plans to initiate a research project to train dental hygienists in anesthesia and restorative therapy for children. In October of 1973, the Board of Dental Examiners notified Forsyth that a hearing would be held to review their project. Subsequently, the State Board voted unanimously that the drilling of teeth by hygienists was a direct violation of the dental practice act of Massachusetts. Forsyth was forced to close its "experiment" in June of 1974, but not before it was able to objectively document that hygienists could be taught to provide quality restorative dental care effectively, and in an efficient and cost-benefit effective manner. Whereas the projected curriculum time to achieve the competencies was 47 thirty-hour weeks, the project was able to achieve its desired training outcomes in 25 weeks.

In February, 1972, Dr. John Ingle, Dean of the University of Southern California School of Dentistry (USC) proposed the use of school dental nurses, as employed in New Zealand, to address the problem of dental caries in school children (41). USC subsequently applied for a training grant of $3.9 million from the Public Health Service to train dental nurses, with Dr. Jay Friedman as the program director. At the same time, then-Governor of California, Ronald Reagan established a committee to study the functions of all dental auxiliaries in order to make recommendations to the California legislature and the State Board of Dental Examiners (42). As a result of these two significant developments, the two existing California Dental Associations established a committee to: study the New Zealand dental care system; the relationship of the school dental nurse to private practice; assess the work of the school dental nurse; and compare the New Zealand and California systems (42). The Committee's report was published in April of 1973 in the *Journal of the Southern California Dental Association* (42), and subsequently summarized in the *Journal of the American Dental Association (JADA)* (43). The report stated that "there is little doubt that dental treatment needs related to caries for most of the New Zealand children age 2½ to 15 have been met." However, the report concluded that the public of California would "probably not" accept the New Zealand type of school dental service, as it would be perceived as a "second class system." Drs. Ingle and Friedman wrote sharp rebukes of the Committee's report, pointing out the inconsistencies of the objective findings of the investigation in relation to the subjective conclusions of the re-

port, which they judged to be drawn to placate the practicing profession in California (44,45). Dunning also criticized the report's conclusions in a letter to the *JADA* editor (46); and Goldhaber, in a *Journal of Dental Education* article, called the committee's conclusion, "absurd" (47). The grant application of Drs. Ingle and Friedman was not funded. Dean Ingle subsequently resigned his position as dean of the School of Dentistry to join the staff of the Institute of Medicine.

Between 1972 and 1974, at the University of Kentucky, another expanded functions project, supported by the Robert Wood Johnson Foundation, took place (48). This also involved the training of dental hygienists in restorative dentistry. Thirty-six students, who were completing a four-year baccalaureate program in dental hygiene, participated in a compressed curriculum that provided 200 hours of didactic instruction in children's dentistry, as well as 150 hours of clinical practice. The program was specifically addressed to providing primary care for children, including administration of local anesthesia, restoration of teeth with amalgams and stainless steel crowns, and pulp therapy. Toward the conclusion of the curriculum, the hygienists participated in a double blind study comparing their restorative skills with fourth year students. No significant differences were found between the quality of their work and that of the graduating dentists.

At the College of Dentistry at the University of Iowa a five year project, conducted between 1971-76, and supported by the W.K. Kellogg Foundation, trained dental hygienists to perform expanded functions in restorative dentistry and periodontal therapy for both children and adults. The results were the same as the studies at Forsyth and Kentucky. Hygienists could be effectively trained, in a relatively brief time period to perform, at a comparable quality level, procedures traditionally reserved for dentists (49).

**Developing Pediatric Oral Health Therapists.** A curriculum for developing pediatric oral health therapists exists, and has been documented to be effective in multiple countries throughout the world. It is the traditional curriculum of the school dental nurse/therapist. The curriculum for a pediatric oral health therapist could be considered comparable to the two-year academic (associate degree) curriculum for preparing dental hygienists. The primary difference would be the focus of the training, with that of the hygienist being on periodontal disease, particularly in the adult; and the therapist on dental caries, specifically as related to the child. The curricula would share many areas of commonality, such as the basic biomedical sciences, oral biology, preventive dentistry, infection control, the diagnostic sciences, and radiography. Evidence suggests that the perceptual motor skills required to restore children's teeth are no more complex than those required to perform root planning and curettage and can readily be taught to individuals with a high school degree, outside the context of earning a baccalaureate degree, and participating in a four-year professional degree course in dentistry.

While it may be possible to shorten the two-year academic training period, were the matriculates in such a program dental hygienists, there is reason to encourage hygienists to continue to be the expanded function allied dental professional for managing adult periodontal health and disease. Hygienists are too valuable in their current role, particularly in the context of their relative shortage and the aging of the population, with concomitant needs for periodontal therapy. Rather, it appears more reasonable to create a new allied professional for the dental team who focuses on the unique oral health needs of children, specifically as these relate to the problem of dental caries.

It is tempting to want to designate these proposed pediatric oral health therapists "midlevel practitioners." However, they do not fit this descriptor as such a designation is typically applied to nurse practitioners and physician's assistants. The entry-level education for nurse practitioners is the master's degree (50), and by 2006, all physician's assistants training programs will be at the master's degree level as well (51). It is more appropriate to relate a pediatric oral health therapist to a registered nurse with an associate's degree. There are approximately 750 two-year registered nursing programs operational in the United States (52). Or, as has been suggested, the pediatric oral health therapist could be related to a registered dental hygienist with similar such associate degree credentials. Of the 260 dental hygiene programs in the U.S., 230 are two-year associate degree programs. Only 30 programs offer a baccalaureate degree (53). The average curriculum clock hours for a two-year dental hygiene program is 1,948,(54) a period of instruction comparable to international training programs in dental therapy.

**Deploying Pediatric Oral Health Therapists.** To effectively address the access problem, it appears clinicians must go to where children are located. As in New Zealand, the most logical place to capture this audience is in the school system. As Dunning stated over 30 years ago, "any large-scale incremental care plan for children, if it is to succeed, must be brought to them in their schools" (55). It is reasonable to deploy pediatric oral therapists in mobile vans to provide care on a financial needs-tested basis, for example, to all Medicaid and S-CHIP eligible children in a school, moving through the year from one school to another. Such a program, begun in an incremental manner with the youngest children (with the least carious experience and the greatest potential for implementation of preventive care), would seem to be a cost-effective way of managing the oral health needs of our poorest and neediest children. In New Zealand, a dental therapist with an assistant is responsible for 1,450 children (19). The Commonwealth of Kentucky has essentially the same population as New Zealand. Kentucky has 384,832 children ages 5-11 (K-6). Of these, approximately 43% (or 172,418 children) live at a level of 200% of poverty or below, and are eligible for Medic-

aid/S-CHIP benefits (56). To manage this number of children would require 212 dental therapists based on the New Zealand model. While no direct economic comparisons can be made, due to the significantly different circumstances, it is interesting to note that New Zealand spends approximately $34 million (US) caring for all enrolled children, ages 6 months through 17 years; (57) and Kentucky's dental expenditures for children Medicaid/S-CHIP alone in 2002-03 were approximately $40 million (58).

Possibly a more realistic environment for *initially* introducing the pediatric oral health therapist in the U.S. is the Indian Health Service (IHS). Dental caries is rampant among the American Indian/Alaskan Native population. These children have the highest decay rate of any population cohort in the U.S., five times the U.S. average for children 2-4 years of age (6). The IHS continues to experience great difficulty in attracting dentists; approximately one-fourth of the dentist positions at 269 IHS and tribal facilities were vacant in April of 2000 (9). The dentist/population ratio in the IHS is 33/100,000, or one dentist for every 2,800 individuals (59). Because dentistry in the Indian Health Service is practiced on federal reservations, state dental practice acts are not applicable. Such a circumstance eliminates a significant barrier to deploying pediatric oral health therapists.

In 2001, the Forsyth Institute approached the Robert Wood Johnson Foundation for funding to develop a training program at Forsyth for pediatric oral health therapists. When funding was not forthcoming, the leadership of the Alaska Native Tribal Health Consortium proceeded, in 2003, to send six Alaskan students to the University of Otago in New Zealand to train as therapists. Six additional Alaskan students enrolled in the training program in January of 2004. The Alaska Tribal Health Consortium is financing the training of these individuals, the first of whom will return in December of 2004 to sovereign tribal lands and provide oral health care for children. They will practice in the context of the Community Health Aide Program (CHAP), a program authorized by federal statute in which Tribes provide primary health care throughout Alaska. The program has been in existence for 36 years. There are over 500 CHAs in Alaska, working in 180 villages, providing culturally sensitive health care to fellow villagers. A component of the CHA program is the Dental Health Aide (DHA). There are three levels of functioning for a DHA; the returning therapists constitute the highest level, a DHA III. CHAs, including DHAs, must meet specific training requirements, undergo a protracted preceptorship, and have their skills re-evaluated every two years. Continuing education is required for continued certification. CHAs and DHAs are recruited from villages they will return to serve. This helps ensure culturally competent care, as well as sustainable jobs in areas that need them most.

The American Dental Association learned of the Alaskan students studying dental therapy in New Zealand and the intention for them to return to the tribal areas to practice. At the October, 2003, annual session in San Francisco, the House of Delegates passed Resolution 50H-2003, calling for a task force to "explore options for delivering high quality oral health care to Alaska Natives," and to submit a report to the Board of Trustees in time for recommendations to be brought to the 2004 House of Delegates (60).

The Alaska Native Oral Health Access Task Force submitted its report to the ADA Board of Trustees in August of 2004. Based on the Task Force's recommendations, the Board advanced to the House of Delegates at the ADA's October 2004 Annual Session Resolution 24, subsequently amended and passed by the House of Delegates as Resolution 24S-2. Among the 14 elements of the resolution to address access to oral health care for Alaska Natives were two dealing specifically with the advanced level Dental Health Aide III (pediatric oral health therapist): (1) "the ADA work with the ADS [Alaska Dental Society] and tribal leaders to seek federal funding with the goal of placing a dental health aide (i.e., a Dental Health Aide I or II) trained to provide oral health education, preventive services and palliative services (except irreversible procedures such as tooth extractions, cavity and stainless steel crown preparations and pulpotomies) in every Alaska Native village that requests an aide;" and (2) "The ADA is opposed to non-dentists making diagnoses or performing irreversible procedures." The resolution passed the House of Delegates overwhelmingly on a voice vote (61).

Subsequently, the ADA initiated an effort to amend the Indian Health Care Improvement Act which was in the process of being reauthorized by the Congress in the closing days of the 108th Congress. This Act authorizes development and operation of the Community Health Aide Pogram, which includes Dental Health Aides. House Bill HR 2440 was amended at mark-up (House Report 108791, Section 121, #7) to read "ensure that no dental health aide is certified under the program to perform treatment of dental caries, pulpotomies, or extractions of teeth." The Senate version of the HR 2440 was S 556. The ADA's amendment was not successful as reauthorization of the Indian Health Care Improvement Act was not able to be accomplished by the 108th Congress; reauthorizing legislation will have to be re-introduced in the 109th Congress (61).

It seems clear that organized dentistry's opposition to developing a member of the dental team to provide primary care for underserved children has not changed since the first attempt to do so in 1949 at Forsyth. It is important to note that this current opposition is in the context of having individuals trained as therapists provide care to native Alaskan children in remote areas who essentially have no access to oral health care.

A third potential environment for pediatric oral health therapists is in private dental offices, as exists in Saskatchewan. In such, therapists could work under the supervision of

a dentist, serving as a dentist-extender for children's primary care, in much the same manner a dental hygienist serves in such a role for adult periodontal care. Saskatchewan dentists testify to the significant economic return on their investment in employing dental therapists apart from the opportunity it provides to care for more patients than could be cared for without such personnel. That is improved access. It would be in dentistry's economic self-interest to develop and deploy pediatric oral health therapists in private dental offices.

A final potential environment for pediatric oral health therapists is the least desirable one, from the perspective of dentistry—the offices of America's pediatricians. The majority of children are seen regularly by the nation's 57,000 pediatricians. In fact, the typical infant/child has had 12 visits to the pediatrician by age three, providing multiple opportunities for early intervention to effect preventive and therapeutic oral health care (62). Recently, the Public Health Practice Office of the Centers for Disease Control funded a study of the dental practice acts of all 50 states and the District of Columbia to determine the limitations the individual state practice acts place on individuals, other than licensed dentists, to provide oral health care (63). The results of the study indicate there would be no restrictions on physicians, such as pediatricians, providing dental care in 23 states; and no restrictions in an additional 11 states as long as dentistry is not practiced "as a specialty." In nine states, physicians would only be allowed to provide emergency care. Three additional state practice acts seemed to suggest physicians would be restricted from providing any oral health services. It is interesting to speculate what might happen if a pediatrician were to hire a dental therapist trained in Canada, New Zealand, or another country, and began to offer primary oral health care for children in his or her office. In 2001, the average pediatrician earned $150,000/year,(64) whereas that same year the average pediatric dentist earned $293,320 (65). It has been expressed in the past that the revolution we are experiencing in health care, both in therapeutic approaches and the environment of practice, is such as to encourage physicians to become more adventuresome in expanding their services to include dentistry (66). Pediatricians are now receiving training in oral health care in a number of settings around the country and are conducting oral exams and applying fluoride varnish to children's teeth, for which they are being remunerated (67). Competition in the marketplace of health care could lead to undesirable economic consequences for dentistry, absent the profession aggressively addressing the oral health disparities among the nation's children.

**Social Justice.** Kopleman and Palumbo have published a thoughtful and compelling article in the American Journal of Law and Medicine entitled: "The U.S. Health Delivery System: Inefficient and Unfair to Children" (68). The paper explores the four major ethical theories of social (distributive) justice: utilitarianism; egalitarianism, libertarianism, and contractarianism. They conclude that no matter which theoretical stance you take, children should receive *priority* consideration in receiving health care. Yet, our children do not even receive *equal*, much less priority, consideration.

One of the most important and influential books of political philosophy written in the 20th century was *A Theory of Justice* by the late Professor John Rawls of Harvard University (69). In it Professor Rawls carefully explicates the nature of justice. In his model of justice, social and economic arrangements would be such as to *maximally benefit the worst off*. Given a Rawlsian view of social justice, our nation's oral health care system, if is it to be just, must be such as to be committed to maximally benefiting the *"worst off."* Our disparities and access problems are visited disproportionately on socio-economic groups that are the least well off. Norman Daniels, professor of bioethics and population health at the Harvard School of Public Health, agrees with Rawls, and argues that a just society should provide basic health care to all, but redistribute health care more favorably to children (70). He justifies this conclusion based on the affect health care has on equality of opportunity for children; with equality of opportunity being a fundamental requirement of justice. As noted, poor and minority children, the most vulnerable individuals in our nation, and the *"worst off,"* have the highest prevalence of oral disease, the poorest access to oral health care, and the poorest overall oral health. Justice demands they be maximally benefited, in order that they ultimately have *"equal opportunity"* to do well.

## Conclusion

The time has come for the profession of dentistry to seriously and courageously provide access to oral health care for all of America's children in such a manner that major barriers are destroyed and so that parents, regardless of their economic status, ethnicity, or cultural circumstance, can be assured their children will be treated justly by society, in that they have an equal opportunity, with other children, for good oral health. A method that can be effective in achieving such is the development and deployment of pediatric oral health therapists, allied professionals uniquely trained to care for the oral health of children. To its credit, the American Association of Public Health Dentistry has endorsed the concept of a pediatric oral health therapist in its strategic plan, released in April of 2004 (71).

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**Statement of Katherine Gottlieb**
**President/CEO, Southcentral Foundation**
**Submitted to the Committees on Health, Education, Labor & Pensions**
**and Indian Affairs**
**United States Senate**
**Hearing on S. 1057, Indian Health Care Improvement Act Amendments of 2005**
**July 28, 2005**

Southcentral Foundation ("SCF") congratulates the Senate Health, Education, Labor & Pensions Committee ("HELP") and the Indian Affairs Committee ("SCIA") on holding the first joint hearing regarding the Indian Health Care Improvement Act ("IHCIA"). SCF joins the two Committee Chairs in their expression of frustration that this bill has failed to be enacted by the Congress despite many years during which it has been considered. SCF is hopeful that this hearing will advance consideration of S. 1057 and lead to enactment this year. It also hopes that the information and views provided in this statement will be helpful to the Committees in their work and ask that this statement be included in the record of the July 14, 2005, hearing.

There are many important provisions of this bill. In this statement SCF will address only a few of the many issues. SCF anticipates submitting other testimony as the bill is considered further.

**Background.**

SCF is a Tribal Organization that compacts with the Secretary of the U.S. Department of Health and Human Services under Title V of the Indian Self-Determination Act and Education Assistance Act ("ISDEAA") to carry out programs of the Indian Health Service. In doing so, SCF acts on behalf of the Cook Inlet Region, Inc., an Alaska Native Regional Corporation.

**Dental Health Aide Therapists.**

SCF read with great interest the testimony of the President-Elect of the American Dental Association ("ADA"). It appreciates the ADA's support for most aspects of the dental health aide program as it has been implemented by the Community Health Aide Certification Board pursuant to 25 U.S.C. § 1616*l*. SCF disagrees fundamentally with the ADA with regard to its opposition to the certification of Dental Health Aide Therapists ("DHATs") as mid-level dental practitioners who may perform a wide range of dental services including three procedures that the ADA describes as "irreversible." SCF urges that the Senate accept no ADA sponsored amendments to Section 121 of S. 1057.

The ADA asserts that the limited irreversible procedures that are allowed within the scope of a DHAT under their federal certification "risk patients' safety and health." The ADA provides NO support for that statement in its testimony or in any other documentation it has provided during the two year debate over this issue. By contrast, there is extremely powerful evidence from the 42 other countries in which mid-level dental practice has become a mainstay of dental services that overwhelmingly supports the positive outcomes associated with the introduction of mid-level dental practitioners. Other testimony submitted in the record of this hearing addresses this in detail so SCF will not repeat it here.

The ADA also asserts that there is concern that DHAT training is not adequate to help DHATs to recognize cases in which patients may have other diseases that add to the complexity of certain dental procedures, especially if performed in a remote village. Once again, this concern is without foundation. This expression of concern reflects the ADA's lack of experience in the villages of rural Alaska. These villages are served by certified community health aides who have been providing primary, acute, and emergency health care services in villages throughout Alaska for more than 30 years. The DHATs will be providing their services in the same clinics that the CHAs are located and where an integrated medical record on each patient is retained. The community health program, including the DHAT component, works because it is part of a comprehensive, integrated health program. The scope of DHATs is specifically designed to ensure that high-risk patients are not among the patients who are served by them. As Dr. Williard testified, one of the strengths associated with the practice of DHATs is that they are so focused on a limited number of procedures that they acquire and maintain a very high skill level in those.

The ADA also suggests that the certification process for DHATs is not rigorous enough, pointing to the "independent verification . . . by a state board, including a clinical examination" that dentists and hygienists must undergo. Once again, the ADA's concerns are misplaced. The qualifications of each DHAT are subject to independent verification by a federally appointed Community Health Aide Program Certification Board. A DHAT must undergo a minimum of a three month preceptorship under the direct supervision of a licensed dentist. During this time they must demonstrate competence, at the same level as a licensed dentist, in each of the procedures that are included within their scope of practice. This is a far more rigorous process than any State board's licensing "clinical examination." In addition, the continuing education requirements are extremely rigorous, including requirements for periodic renewal preceptorships in which each DHAT's skills can be reevaluated and improved by working closely with a licensed dentist.

The ADA, having failed to support its proposition that the skills of DHATs are inadequate, attempts to sidestep that question by suggesting that there is really no need. Nothing could be further from the truth. We agree with the ADA that there is a need for dental prevention services in every village. However, as critical as prevention is, it will not eliminate the enormous backlog of unmet dental health care needs that exists among Alaska Native adults and children. Neither will a "volunteer" program, whether "credentialing" is simplified or not. SCF provides dental services not only through its primary program in Anchorage, but also in McGrath and the surrounding villages. Rural delivery presents special challenges that cannot be optimally addressed solely by any model of visiting dentists. As important as itinerant care by dentists is, it cannot be as successful as a model of delivery in which well-trained, highly skilled, mid-level practitioners from the villages they serve both provide care and, by their regular presence, change attitudes about dental treatment.

The ADA also tries to justify its opposition to the scope of practice of DHATs by suggesting that an alternative is to implement another type of provider called "Community Oral Health Providers" ("COHP"). The ADA attaches to its testimony a paper by four dentists, one of whom is Dr. Tom Kovaleski, the director of SCF's dental program. COHP has great possibilities for

addressing dental provider shortages in many communities. It is NOT, however, nor was it intended to be, an alternative to DHATs. Operational efficiencies are important. COHP provides one model for achieving them; one that should be considered throughout the United States. In our view, the COHP study validates the levels of dental health aide certification adopted by the Community Health Aide Program Certification Board, which includes primary prevention practitioners, expanded function dental assistants (who are very similar to the COHPs as described in the paper), and DHATs. The DHATs are the penultimate level in the new paradigm for Indian health program service delivery – one now built on many of the same assumptions as the COHP model.

While SCF appreciates the contributions made by the COHP paper, as well as the positive comments the ADA made about SCF and the accomplishments of SCF's dental program, it cannot and does not endorse the unsupported suggestion of the ADA that COHP can eliminate the need for DHATs. SCF does not believe that one conclusion leads to the other, and it certainly does not agree with the second conclusion reached by the ADA.

In summary, SCF is proud of its accomplishments in dental program operation and of the recognition by the ADA of its work. SCF does NOT endorse the ADA's request that Congress limit the scope of practice of DHATs. SCF believes that DHATs offer great promise for improving the delivery of high quality dental health services. SCF urges the Senate to reject any change to Section 121 of the Indian Health Care Improvement Act that would result in statutory restriction on the scope of practice of DHATs.

Thank you for your consideration of this statement. If SCF can respond to any questions, please contact me.

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STATEMENT

OF

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

UNITED STATES SENATE

COMMITTEE ON INDIAN AFFAIRS

AND

HEALTH, EDUCATION, LABOR, AND PENSIONS COMMITTEE

DR. CHARLES W. GRIM

DIRECTOR, INDIAN HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

S. 1057

"INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2005"

JULY 14, 2005

Statement of the Department Of Health and Human Services

On S. 1057, - A Bill to Amend the "Indian Health Care Improvement Act Amendments of 2005"

Mr. Chairmen and Members of the Committees:

I am honored to testify before you today on the important issue of reauthorization of the Indian Health Care Improvement Act (IHCIA). Accompanying me today are Robert McSwain, Deputy Director, Craig Vanderwagen, M.D., Acting Chief Medical Officer, and Gary Hartz, Director, Office of Environmental Health and Engineering.

This landmark legislation forms the backbone of the system through which Federal health programs serve American Indians/Alaska Natives and encourages participation of eligible American Indian/Alaska Natives in these and other programs.

The IHS has the responsibility for the delivery of health services to more than 1.8 million Federally-recognized American Indians/Alaska Natives through a system of IHS, tribal, and urban (I/T/U) health programs based on judicial decisions and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indian/Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal government's responsibility to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major statutes are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L. 94-437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the Federal government programs that deliver health services to Indian people, but it also provides additional guidance in several areas. The IHCIA contains specific language addressing the recruitment and retention of health professionals serving Indian communities; the provision of health services; the construction, replacement, and repair of health care facilities; access to health services; and, the provision of health services for urban Indian people.

**DHHS Activities**

Since enactment of the IHCIA in 1976, statutory authority has substantially expanded programs and activities to keep pace with changes in healthcare services and administration. Federal funding for the IHCIA has contributed billions of dollars to improve the health status of American Indians/Alaska Natives. And, much progress has been made particularly in the areas of infant and maternal mortality.

The Department under this Administration's leadership reactivated the Intradepartmental Council on Native American Affairs (ICNAA) to provide for a consistent HHS policy when working with the more than 560 Federally recognized Tribes. This Council gives the IHS Director a highly visible role within the Department on Indian policy where he serves as vice chairperson of the Council.

The Department has also recently completed work ushering through a revised HHS Tribal consultation policy and involving Tribal leaders in the process. This new policy further emphasizes the unique government-to-government relationship between Indian Tribes and the Federal government and assists in improving services to the Indian community through better communications. Consultation may take place at many different levels. To ensure the active participation of Tribes in the development of its budget request, an HHS-wide budget consultation session is held annually. This meeting provides Tribes with an opportunity to meet directly with leadership from all Department agencies and identify their priorities for upcoming program requests. Last year, Tribes identified inflation and population growth as their top budget priorities and IHS's FY 2006 budget request included an increase of $80 million for these items. Both the House and the Senate have included these increases in FY 2006 appropriations action, and we appreciate their efforts in this regard.

Through the Centers for Medicare & Medicaid Services (CMS), a Technical Tribal Advisory Group was established which provides Tribes with a vehicle for communicating concerns and comments to CMS on Medicare, Medicaid and SCHIP policies impacting their members. And,

the IHS has been vigilant about improving outcomes of Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible to, or struggling with, this potentially disabling disease.

It is clear the Department has not been a passive observer of the health needs of eligible American Indians/Alaska Natives. Yet, we recognize that health disparities among this population do exist and are among some of the highest in the Nation for certain diseases (e.g., alcoholism, tuberculosis, diabetes, and injuries), and that improvements in access to IHS and other Federal and private sector programs will result in improved health status for Indian people.

The IHCIA was enacted to provide basic primary and preventive services in recognition of the Federal government's unique relationship with members of Federally recognized Tribes. Members of Federally recognized Tribes are also eligible for other Federal health programs (such as Medicare, Medicaid and SCHIP), on the same basis as other Americans, and many also receive health care through employer-sponsored or other healthcare coverage.

It is within the context of current law and programs, that we turn out attention to S.1057.

**S.1057**

We are here today to discuss reauthorization of the IHCIA, and its impact on programs and services provided for in current law. Improving access to healthcare for all eligible American Indians and Alaska Natives is critical to the Department and a priority for all of those involved in

the administration of these important programs. We, therefore, commend your interest and will note positive provisions in S.1057. However, we will also note concern on provisions which may negatively impact our ability to provide needed access to services by establishing program mandates and burdensome requirements that may divert resources from important services. We hope to work with you to address these issues.

The Department brings a keen awareness of the health care needs of Indian country and is supportive of reauthorization of the IHCIA. We support provisions that increase the flexibility of the Department to work with Tribes, to increase the availability of health care, including new approaches to delivering care, and to expand the range of options of health services available to eligible American Indians and Alaska Natives. Accordingly, I commend Congress for including in S. 1057 various changes that respond to concerns raised in previous proposals. Some of these changes go a long way toward improving the ability of the Secretary to effectively manage the program within current budgetary resources.

Moreover, I would like to note our particular interest in other provisions of S. 1057.

In the area of behavioral health, title VII of S. 1057 provides for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but opposes language in Sections 704, 706, 711(b) and 712 that requires the establishment or expansion of specific additional services. The Department should be given the flexibility to provide for all Behavioral

Health Programs in a manner that supports the local control and priorities of Tribes, and to address their specific needs within IHS overall budgetary levels.

**Provisions Related to Medicare and Medicaid**

In general, we believe the provisions of the bill that relate to the Medicaid and State Children's Health Insurance (SCHIP) programs should be considered by the authorizing committees and in a framework consistent with the FY 2006 Budget Resolution and the Reconciliation process. As part of the larger Resolution and Reconciliation process, a Medicaid Commission was established to examine many aspects of that program. The Commission is charged with advising the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way. Tribes are represented on the Commission through Secretary Leavitt's recent appointment of the Chair of the Centers for Medicaid and Medicaid Services Tribal Technical Advisory Group.

**Reporting Requirements**

S.1057 includes new requirements for reporting to Congress within the President's Budget. The IHS and HHS will work with Congress to provide the most complete and relevant information on IHS programs, activities, and performance. However, we recommend striking language that provides additional specificity about what should be included in the President's budget request.

**Indian Health Professions Scholarships**

Currently, the scholarship program regularly consults with the I/T/U's to determine the priorities.

Each year, the program sends letters to all tribal chairmen, tribal health directors, urban program directors, IHS clinical directors, and IHS headquarters offices. Through this communication, scholarship program staff will update the relevant parties regarding the health professions for which awards were made in the current year and ask for their recommendations for the professions for which awards should be made in the coming year. Recommendations are aggregated and reviewed with the Office of Public Health and the Office of Management Support to determine which professions will be funded for the coming year.

New section 104(a) (2) proposes to allocate the program funding by formula to the twelve IHS areas. If allocation by formula is authorized Indian, students will not be given an opportunity to apply for a scholarship if their area does not receive adequate allocation and if their profession is not considered a priority in their area e.g., dental hygienist, physical therapist, medical technology. This would even impact a medical student who has identified general surgery or general psychiatry as a specialty. They will not receive the scholarship, because it is not a priority or there are no positions available for these disciplines/specialties.

We are concerned that the large areas will receive the greatest amount of appropriated funds, leaving the smaller areas with amounts sufficient to fund only a small portion of their health professional needs. If an area chooses to allocate the funds among the tribes within the area, funds available to many will be insufficient to support even one student.

We recommend retaining the provision in current law which would maintain the national focus

of the scholarship program to more appropriately meet the health professions needs of Indian country.

**Diabetes Evaluation and Coordination**

The bill has eliminated the current requirement for an evaluation of the 20 model diabetes programs for effectiveness and for each Area to employ at least one diabetes control officer, commonly now known as the Area Diabetes Consultant/Coordinator, to coordinate and manage on a full-time basis activities within the Area Office for the prevention, treatment, and control of diabetes. Area Diabetes Consultants/Coordinators are critical to the ability of the Service to provide support to the local Indian health programs as they implement the Special Diabetes for Indians Program formula and competitive grants programs. The evaluation provision for the model diabetes programs also is important to ensure that this program's effectiveness is assessed to make sure it maintains a productive role in the context of the implementation of the Special Diabetes for Indians Program at the local level. Both the National Diabetes Program and the Tribal Leaders Diabetes Committee (TLDC) have advocated for Area Diabetes Consultant/Coordinators.

We recommend that the requirement to employ at least one diabetes control officer in each of the 12 areas, as well as the requirement to evaluate the effectiveness of services provided through model diabetes projects established under this section, be retained.

**Health Care Facilities**

Sanitation facilities construction is conducted in 38 States with Federally recognized Tribes who take ownership of the facilities to operate and maintain them once completed. There are 49 hospitals, 247 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to Indian people.

**Health Care Facilities Needs Assessment & Report**

New section 301(d)(1) authorizes Government Accountability Office (GAO) to complete a report, after consultation with Tribes, on the needs for health care facilities construction, including renovation and expansion needs. However, efforts are currently underway to develop a complete description of need similar to what would be required by the bill. The plan is to base our future facilities construction priority system methodology application on a more complete listing of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the Tribes less resource intensive means for acquiring and updating the information that would be required in these reports.

We recommend the deletion of the reference to the Government Accountability Office undertaking the report because it would be redundant of and a setback for IHS's current efforts to develop an improved facilities construction methodology. This would allow the IHS to complete its new priority construction methodology which will address the future federal and tribal health facility needs.

**Retroactive funding of Joint Venture Construction Projects**

New section 311(a)(1) would permit a tribe that has "begun or substantially completed" the process of acquisition of a facility to participate in the Joint Venture Program, regardless of government involvement or lack thereof in the facility acquisition. An agreement implies that all parties have participated in the development of a plan and have arrived at some kind of consensus regarding the actions to be taken. By permitting a tribe that has "begun or substantially completed" the process of acquisition or construction, the proposed provisions could force IHS to commit the government to support already completed actions that have not included the government in the review and approval process. We are concerned that this language could put the government in the position of accepting space that is inefficient or ineffective to operate and recommend that it be deleted.

**Sanitation Facilities Deficiency Definitions**

New section 302(h)(4) provides definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country, which are ambiguous. As proposed deficiency level III could be interpreted to mean all methods of service delivery (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) are adequate to meet the level III requirements and only the operating condition, such as frequent service interruptions, makes that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe it is important to distinguish between the two.

In addition, the definition for deficiency level V and deficiency level IV, though phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas, level V should refer to an individual home or community lacking both water and wastewater facilities.

We recommend retaining current law as more appropriate for distinguishing the various levels of deficiencies which determine the allocation of existing resources.

**Threshold Criteria for Small Ambulatory Program**

New Section 305(b) (1) amends current law to set two minimum thresholds - one for number of patient visits and another for the number of eligible Indians. In order to be eligible under the criteria of S. 1057, a facility must provide at least 150 patient visits annually in a service area with no fewer than 1500 eligible Indians. Aside from the fact that these are both minimum thresholds and so somewhat contradictory, the new makes implementation difficult. First, the IHS cannot validate patient visits unless the applicant participates in the Resource Patient Management System (RPMS). Since some tribes do not participate in the RPMS, it is difficult to ensure a fair evaluation of all applicants. Second, the term "eligible Indians" refers to the census population figures, which cannot be verified, since they are based on the individual's statement regarding ethnicity. In order to make the language clear and equitable, the provision should provide one minimum threshold that can be validated.

**New Negotiated Rulemaking and Consultation Requirements**

We are concerned about the remaining requirements for negotiated rulemaking and increased requirements for consultation in the bill because of the high cost and staff time associated with this approach. We are committed to our on-going consultation with Tribes and urban Indian organizations under current Executive Orders, as well as promulgating regulations where necessary to carry out IHCIA using the procedures required by Chapter V of title 6, United States Code (commonly known as the Administrative Procedures Act).

We have other objections to S.1057, including, for example: new requirements using "shall" instead of "may" in provisions that will create budget pressures on current program activity; expansion of the scope of Federal Torts Claim Coverage for services provided to otherwise ineligible non-Indians; expansion of authorities for Urban Indian Organizations; elimination of the term "grant" and replacement with the term "funding"; and new provisions that contemplate the Secretary exercising authority through the Service, Tribes and Tribal Organizations which is not tied to agreements entered into under the Indian Self-Determination and Education Assistance Act (ISDEAA). The Administration may also have additional views on this legislation.

I reiterate our commitment to working with you to reauthorize of the Indian Health Care Improvement Act, and the strengthening of Indian health care programs. I hope to work with this Committee and other Committees of the Congress, the National Tribal Steering Committee, and other representatives of Indian country to develop a bill that all stakeholders in these important

programs can support. Again, I appreciate the opportunity to appear before you today to discuss this important legislative proposal. I will be pleased to try to answer any questions that you may have. Thank you.

# *THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES*

**Testimony of**

**Georgiana Ignace, President**
**National Council of Urban Indian Health**

**Before the**
**Senate Committee on Indian Affairs**
**And the**
**Senate Health, Education, Labor and Pensions Committee**

**On the**
**Indian Health Care Improvement Act Amendments of 2005**
**S. 1057**

**July 14, 2005**

# *THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES*

**"Between the intentions of the lawmakers and the reality of regulatory actions lies the *service gap* that confronts the urban Indian. The result is untold desperation and waste of human resources."**

Final Report of the American Indian Policy Review Commission, Vol. 1, p. 436 (emphasis added).

## I. INTRODUCTION

Honorable Chairman and Committee Members, my name is Georgiana Ignace, President of the National Council of Urban Indian Health (NCUIH). I am a member of the Menominee Tribe and serve on the board of the Gerald L. Ignace Indian Health Center, Inc., which provides health care services to the Milwaukee urban Indian community. On behalf of NCUIH, and its 34 member programs, I would like to express our appreciation for this opportunity to testify before your Committee on urban Indian health issues.

Founded in 1998, NCUIH is the only national membership organization of urban Indian health programs. NCUIH seeks, through education, training and advocacy, to meet the unique health care needs of the urban Indian population. Title V urban Indian health programs provide a wide range of health care and referral services in 41 cities, actively serving approximately 150,000 urban Indians per year.[1] NCUIH is the successor organization to the American Indian Health Care Association, which provided advocacy and educational services on behalf of urban Indian health organizations for nearly 15 years prior to the establishment of NCUIH.

In general, S. 1057 contains many provisions that will support urban Indian programs. In this testimony I address the critical importance of providing Urban Indian Health Programs with access to the Federal Supply Schedule, as well as Federal Tort Claims Act coverage and a 100% Federal matching rate for Medicaid services. My testimony also focuses on the unique circumstances of urban Indians, the barriers they face in accessing health care, and the Federal obligation to address urban Indian health care needs. As set forth below, the Federal government has long acknowledged that its trust obligation to Native peoples is not just based on reservation geography, but extends in some measure to wherever Native people live within the United States.

## II. GUIDING PRINCIPLES FOR URBAN INDIAN HEALTH PROGRAMS

In 1994, urban Indian health providers, during the tenure of the American Indian Health Care Association - NCUIH's predecessor organization - met in San Diego and adopted four

[1] According to the 2000 census, 66% of American Indians and Alaska Natives live in urban areas, up from 45% in 1970, 52% in 1980 and 58% in 1990.

"Guiding Principles." These principles still hold true for NCUIH's current efforts on behalf of urban Indians and directly address the relationships between and among urban Indians, Indian Tribes and the Federal government.

**A. Sovereignty of the Tribes.** The first principle addresses the understanding of urban Indians regarding the central importance of tribal sovereignty and the government-to-government relationship between Tribes and the United States:

> **Sovereignty of the Tribes:** ***We believe that tribal sovereignty, based on government-to-government treaties and trust responsibilities, along with certain moral obligations, of the United States government, is the foundation for all Indian affairs, including health care.***

In the National Steering Committee's deliberations there was recognition of the importance of emphasizing the sovereignty of tribal governments and the Federal government's trust obligation to Tribes and tribal peoples. There was also a recognition of the historical circumstances, largely a result of Federal government actions and policies, which gave rise to urban Indian communities consisting of Indians from a wide variety of tribal backgrounds (these circumstances are discussed in Section IV).

Although Congress has been specific about its commitment to both Tribes and urban Indians,[2] we recognize that, despite our common interest in health services, Tribes and urban Indians generally occupy different places in Federal Indian policy. Federally recognized tribes have sovereignty and a trust relationship with the United States; as a result there are many different federal laws addressing that relationship in such areas as land, water, criminal justice, and jurisdiction, which have no applicability to urban Indians. Although most urban Indians belong to federally recognized tribes, urban Indians do not aspire as such to be recognized as having sovereign powers or as being in a government-to-government relationship with the United States.

**B. All Indian People.** The second principle addresses the reality of the urban Indian experience.

> **All Indian People.** ***We believe that all Indian people, regardless of tribal affiliation, blood quantum, or their place of residence are entitled to all the necessary health resources and services to achieve the highest possible health status.***

Many Indians, from many different tribes have ended up in urban areas. As described in greater detail in Section IV below, for a variety of reasons, mostly traceable to federal government action, they find themselves among the ranks of the urban poor. Most are members of Federally recognized tribes; some are not. Many among the latter have become so disconnected from their

[2] Congress has made clear, as set forth in the current Indian Health Care Improvement Act, "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and urban Indians and to provide all resources necessary to effect that policy." 25 U.S.C. Section 1602(a) (emphasis added).

tribes that it is difficult for them to obtain tribal membership, or their tribes have been terminated or otherwise marginalized. Yet they are all Indian; they are recognized as Indian by their community; their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.

**C. Traditional Medicine.** For urban Indians, as much as for reservation Indians, traditional medicine is critically important to maintaining a connection with tribal and cultural identity and plays an important role in a holistic approach to their health.

> **Traditional Medicine.** ***We believe that traditional Indian medicine is intrinsic to our culture and essential to a holistic approach to healing the body, mind, and spirit of our people.***

Urban Indians stand shoulder-to-shoulder with their reservation brothers and sisters on the critical importance of preserving and integrating traditional medicine into Indian health programs.

**D. Unified Urban/Tribal Partnership.** We believe in working closely with the Tribes.

> **Unified Urban/Tribal Partnership.** ***We believe that a unified Indian partnership is vital to assure access to comprehensive health services to achieve the highest possible health status for all Indian people.***

Many tribal peoples live in urban areas; some permanently, some periodically.[3] However, in many urban centers, it is not practical for any one tribal government to set up an outreach to only its own tribal members. In fact, "in some urban centers, there are as many as 40 tribal governments nearby, and representation of tribes on urban Indian programs might include over 80 different tribes."[4] The urban Indians have developed skills necessary for survival (if not yet prosperity) in the urban environment;[5] the tribes are the great repository of cultural tradition and knowledge. The practical approach is the current approach: working together, Tribes and urban Indian health organizations can provide the best possible health care for our people. The

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[3] One Federal court has noted that the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." United States v. Raszkiewicz, 169 F.3d 459, 465 (7th Cir. 1999)

[4] U.S. Congress, Office of Technology Assessment, *Indian Health Care*, OTA-H-290 (Washington, DC: U.S. Government Printing Office, April 1986), p. 38.

[5] "The Committee views the health dilemma of urban Indians as a serious obstacle in their quest to become self-sufficient and participating citizens. Fortunately, an evolving Congressional policy addressed to this problem has served to provide the essential experience and information for the provisions contained in Title V. That evolving policy has been built on the concept of self-determination with the Indians themselves managing federally subsidized health efforts tailored to fit the health circumstances of Indian populations residing in specific urban centers." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) p. 2652 and 2752.

extraordinary level of cooperation in the work of the National Steering Committee is proof positive of the value of this approach.

**III. HEALTH STATUS OF URBAN INDIANS**

According to a fact sheet developed by the National Urban Indian Policy Coalition urban Indian unemployment is double that of all other races [in some cities, like Boston, there is evidence that the Indian unemployment rate is quadruple the rate for all other races]; urban Indian poverty levels are three times that of any other race; the urban Indian high school drop out rate is over 75%; the urban Indian business development rate is the lowest of any race; urban Indians have higher mortality rate from alcoholism and related causes than other races; the urban Indian suicide rate is four times that of all other races; and urban Indians have three times the national rate for diabetes and heart disease.

NCUIH has consulted with the Urban Indian Health Programs to identify 19 program priorities of equal importance to address the health care crisis among urban Indians. They are as follows:

- Diabetes
- Cancer
- Alcohol and Substance Abuse
- Heart Disease
- Mental Health
- Maternal and Child Health
- Dental Health
- Injuries
- Elder Health
- Respiratory / Pulmonary
- Violence / Abuse
- Infectious Disease
- Hearing Disease
- Eye Disease
- Health Promo / Disease Prevention
- Tobacco Cessation
- Information Technology Support
- Maintenance and Repair
- Facilities and Environmental Health Support

## IV. BARRIERS TO MAINSTREAM HEALTH CARE EXPERIENCED BY URBAN INDIANS[6]

> **"The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the *service gap* reveals itself again."**
>
> Final Report of the American Indian Policy Review Commission, p. 437 (emphasis added).

The status of Urban Indian health is as poor as that for reservation Indians.[7] This section describes the many barriers that Urban Indians face in their efforts to access adequate health care in the urban environment:

**Physical/geographic barriers can include (1) telephone availability; less access to transportation; and (3) high mobility.** Many Native Americans do not have phones, increasing the difficulty in making appointments. For example, in Arizona, thirty percent of urban Indians have no household access to phone services. Indian people have much less access to private vehicles than the general population. Not having a vehicle creates barriers for people who must make arrangements with others to bring them to appointments. Public transportation (if available) makes for a longer travel time and can be costly. The high mobility of Indian people is another barrier to care. People who move often are not able to follow with the same provider, and this disrupts continuity of care and can lead to a decrease in the quality of care. When a person moves to another area, they must go through the system again to qualify for benefits, locate a provider, and receive care. In addition, movement back and forth between the reservation is common, which can significantly affect the ability of health professionals to provide prompt, quality follow-up care.

**Financial/Economic barriers also contribute to the poor quality of urban Indian health care.** People who do not have the resources, either through insurance or out-of-pocket, to pay for prevention and early intervention care may delay seeking treatment until a disease or condition has advanced to the stage where treatment is more costly and the probability of survival or correction is lower.

**Medicaid is available for urban Indians, but difficult to access.** Applying for Medicaid or other medical assistance is a long and detailed process, presenting many barriers to people who don't understand the system or lack the necessary skills to complete the paperwork involved. Furthermore, the required documentation is difficult for many urban Indians to obtain.

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[6] For more details on these issues see the September 30, 1989 report prepared for the American Indian Health Care Association, by Ruth Hograbe, R.D., M.P.H., Program Analyst and Donna Isham, Program Analyst. The framework for the report is the 1988 report Minority Health in Michigan: Closing the Gap.

[7] See Attachment A for a leading study on Urban Indian health: *Health Status of Urban American Indians and Alaska Natives*, Grossman et. al, Journal of the American Medical Association, Vol. 271, No. 11, p. 845.

For example, if one does not have a car, one may not have a drivers license. With high mobility among urban Indians, there is likely to be no documentation with the current address; or if they have just moved to the city from the reservation, there may be no birth certificate or identification. Once an individual is accepted, access to care is not guaranteed. Because of Medicaid reimbursement rates and restrictions, many providers are reluctant to accept Medicaid patients.

**Health insurance coverage does not automatically remove financial barriers to care.** Many persons, particularly those employed at or near minimum wage, have coverage through plans that do not cover preventive or major medical care. While professional positions generally provide health insurance, service and laborer positions generally do not. Urban Indians hold more of those occupations that do not provide health insurance benefits. Deductibles and co-payments are high enough that many persons who do have health insurance cannot afford to pay them and consequently do not seek care.

**No insurance or assistance is another common barrier.** Those who have no means to pay for care are often turned away. There is a high rate of urban Indians who are uninsured. For example, in Boston, 87% of the Boston Indian Center's clients have no health insurance, and two out of every three urban Indians in Arizona are uninsured.

**Emergency room use is high among the poor, minorities and the uninsured.** Unfortunately, emergency room use as a primary medical resource is costly and compromises quality care. Follow-up and preventive services are not possible with emergency room personnel serving as primary care providers. In Arizona, urban Indians use the emergency room 250% more often than the general public.

**Cultural/structural barriers also exist for urban Indians receiving health care.** The Indian Health Service conducted a survey which concluded that the majority of state, county and city health departments do not have the resources to meet the health care needs of urban Indians. Major stumbling blocks are inadequate funds and lack of staff trained to work with American Indians in a culturally sensitive way. Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of some Indians. Other factors include a lack of trained Indian health professionals that get placed in urban Indian health programs and inadequate Indian outreach.

## V. FEDERAL POLICIES AND THE URBAN INDIAN

> **"Most Indians who migrate to the cities say they would have preferred not to do so at all."**
>
> Final Report of the American Indian Policy Review Commission, Vol. 1., p. 436.[8]

[8] For a more detailed summary of the history of off-reservation Indians see Attachment B, which is the relevant chapter from the Final Report of the American Indian Policy Review Commission.

The urban Indian is an Indian who has become physically separated from his or her traditional lands and people, generally due to Federal policies. Some of these federal policies were designed to force assimilation and to break-down tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed miserably. The result of this "course of dealing," however, is the same - a Federal obligation to urban Indians.[9]

**A. The Federal Relocation of Indians.** The BIA's Relocation program originated in the early 1950s as a response to adverse weather and economic conditions on the Navajo reservation. A limited program was initiated to relieve the crisis by finding jobs for Navajos who wanted to work off the reservation as little or no job opportunities existed on the reservation. Shortly afterward, the BIA converted its Navajo program into a full-fledged Bureau of Indian Affairs program applicable to many Indian tribes.

The BIA employees who developed the program made many mistakes and miscalculations. Even before the 1950's had ended there was concern that many relocatees were experiencing great difficulty adjusting to life in a large city, or to their jobs. Some felt they were being stranded far away from home. Solving reservation economic problems by relocating Indians off of their tribal lands is roughly the equivalent of the Federal government, during the Depression, sending Americans overseas to find work – something the Federal government would never have done. Many understood the relocation program as just another form of "termination." A Jesuit priest on the Fort Belknap Reservation noted that relocation programs drained the reservation of much of its potential leadership, further weakening tribal governments.

All told, between 1953-1961, over 160,000 Indians were relocated to cities.[10] Where they quickly joined the ranks of the urban poor.[11] Set forth below in *italics* is a description of the experience of Indians who relocated.

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[9] The unique legal relationship of the United States with Indian tribes and people is defined not only in the Constitution of the United States, treaties, statutes, Executive orders, and court decisions, but also in the "course of dealing" of the United States with Indians. As the Supreme Court noted in a major Indian law case, "[f]rom their very weakness and helplessness, so largely due to the *course of dealing* of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection and with it the power." *United States v. Kagama* (1886) (emphasis added). Congress acknowledged this in its findings to the Native American Housing Assistance and Self-Determination Act (NAHASDA): "The Congress through treaties, statutes *and the general course of dealing* with Indian tribes, has assumed a trust responsibility . . . for working with tribes *and their members* to improve their housing conditions and good economic status so that they are able to take greater responsibility for their own economic condition." 25 U.S.C. 4101(4). Notably, NAHASDA also applies to state-recognized tribes. 25 U.S.C. 4103(12)(A).

[10] 1992 Roundtable Conference, Urban Indian Health Programs, Indian Health Service, "Working in Unity Toward our Future." p.2.

[11] "Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, p. 2747.

## *URBAN GENOCIDE - THE INDIAN IN THE CITY (excerpts)*[12]

*"The economic status of the reservation Indian is far below the poverty bracket. This is due to the lack of employment both on and off the reservations with the exception maybe of the larger cities. The main source of employment to be found on most reservations is working with the Bureau of Indian Affairs. In this way, the "Bureau" can instill its white culture on the Indians and eventually brainwash them into working against their own people. The reservation towns bordering the reservations can offer no employment for Indian people because of the great amount of racism, discrimination and prejudice that exist among the whites and other non-Indians.*

*"Consequently, the bad conditions and individual economic situations that have evolved from these indignities have forced the Indians to seek other sources of employment and education. With 75 percent of the Indian population unemployed for three generations, parents of Indian children could not, and still cannot afford to send them to public schools and have to depend on the government to educate them in "free" government boarding schools. Since it was a law to send their children to school, small children were forced to leave their parents and be shipped off to school thousands of miles away from their homes. These Indian boarding schools, established in various areas, were the prime weapons used to inculcate the white culture among the children or, in the common terms used at that time, "to civilize the barbarians." Any part of the Indian culture was forbidden and the children were physically beaten if they used their native tongue or practiced their own dances. It has not been until just recently that this law has been officially lifted and is not in force, but the principle motive of de-Indianizing the Indians is still in effect.*

*"During the summer months while school is not in session, they send these Indian students to white homes to work as indentured servants. After graduation, they are sent directly out on relocation from the schools into the cities.*

*"Conveniently enough, the relocation program has been established to speed assimilation of Indians into the cities at this time of dead-end streets, reservation confusion and unemployment. Through this program they relocate the younger Indians from the ages of 18 to 36 on direct employment or vocational training. It is a one-way ticket to the city in hopes that you will melt with the melting pot and forget you are Indian or still have a reservation that the white man does not have yet.*

*"Numerous problems have developed as the result of the "dislocation program," therefore the following chapters will focus on the urban Indian situation.*

*What Happens to the Indians After Arrival in the Cities*

*"On arrival to the city on relocation, the individual Indian has in his possession an envelope with orders and instructions, telling where to go and what to do. First of all, he is to*

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[12] This document was obtained from the National Urban Indian Policy Coalition. The author of this piece is unknown.

*report to the Bureau of Indian Affairs if he arrives during office hours. If not, he reports to a BIA-approved hotel until the next day if he has any money.*

*"If they have time to see you the first day, they dole out a small amount of money to last until the end of the month if he is on the training program or until the next week if he is seeking employment. If they do not have time to see him the first day, he is to come back the following day at office hours and maybe some one will see him. In the meantime, he can sleep in the park or walk the lone deserted streets all night long.*

*"When he is received at the BIA headquarters in the city, he attends a short orientation period and an elderly lady will counsel him about sex and how to dial "0" for the operator on the telephone. A brief question and answer period follows and he is told to come back the next day at eight AM or to report to his designated school.*

*"The BIA locates his place of residence in the city and he is required to stay there if he is a student. They will discontinue his subsistence if he opposes and he will not be eligible for any more aid.*

*"The vocational school he is sent to may not be the particular training he originally signed up for back on the reservation, but this is the school he is required to attend.*

*"If the relocatee signed up for direct employment, he must take the first job available even if it is not his trade or type of work he wants. He is told it will be temporary until the type of job he wants comes up but after he receives his first salary on his temporary janitor job, he is cut off their records and cannot receive any additional help after he quits, gets fired or the job runs out.*

*"The "Bureau" pays the student's tuition in the vocational school directly to the school. The student receives subsistence twice a month, doled out in payments of $74.00. From this amount, he must budget $59.00 per month per rent, and the other $15.00 must be divided into his expenses for food, cab fare, medical care, clothes and whatever else that should develop during the month. This budget was made up in 1953 when the program first developed and has not taken into consideration the rises in living and the area or city he is in. California has the highest cost of living especially in San Francisco, which is the central concentration point of relocatees coming from every reservation in existence today. This income is far below the poverty bracket nation-wide, yet this is the "help" the Indian Bureau is giving.*

*"All persons on the relocation program are issued a medical card which they can present to a physician and receive medical help up to a six-month period. The only problem here is that these medical cards only guarantee to pay $4.00 of the entire bill when the office calls alone are $5.00 at the very minimum.*

*What Problems They Face and Why*

*"The cultural background of the American Indians differs extremely from the white culture, creating a problem of communication between the two. Not only this, but the Indian*

*culture has also been corrupted, bringing about a drastic change of social environment. This disintegration of culture has been attributed to disturbing early experiences in school, the generally poor level of education, poverty and the ambivalent position of the government in relation to the Indian.*

*"Prejudice and discrimination which does exist near reservations or anyplace where there is a large concentration of Indians, (although now in the city and away from being singled out as being an Indian), tends to have developed hostile and stereo-typed attitudes towards the other groups of society. The Indians have also collectively experienced a deterioration of personality, self-doubt, self-hate, impulsive and suspicious behavior, feelings of inferiority, deviant behavior, mental illness and suicidal tendencies.*

*"Depending on the environmental background, these adverse behaviors vary. Individual exceptions are due to the degree of orientation to the white culture or restored self-image through education.*

*"In dealing with the many Indian people who go through the BIA agencies, or any other type of agency established in the cities for employment or vocational training, the employees lack the experience of knowing the type of environment the individual Indian has been subject to and they do not know how to handle his particular situation. In many cases even where minority people hold agency positions, generally, they have developed superiority attitudes over the people they are trying to help and therefore stunt their full capabilities for helping others.*

*"[Many businesses] resent the BIA in its assistance of seeking employment for the Indian relocatees. This is due to the business' general dislike of any form of government transactions or to be told how to run their business concerns. This creates a great amount of conflict and the BIA, in order to retain a certain amount of prestige, often finds the Indian relocatee employment with a business concern that pays a low wage scale, hard labor with no company obligations, such as insurance policies, sick leave and vacation with pay. These small businesses often take no safety precautions and are constantly hood-winking the safety inspectors. Consequently, the Indian relocatees are more or less siding with the illegal aspects of the concern in which they are employed in order to retain their jobs. Employment competition is great and the relocatees can be dismissed from their job for little or no cause at all, and they are often plagued by this fear of being fired.*

*"In the event that a relocatee is fired for one reason or another and needs assistance, he cannot go back to the BIA for further help. The BIA tells him that his files have been sent back to his agency and they have no more funds or time to help him because their hands are tied with the other relocatees who are coming in.*

*"The budget set up for financing a student in vocational training are not only inadequate for one person's needs, but are not set to the area standards of living. In other words, they are transformed from one pocket of poverty to another, which in this case would be from a reservation to an urban ghetto.*

*"The vocational schools that Indian relocatees are sent to, in most cases are not accredited and after graduation from one of these schools, the relocatee cannot obtain a job. Most of the teachers in vocational schools are not qualified teachers, and there is a great shortage of instruction. The BIA gives the schools extra money for materials yet the conditions and facilities in these schools are still very bad. The students come out of these schools unqualified and inexperienced in the type of work for which they thought they had been trained and cannot find suitable employment.*

*"There are more and more students who are sick and tired of being treated as second-class people who do want to get a decent education and go to junior colleges and universities. The biggest problem here is not being able to get any finances, "Bureau" or otherwise. Also, Indian students' second-rate educations do not prepare them well enough for college work. Most reservation Indians are subject to irregular school and employment backgrounds and a great majority of the younger Indians have criminal or prison records. This does not mean that they cannot do the work academically; but, basically, they have never had the full opportunity to do so.*

*"The Bureau of Indian Affairs sends newly-arrived relocatees to unsanitary, immoral, crowded and unsafe places of residence. If the student wants to leave these conditions, the landlord promptly calls the BIA about the matter and the student is required to live there or have his subsistence discontinued. In one of the girls' boarding homes the landlady encouraged parties and drinking and let the girls' boyfriends come over. Then she would go into their rooms and take pictures of the different couples sleeping together. If the girls wanted to leave, she would then threaten to blackmail them with the pictures she had and in this way would keep her business. A business college for female relocatees also housed the students, putting four girls to one small room and charging $100 per person, not including food or utilities. This establishment also received additional money from the BIA for recreational purposes which the girls never did see. If the girls tried to leave their residence, they were threatened with expulsion from the business college and have their subsistence discontinued. Most of these young Indian girls were between the ages of 18 to 20 years, who were eventually expelled for little or no reason and left to roam the city streets. Individual follow-up showed that 80 percent of these girls got pregnant, were drinking excessively and were living with men from time to time. This college is still in operation receiving relocatees from the Bureau of Indian Affairs.*

*"A boys' boarding house in the city was over-crowded with four bunks to a room, no studying facilities, unsanitary conditions, inadequate food and displaying a sign in the front of the house, CONDEMNED.*

*"These are typical living conditions, Indian youth are subject to when placed in the city through relocation. When a young Indian approached a BIA counselor why they had to live under such adverse conditions and was told, "The filthiest conditions you Indians are put under, the more at home you will be."*

*"Landlords and vocational schools are getting wise to the BIA and are making the largest profit and racket out of the Indian business at the cost of young Indian lives.*

*"Indian health is generally poor due to the economic standards and lack of proper diet and nutrition. Free medical facilities are provided on all reservations due to the unsatisfactory health conditions. Tuberculosis, cirrhosis of the liver, sugar diabetes, and trichoma are a few of the more prevalent diseases which Indian people are susceptible to. Trichoma, which is an eye disease, is very rarely heard of among Indians. Poverty conditions breed diseases.*

*"The BIA believes that when an Indian leaves the reservation, he suddenly leaves his "Indianness" and becomes a healthy, happy human being, and needs no more of the medical services he had before. Consequently, Indian health in the city becomes twice as bad as it might have been before because he cannot afford good medical care.*

*"Pregnant Indian women risk possibly losing their child by having to return to the reservation their last month so that they can receive medical care upon delivery of their baby.*

*"From the time Indians were victims of wars, they lost their identity which comes from pride and self-esteem. Indians became a lost people exhibiting schizoid behavior at times. An Indian who does not like himself, does not like other Indians because he can see himself reflected in the others. An Indian suffers from inferiority plus self-hate that leads to trying to escape these unbearable conditions. By escaping, he is rejecting the society that has made him this way. His means of escape is either through alcohol or suicide which are 100 percent times higher than the national average among the American Indians.*

*"An internal problem of self-identity and lost culture plus an external problem of discrimination and racism by people in power has suppressed and made what is left of the American Indian today."*

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Today, the children, grandchildren and great-grandchildren of the 160,000 Indians relocated by the BIA are still in the cities. They maintain their Indian identity even if, in some cases, these "descendants have been unable to re-establish ties (including membership) with their tribes."[13]

**B. Failure of Federal Efforts to Economically Develop the Reservations.** The second major reason Indians have moved to the city is the near total failure of Federal programs to promote economic development on Indian lands, coupled with the ongoing success of the Federal efforts in the 1800's to undermine the economic way of life of Indian peoples, locking nearly all Indians into hopeless poverty which still plagues most reservations today. The long history of treaty-breaking by the Federal government is an important part of this tale. As a result, out of desperation, a number of Indians have left their homelands to go to the cities in search of work, even without the dubious benefit of the BIA's relocation program. Generally, these Indians were no better equipped to handle life in the city than the BIA relocatees and

[13] See Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 22-23.

quickly joined the ranks of the urban poor. Congress has noted the correlation between the failure of Federal economic policies and the swelling of the ranks of urban Indians: "It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."[14]

**C. Termination of Tribes.** In 1953, Congress adopted a policy of terminating the Federal relationship with Indian tribes. Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, executive orders, and through the "course of dealing" with Tribes, to protect their interests. Many tribes were coerced to accept termination in order to receive money from settlements for claims against the United States for misappropriation of tribal land, water or mineral rights in violation of treaties.[15] The results of termination were devastating: having lost Federal support, and without tribal sovereign authority over an established land basis, and with tribal members no longer eligible for Federal programs and IHS services, the Tribes collapsed. Some members remained in the area of their old reservations; many went to the cities, where they, too, joined the ranks of the urban poor.

**D. Indian Patriotism -- World War I and World War II.** Many Indians served the United States in time of war[16] and, subsequently, were stationed in or near urban centers. At the end of their service to the United States, seeing the poor economic conditions on their reservations (resulting from the Federal war on Indians), many chose not to go back. The fact that they chose to stay in an urban area did not make them any less Indian, nor did it reduce the Federal government's obligation to them.

**E. The General Allotment Act.** The General Allotment Act ("Dawes Act") had two principal goals: (1) by allocating communal tribal land to individual Indians it would breakdown the authority of the tribal governments while encouraging the assimilation of Indians as farmers into mainstream American culture; and (2) it provided for unalloted land (two-thirds of the Indian land base) to be transferred to non-Indians. CITE. The General Allotment Act succeeded at transferring the majority of Indian land to non-Indians and further disrupting tribal culture. For the purposes of this testimony, we only need to note that some Indians who received allotments became U.S. Citizens and, after losing their lands, moved into nearby cities and towns.

**F. Non-Indian Adoption of Indian Children.** The common practice of adopting Indian children into non-Indian families has created another group of Indians in urban areas who, because of the racial bias of the courts, have lost their core cultural connection with their tribal

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[14] Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652,at p. 2754.

[15] Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 23.

[16] It is in part because of their gallant service in World War I that the U.S. Congress granted U.S. citizenship as a group to American Indians in 1924.

people and homelands. Many of the adopted Indians have successfully sought to restore those connections, but because of their upbringing are likely to remain in urban areas.[17]

**G. Boarding Schools.** The Federal program of taking Indian children and educating them away from their reservations in boarding schools where they were prohibited from speaking their native language and otherwise subject to harsh treatment, created a group of Indians who struggled to fit back into the reservation environment. Eventually, some moved to the cities. The boarding school philosophy of "Kill the Indian, Save the Man" epitomizes the thinking behind this approach and the racist Federal effort to assimilate American Indians which, as a result, led to a number of Indians moving to urban areas.

**H. The Fracturing of the Indian Nations.** The result of these, and other Federal Indian policies, has been the fracturing of Indian tribes and the creation, in the urban setting, of highly diverse Indian communities with members who fall into one or more of the following categories: Federal relocatees; economic hardship refugees; members of Federally recognized tribes, terminated tribes, state recognized tribes, and unrecognized Tribes (that is, unrecognized by the Federal government);[18] and adoptees.

The urban Indian community consists of Indians from a wide variety of backgrounds, almost all of whom can tie their urban existence to some Federal policy or action. Many of these Indians are in urban areas due to some traumatic disruption in their connection with their Tribes, or because something has happened to their Tribes (termination or marginalization such that they are not currently federal recognized). As a result, unlike the Indian population on reservations, most, but not all are members of federally recognized tribes. Yet they are all Indian; they are recognized as Indian by their community; their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.[19]

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[17] In recognition of the severity of this problem, Congress passed in 1978 the Indian Child Welfare Act to give Tribes and Indian parents a greater say in the adoption process for Indian children. See Indian Child Welfare Act of 1978, 25 U.S.C. Sections 1901-1963.

[18] There are still scores of tribes working their way through the byzantine acknowledgement process, which is widely criticized for its glacial pace and alleged bias against certain Indian groups.

[19] The Executive Director of the Seattle Indian Health Board, Ralph Forquera, M.P.H., commented eloquently on this issue in a May 24, 2000 letter to NCUIH:

> "There are two principle reasons why I believe that the definition should remain as is [i.e., including certain Indian populations that are not federally recognized]. First, the Act itself continues to address the health needs of all Indian people, not just those living on or near reservations. The redesign of the Indian Health Service in 1996 and adoption of the I/T/U model further supports this claim. Clearly the Congress intended for there to be a separation between 437 and 638. Thus, the adoption of the 638 language now [which would have excluded certain Indians now covered by the Indian Health Care Improvement Act], in my opinion, would tarnish the original Congressional intent by shifting the Act to a tribally based orientation.
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> "Second, the conditions that lead to the original enactment of both the Act itself and Title V in particular have not changed. There remains a large and growing group of Indian people who are handicapped by poverty, inadequate education, and other socio-economic challenges that

## VI. THE FEDERAL GOVERNMENT AND THE PROVISION OF HEALTH CARE TO URBAN INDIANS

The Congress has long recognized that its obligation to provide health care for Indians, includes providing health care off the reservation.

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

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).[20] Congress has "a responsibility to assist" urban Indians in achieving "a life

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contribute to diminished health status. Many continue to be victimized by alcoholism, violence, and the myriad temptation that diminish one's capacity to achieve optimal health. The social dynamics that served to disenfranchise Indians throughout the century remain. Indians, particularly in cities, continue to struggle with identity and acceptance both within Indian Country and within the nation as a whole.

"But perhaps the most compelling reason to continue the broader definition of Indian is the psychic benefits. The ability of urban programs to provide the gift of acceptance to those Indians who by circumstances or policy were denied their rightful identity as an Indian person is vital, in my opinion, to improving the health status of this group. Only in the past few years have I personally begun to appreciate the tremendous emotional burden many Indian people have had to bare by being denied their identity through structural limitations. Not knowing who you are is one thing; but knowing and not feeling accepted by your peers has devastated many Indian people. I have had the good fortune to witness the positive effect that acceptance can play in the lives of several here in Seattle. The health effect of this simple practice is enormous."

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

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

of decency and self-sufficiency" and has acknowledged that "[i]t is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs which failed to provide the Indian with an improved lifestyle on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities." House Report No. 94-1026 on Pub. Law 94-437, p. 116 (April 9, 1976).

The Supreme Court has also acknowledged the duty of the Federal government to Indians, no matter where located: "The overriding duty of our Federal Government to deal fairly with Indians *wherever located* has been recognized by this Court on many occasions." *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); and *Board of County Comm'rs v. Seber*, 318 U.S. 705 (1943). In other areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian housing rather than dismantle it where it exists. The Court generally agrees." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987).[21]

Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided:

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

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

The courts have also stated that there is a trust responsibility for individual Indians. "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members*

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

[21] Federal responsibility for Indian health care is frequently declared "primary" but it is not exclusive and preemptive of state responsibility. See *McNabb v. Bowen*, 829 F.2d 787, 792 (9th Cir. 1987). Congress enunciated its objective with regard to urban Indians in a 1976 House Report: "To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cond Cong. & Admin. News (USCAN) 2652, 2657.

*living collectively or individually, on or off the reservation.*" *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987)(emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising *that it can extend to Indians individually*, as well as collectively, *and off the reservation*, as well as on it." *St. Paul Intertribal Housing Board v. Reynolds*, 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

> "As the history of the trust doctrine shows, the doctrine is not static and sharply delineated, but rather is a flexible doctrine which has changed and adapted to meet the changing needs of the Indian community. This is to be expected in the development of any guardian-ward relationship. *The increasing urbanization of American Indians has created new problems for Indian tribes and tribal members.* One of the most acute is the need for adequate urban housing. Both Congress and Minnesota Legislature have recognized this. The Board's program, as adopted by the Agency, is an Indian created and supported approach to Indian housing problems. *This court must conclude that the [urban Indian housing] program falls within the scope of the trust doctrine . . . .*"
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> Id. At 1414-1415 (emphasis added).

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

The Federal courts have also found, that the United States can have an obligation to state-recognized tribes under Federal law. See *Joint Tribal Council of Passamaquoddy v. Morton*, 528 F.2d 370 (1st Cir. 1975). Congress has provided, not only in the IHCIA,[22] but also in

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

NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

## VII. REAFFIRMING FEDERAL SUPPORT FOR URBAN INDIAN HEALTH CARE IN THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

NCUIH has generally supported the recommendations of the National Steering Committee for the reauthorization of the Indian Health Care Improvement Act. However, in the course of previous testimony we have made several recommendations for refinements. One recommendation that I would like to highlight here is the need to assure that the IHCIA's policy statement clearly includes "urban Indians". The existing Indian Health Care Improvement Act includes urban Indians in the Congressional policy statement:

> "it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians *and urban Indians* and to provide all resources necessary to effect that policy.
>
> "(b) It is the intent of the Congress that the Nation meet the following health status objectives with respect to Indians *and urban Indians* by the year 2000:"

25 U.S.C. Section 1602(a)-(b) (emphasis added). Over the last several years, some versions of the Indian Health Care Improvement Act reauthorization legislation did <u>not</u> include a reference to urban Indians in the equivalent paragraphs. Removing "urban Indians" from this important policy statement would imply that the Congress no longer considers the health status of urban Indians to be a national priority. We are happy to see that S. 1057 provides a definition for "Indians" which would appear to include "urban Indians" as well. Still, it would be valuable if urban Indians were specifically named in Section 3, since they are also separately defined in the law, as recommended below:

> ***"SECTION 3. DECLARATION OF HEALTH OBJECTIVES***
>
> *"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people--*
>
> *"(1) to assure the highest possible health status for Indians <u>and urban Indians</u> and to provide all resources necessary to effect that policy;"*
>
> *(2) to raise the health status of Indians <u>and urban Indians</u> by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010, or successor objectives;"*

## VIII. HISTORIC PERCENTAGE DECLINE IN FUNDING FOR URBAN INDIAN HEALTH PROGRAMS

In FY 2005, Urban Indian Health Programs received 1.06% of the total Indian Health Service budget. The President has proposed in his FY 2006 budget to reduce Urban Indian programs to just 0.9% of the IHS budget. In 1979, at a time when off reservation American Indians/Alaska Natives made up a smaller percentage of the overall Indian population, the urban Indian programs received 1.48% of the Indian Health Service budget.

Disease knows no boundaries. As one Federal court has noted, the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." *United States v. Raszkiewicz*, 169 F.3d 459, 465 (7th Cir. 1999). With the 2000 census showing that well over half of the Indian population now resides in urban areas, we strongly believe that the health problems associated strongly with the Indian population can only be successfully combated if there is significant funding directed at the urban Indian population, as well as the reservation population.

The National Council of Urban Indian Health has asked for a $12.2 million dollar increase to the President Bush's proposed FY 2007 budget for Urban Indian programs as a first-step towards addressing this funding gap. This increase will elevate the Urban Indian Health Program funding from $31,816,000 to $44,016,000. While this cannot address the total need, it will make a huge difference in access to and quality of care for American Indians/Alaska Natives living in urban areas.

The rationale for the proposed increases is based upon:

- The steady decline of funding since 1979 when the program received 1.48% of the IHS budget to 2005 when the program received 1.06% of the IHS budget.
- The unmet need of 2 billion dollars and the actual appropriation of only $30 million. The urban Indian health programs can only serve 100,000 Indians of the 1 million eligible Indians residing in the urban setting.
- The need to conduct a planning study on the18 new urban Indian health programs throughout the United States.
- To enhance the soon to be transferred urban Indian health program Alcohol and Substance Abuse programs into Title V.
- The development of the urban Indian health centers of excellence.
- The enhancement of the urban Indian health program epidemiology center in Seattle, Washington.
- To continue to establish an automated mutually compatible information system to capture health status and patient care data for urban Indian health programs.

- To enhance existing programs in order to enable them to be elevated to provide the highest level of quality health care.

## IX. FEDERAL TORT CLAIMS ACT COVERAGE IS ESSENTIAL TO THE EFFECTIVE DELIVERY OF URBAN INDIAN HEALTH CARE SERVICES

**The ability of Urban Indian Health Programs to provide cost-effective health services has been jeopardized by the lack of FTCA coverage commonly accorded other federally funded Indian health programs.** The skyrocketing cost of malpractice insurance in recent years has compromised the scope of services that Urban Indian Health Programs can provide pursuant to contracts or grants that they receive from the Indian Health Service. Because of this, the fulfillment of the Federal government's trust responsibility to Indian peoples, as well as the effective implementation of IHS's Urban programs, has been seriously undermined.

**Consistent with the Federal government's trust responsibility to Indian peoples, Congress has funded, through the Indian Health Service, 33 Urban Indian Health Programs.** As the Senate has noted:

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

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

**Since 1990, FTCA coverage has been provided to tribes and tribal organizations that have contracts with the Indian Health Service.** The Urban Indian Health Programs secure their Federal funding from the exact same source as the tribes and tribal organizations and for the exact same purpose – to provide health care services to Indians in accordance with the Federal trust responsibility. Notably, the FTCA coverage provided to tribes and tribal organizations also covers individuals who provide health care services under a personal services contract in an IHS facility (25 CFR 900.193), as well as services provided under a staff privileges agreement with a *non-IHS facility* where the agreement requires a health care practitioner to provide reciprocal services to the general population (25 CFR 900.194). If these individuals and these services have FTCA coverage, as well as tribes and tribal organizations, then urban Indian health programs should have similar coverage.

**There is a mistaken impression that urban programs are serving non-Indians and that, therefore, they are not fulfilling a federal purpose and FTCA coverage is not appropriate**. Those few Urban Indian Health Programs that serve non-Indians are already

classified as Community Health Centers, receive Section 330 funds and, therefore, have FTCA coverage. The vast majority of Urban Indian Health Programs limit their services to Indians, are not Section 330 Community Health Centers and, therefore, do not have FTCA coverage.

**There is a mistaken impression that most, if not all, Urban Indian health programs can secure FTCA coverage as Federally Qualified Health Centers.** Based on the experience of one urban Indian health program that sought FQHC status, the process is ambiguous (it does not clearly provide for urban Indian programs to receive such status), time-consuming (18 months), costly and, at the end, of dubious benefit (this program only secured "look-a-like" FQHC status which, apparently, does not include FTCA coverage). It is essential that the issue of FTCA coverage be clearly addressed for Urban Indian Health Programs.

**According to a recent survey, only one of the 33 Urban Indian Health Programs has been the subject of a malpractice claim.** Due to the relatively limited nature of the services they provide, the actual risk of a claim against an Urban Indian Health Program is low and, therefore, the cost to the United States of providing FTCA coverage would be low. However, this has not deterred the insurance companies from charging ever more exorbitant rates.

**In some areas, there are few insurance carriers available, so the carriers use this leverage to make other demands.** One Urban Indian Health Program, which serves a large number of Navajo patients and was located relatively closely to the Navajo reservation, had a carrier state that it would not renew coverage out of fear that it would get dragged into the tribal courts. Despite detailed explanations as to why this was unlikely, the carrier would not relent. At the last hour, the program changed the status of its doctors from employees to independent contractors in order to maintain insurance coverage. Although a fix was found, it caused substantial problems for all parties concerned.

The FTCA's limited waiver of the federal government's sovereign immunity is now extended to tribes, tribal organizations and to non-tribal community health centers. It is illogical, and undermines the fundamental purpose for establishing federally funded urban Indian health programs, to not extend coverage to them as well. Section 515 of the Indian Health Care Improvement Act (S. 556) is essential to the future well-being of these programs and to the provision of basic services to urban Indian communities and should be preserved in the final version of this important legislation.

## X. FEDERAL SUPPLY SCHEDULE PRICING FOR PHARMACEUTICALS FOR URBAN INDIAN HEALTH PROGRAMS

**The ability of Urban Indian Health Programs to provide cost-effective pharmaceutical services depends on access to the Federal Supply Schedule.** Pharmaceutical costs have skyrocketed. Notably, many Americans now travel to Canada to purchase their prescription drugs. This option is not viable for most urban Indian communities and is not preferable to receiving properly dispensed pharmaceuticals from an urban Indian health program. Without access to the Federal Supply Schedule, the fulfillment of the Federal government's trust responsibility to Indian peoples, as well as the cost-effective implementation of IHS's Urban programs, is seriously impeded.

**Only five of the 33 Urban Indian Health Programs have access to federally discounted pharmaceuticals.** All five of these are accorded this savings by virtue of their status as Section 330 community health centers. The rest of the Urban Indian Health Programs do not have this status and are not in a position to readily attain it. Instead, they look for the cheapest supplier on the market, usually paying far higher than the Federal Supply Schedule rate. As a result, the average expenditure on pharmaceuticals by a UIHP is $134,000/year, which for these small programs is a disproportionately and unnecessarily high portion of their total budget that substantially restricts the provision of other services.

**Tribes and tribal organizations that have contracts with the Indian Health Service already have access to pharmaceuticals at Federal Supply Schedule pricing.** Tribes and tribal organizations receive this access based on the Federal trust responsibility and on a commonsense commitment to maximizing the value of Federal dollars, not based upon their status as governmental organizations. The Urban Indian Health Programs secure their Federal funding from the exact same source as these tribes and tribal organizations and for the exact same purpose – to provide health care services to Indians in accordance with the Federal trust responsibility. For the same reasons, therefore, urban Indian health programs which utilize federal funds should also have access to the Federal Supply Schedule.

**Consistent with the Federal government's trust responsibility to Indian peoples, Congress has funded, through the Indian Health Service, 33 Urban Indian Health Programs.** Urban Indian Health Programs are a direct and important manifestation of the Federal government's trust responsibility to Indian peoples. As the Senate has noted:

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

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

**A legislative solution to this inequity.** Section 517 of the Indian Health Care Improvement Act provides, among other things, that urban Indian organizations that have entered into a Federal contract or received a Federal grant pursuant to that title shall have access to the same sources of supply as Federal agencies. This is a critically important provision since the Federal Supply Schedule often provides the lowest cost available for a wide range of items, including pharmaceuticals. Access to this schedule greatly expands the purchasing power of the Federal dollars that urban Indian organizations receive, which, in turn, advances the implementation of Federal health care policy in support of urban Indians. That policy, as noted above, is rooted in the Federal government's trust obligation to Indian peoples.

The Federal government's policy of establishing an urban Indian health program, consistent with the Federal trust responsibility, would be greatly advanced by Section 517 of the Indian Health Care Improvement Act. Access to the Federal Supply Schedule not only maximizes the value of federal dollars, but is consistent with the current policy of providing such access to tribes and tribal organizations that have IHS contracts – a policy based in practicality and the Federal government's trust responsibility, not the governmental status of those entities.

## XI. THE NEED FOR A 100 PERCENT FEDERAL MATCHING RATE FOR MEDICAID SERVICES PROVIDED AT URBAN INDIAN HEALTH PROGRAMS

Urban Indian health programs may participate as providers in their state's Medicaid program and receive payment for services covered by Medicaid that they furnish to Medicaid-eligible American Indians. Whatever amount the state pays the urban Indian program for a visit by a Medicaid patient, the Federal government will match the state's expenditure at the state's regular Federal Medicaid matching rate, or FMAP. For example, Arizona receives 65 percent of the cost of each Medicaid patient visit from the Federal government, California 51 percent, Colorado 50 percent, etc. In contrast, if an American Indian who is eligible for Medicaid receives primary care services covered by Medicaid at an outpatient facility operated directly by the I.H.S., or from a facility operated by a tribe or tribal organization under contract with the I.H.S., the Federal government will match 100 percent of the cost of the service.

NCUIH supports raising the Federal Medicaid matching rate in all states to 100 percent for the costs of covered services furnished to a Medicaid beneficiary directly by an urban Indian health program receiving funds under Title V of the Indian Health Care Improvement Act. Note that under this proposal, the enhanced FMAP would *not* apply to services furnished by providers to whom an Indian Medicaid beneficiary has been referred by an urban Indian health program. CBO estimates the cost of providing this fiscal relief to the states at $60 million over 5 years and $150 million over 10 years.

## XII. URBAN INDIAN DEMONSTRATION PROJECTS – A THANK YOU

With leadership from this Committee, the Congress made permanent the Section 512 Demonstration projects, which include the Oklahoma City Indian Clinic, which I oversee in my capacity as president of the of the Central Oklahoma American Indian Health Council, Inc., operators of the Oklahoma City Indian Clinic. I would like to take this opportunity to formally thank you for your support. As a result, our excellent clinic will, in a stable environment, be able to continue to provide invaluable health care services to urban Indians in Oklahoma City.

## XIII. CONCLUSION

Notwithstanding the difficulties, urban Indian health organizations, working with limited funds, have made a great difference in addressing the health care service gap for urban Indians.

However, there is much more work to be done. NCUIH thanks the Committee for its support in the past and thanks the Committee for this opportunity to provide testimony on the health status of urban Indians. NCUIH looks forward to working closely with the Committee in its work to assure the best possible health care for all American Indians.

**Testimony by Rachel A. Joseph**
**Co-Chairperson of the**
***National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act***

## Before a Joint Hearing of the Senate Committees on Indian Affairs and Health, Education, Labor, and Pensions

**July 14, 2005 – 2:30 PM**
**Room 430, Senate Dirksen Building**

Good afternoon Chairman McCain, Vice Chairman Dorgan, Chairman Enzi, Ranking Member Kennedy and members of both Committees. My name is Rachel A. Joseph. I am Co-Chair of the National Steering Committee for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA) and Chairperson for the Toiyabe Indian Health Program, a consortium of nine Tribes which serves Mono and Inyo Counties in central California. I have served for several years on the Indian Health Service (IHS) National Budget Formulation team representing California and have been elected to represent the East Central California Tribes to the California Area Office Advisory Committee. In these capacities, and others, I have been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Thank you for having this joint hearing and providing me the opportunity to testify in support of S. 1057, a bill to reauthorize the Indian Health Care Improvement Act.

This testimony is also offered on behalf of the National Indian Health Board (NIHB) and the National Congress of American Indians (NCAI). NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives, as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. The NCAI was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments dedicated to preserving, protecting, and promoting the inherent sovereign rights of Indian nations.

The National Steering Committee is pleased that the Senate Reauthorization bill, S. 1057, was introduced early this year and that hearings are being held.

Today, I respectfully request Congress and the Administration to work together to enact the reauthorization of the Indian Health Care Improvement Act and to support the efforts of Indian Affairs Committee Chairman John McCain and Committee Vice Chairman Dorgan in this endeavor. Also, we thank Chairman Enzi and Ranking Member Kennedy for your interest in this legislation. We are committed to working with you to achieve the passage of S. 1057 during **THIS** Congress.

### History of Reauthorization Efforts

This reauthorization effort has been long, difficult and disappointing for us. We believe we also need to be "at the table" with Congress and the Administration as we continue the dialogue on

reauthorization and it is consistent with a meaningful government-to-government relationship. During the last session of Congress Indian Country did not have this level of participation; however, we remain ready to work with the Administration and look forward to it.

In June 1999, the Director of the Indian Health Service (IHS) convened a National Steering Committee (NSC) composed of representatives from Tribal governments and national Indian organizations to provide assistance and advice regarding the reauthorization of the IHCIA. I was elected co-chair of the NSC during the organizing meeting in 1999. Over the course of five months, the National Steering Committee drafted proposed legislation, which was based upon the consensus recommendations developed at Area meetings, four (4) regional consultation meetings held earlier in that year and a national meeting here in Washington, DC. The consensus recommendations formed the foundation upon which the National Steering Committee began to draft proposed legislation to reauthorize the IHCIA. In October 1999, the National Steering Committee forwarded our final proposed bill to the IHS Director, to each authorizing committee in the House and Senate and the President. The House and Senate have introduced legislation based on the tribal bill, but none have passed.

The bill, S. 1057 is a culmination of a bi-partisan, community-based endeavor arising from exemplary tribal coordination and consultation. At the request of the Department of Health and Human Services, Native American leaders drafted changes to this lengthy law, worked out endless compromises and reached consensus on key policy issues. We discussed and agreed to what would contribute to good health and well-being of AI/AN families.

The IHCIA has had a unique legislative history. After passage in 1976, it was amended in 1980, continuing authority for appropriations for the provision of health care services to American Indians and Alaska Natives (AI/AN) through September 30, 1984. Despite majority support in the Congress, under both Democrat and Republican leadership, reauthorization has failed too many times. A reauthorization bill was vetoed in 1984, and twice failed because the Congress could not resolve differences in bills that had passed the House and the Senate. Since passage it has been reauthorized five times. However, the Snyder Act still forms the basis for Indian health care programs' appropriations.

Important pieces of legislation dealing with human needs are reconsidered and amended periodically so programs stay relevant and effective in carrying out the intended purposes of the original law. For example, the elementary and Secondary Education Act of 1965 is reviewed and amended by Congress approximately every five years. Congress enacted the Indian Health Care Improvement Act in 1976 and it has not been reauthorized since 1992.

Congress passed the Indian Health Care Improvement Act (IHCIA) in 1976 with a specific mission: to bring the health status of Native individuals and communities up to the level of other populations. Although Native people still experience significant health disparities and have lower life expectancy than the general population, progress has been made and the enhancements in S. 1057 will facilitate further improvements.

Among the key priorities of IHCIA are:

1. Equivalence: To end disparities, control diseases and environmental hazards, and to provide equivalent basic and specialized medical resources.
2. Quality: To assure quality services and facilities. To facilitate and support provider training and to help Native people become health professionals.

3. Local Control: To allow tribes and urban centers to fill gaps in services and to have more control over health programs to meet local needs.
4. Coordination: To permit the collection of monies from insurance companies, Medicare, Medicaid, Children's Health Insurance Program and other sources.

## Highlight on Key Provisions of S.1057

***Behavioral Health Programs***
Indian Country strongly supports Title VII of S. 1057 authorizing comprehensive behavioral health programs which reflect tribal values and emphasizes collaboration among alcohol and substance abuse programs, social service programs and mental health programs. Title VII addresses all age groups and authorizes specific programs for Indian youth including suicide prevention, substance abuse and family inclusion.

We also need to ensure that the "systems of care" approach to mental health services is available in Indian Country.

The "systems of care" approach means more than just coordinated or comprehensive mental health services. It involves making families and communities partners in the development of behavioral/mental health services, a methodology formally recognized and encouraged by the Substance Abuse and Mental Health Services Administration (SAMHSA). In fact, an existing SAMHSA program, operated in coordination with other federal agencies, provides six-year grants to a number of Indian tribes for the express purpose of developing systems of care for mental health services in Indian communities.

Increased IHS/tribal utilization of Systems of Care methodologies for delivery of mental heath services will help tribes leverage assistance from SAMHSA, the National Institutes of Mental Health and other agencies for services to Indian children. Local evaluations of Systems of Care programs have shown less acute psychiatric hospitalizations and out-of-home placements for adolescents, better school performance and fewer crimes by children in the program. As the recent tragic events on the Red Lake Reservation have demonstrated, we must improve and enhance the effectiveness of mental health services for Indian children.

***Elevation of the Indian Health Service Director***
Tribal leaders have long advocated for "elevation" of the IHS Director to that of an Assistant Secretary. We believe "elevation" is consistent with the government-to-government relationship and the trust responsibility to AI/AN Tribal governments throughout all agencies of the Department of Health and Human Services (HHS). While HHS has made great strides over the past several years to address Tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department and provide greater collaboration with other agencies and programs of the Department concerning matters of Indian health.

The disparities in Indian health indicators compared to the general population requires us to assert that we need to approach our responsibilities differently. Status quo is not acceptable. We believe that "elevation" would be comparable to the administration of the Bureau of Indian Affairs programs by an Assistant Secretary in the Department of Interior and the Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development.

***Bipartisan Commission***

The NSC strongly supported the authorization of an Entitlement Commission to study and make recommendations for the optimal manner in which to provide health care to AI/AN. Indian tribes ceded 400 million acres of land to the United States in exchange for promises of health care and other services, a fact that is reflected in treaties. We believe these documents and actions secured a de-facto contract, which entitles Native peoples to health care in perpetuity and are based on moral, legal and historic obligations of the United States. An Entitlement Commission would provide recommendations to Congress concerning the delivery of health care and other services to Indians, and advise Congress about which should be discretionary or entitlement programs. The NSC recommendation is addressed in S. 1057, Title VIII, Sec. 814, which authorizes a National Bipartisan Commission on Indian Health Care.

***Alaska Dental Health Aide Program (DHA) – A Local Solution to a Crisis***

Alaska has a severe shortage of dentists. Imagine your child has an unbearably painful toothache and the dentist comes to your community just once a year. In fact, the only ways in or out of your village is by boat or airplane; and, the airfare is several hundred dollars.

Tribal and IHS dentists make the care of children's teeth their first priority; thus, an adult may not get an appointment during the dentist's annual visit. This is reality for approximately 85,000 Alaska Natives in rural Alaska. Alaska Natives are fighting an epidemic of dental decay and have implemented the Alaska Dental Health Aide (DHA) program as an effective means of fighting these conditions. DHAs are needed to address shocking rates of oral disease in Alaska; for example, Alaska Natives suffer rates of dental caries 2.5 times the national rate; one-third of rural Alaska school children miss school because of dental pain; one quarter of the children report covering their laughter or smiles because of the way their teeth look. A few more startling statistics are detailed in the chart below.

| American Indian and Alaska Native Children | | |
|---|---|---|
| **Age** | **Have had caries** | **Untreated caries** |
| 2-4 | 79% | 68% |
| 6-14 | 87% | 66% |
| 15-19 | 91% | 68% |

The DHA Program is a local solution to a critical problem and consists of a specialty practice area focused on prevention, relief of pain and infection, and basic restorative services. Dental Health Aides and Therapists provide sorely needed access and continuity of dental care in rural Alaska. The DHA program is authorized under section 121 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1616l.

The American Dental Association has been advocating for the removal of this authorization, arguing that DHAs do not have the training necessary to perform within their scope of practice. It is important to note that DHAs must meet rigorous requirements, which includes training that

requires hands-on practice under a dentist's supervision; continuous education; federal certification; and, ongoing performance evaluations.

DHA therapists receive two years, or 2,400 hours, of classroom training and clinical experience. They spend about 760 hours in a clinic treating children. While in college, they perform more clinical procedures than the average graduate of American dental schools experience.

While DHAs are new to the United States, New Zealand has a 75-year history of success in using dental health paraprofessionals. The World Health Organization shows that dental health aide/therapists now work in 42 countries, including Great Britain and Canada. After Canada started its program, the ratio of teeth pulled to teeth fixed dropped from over 50 percent to less than 10 percent. A study of the Canadian effort compared the work of dental therapists and dentists and found that the quality of restorations by therapists equal that of the dentists.

Significantly, organizations with a profound interest in public health, but no profit motive, support the DHA program. Some of these include the Indian Health Service, under Director Dr. Charles Grim, who is a dentist; the Alaska Department of Health and Social Services, whose Commissioner, Joel Gilbertson, said [DHA] "holds great promise for addressing the profound dental problems of rural Alaskans, and we applaud Congress for giving the program a chance to demonstrate its potential for success" and the American Association of Public Health Dentistry.

America has seen this kind of resistance to mid-level health practitioners and physician extenders for many years. For example, chiropractors fought for more than a decade to provide patient care, unfettered, within their scope of practice, despite vociferous objections by the American Medical Association. That conflict was decided in favor of the chiropractic profession in the Supreme Court decision on *Wilk, et. Al .v. AMA*. Nurse Anesthetists, Osteopathic Physicians, occupational therapists, physical therapists and other health professions have fought, and continue to fight, battles similar to the one the DHAs now face. Today, mid-level medical personnel have proven to be an effective, cost efficient and important part of the health care team. We support the DHAs as part of a health care team.

***Long-Term Care – An Innovation for Indian Country***

Title II, Section 213 provides for the authorization for the Indian Health Service and Tribally-operated health systems to provide long-term health care, assisted living, home health services, hospice, and other related programs. While the life expectancy of American Indians and Alaska Natives is substantially lower than the rest of the general population, the ability to provide health care and related services for the elderly population remains one of the most pressing issues for Indian country. The need to improve and expand services for all stages of the life cycle are desperately needed, however services utilized during the waning years of life are severely lacking in AI/AN communities. If you were to ask American Indians and Alaska Native what services or programs are absent and/or inaccessible in Indian Country, the response you will receive is long-term health care, quality nursing homes, home-health programs, hospice and other similar programs.

***Health & Wellness Foundation***

Title VIII of S. 1057 authorizes the establishment of the Native American Health & Wellness Foundation, which is a new authorization for the Indian Health Care Improvement Act.

The Foundation will be a charitable and non-profit federally chartered corporation. The duties of the Foundation shall be to encourage, accept and administer private gifts of real and personal

property, and any income from or interest in such gifts for the benefit of, or in support of, the Indian Health Service. We see the Foundation as an exciting opportunity to supplement the funding for the HIS; and, we emphasize any funding provided to the IHS by the Foundation should not supplant Federal appropriations to the IHS.

***Centers for Medicare & Medicaid Services (CMS)***
In response to the growing importance to Indian country of programs administered by the Center for Medicare and Medicaid Services (CMS) which includes the S-CHIP program, the National Steering Committee (NSC) for the reauthorization of the IHCIA and Tribes recommended the establishment of a formal consultation body for CMS to assist in the development of CMS Indian policy and regulation. In response to these requests CMS established a Tribal Technical Assistance Group (TTAG).

The TTAG has been active in reviewing the impacts of the recently passed Medicare Modernization Act (MMA). The first round of MMA implementation focused on the Transitional Assistance program which was touted as a "new benefit" for seniors, especially low income seniors. Unfortunately, the roll out was too slow and the program too confusing to have much affect in Indian country. Out of a nationwide projected benefit of $12,000,000, only a little over $1,000,000 was actually collected by IHS and Tribal programs. The implementation of the permanent program (Medicare Advantage and Part D Pharmacy Benefits) is occurring under statute with less Indian specific language than the Transitional Assistance section. Of particular concern going forward is the affect of the MMA on dual eligibles who currently receive their pharmacy coverage through the Medicaid program. Low income elders make up a large portion of the Indian elder population. Like other elders they are confronting confusion of enrolling in a plan and face new co-payments for services. They will also experience the gap in coverage when their costs exceed the $1500 initial coverage limit. These clients will expect their IHS and Tribal Clinics to pay for their pharmaceuticals after they fully utilize their Part D coverage. Sadly, IHS expenditures will not be counted toward the threshold to qualify for catastrophic coverage under Part D. IHS will have to absorb all pharmacy costs for Indian elders up to the **$3600 annual True Out of Pocket costs (TrOOP).**

Of equal concern is the issue of charging Indian clients premiums and co-pays. We recommended that premiums and co-payments should be waived as was done in the State Children's Health Insurance program. Some provisions of the MMA will be helpful to Indian country such as the "capping" of Contract Health Service payments at Medicare rates and reimbursement for hospital emergency treatments provided to undocumented immigrants. These issues and the establishment of the CMS/TTAG is reflective of recognition by both CMS and Tribes of the increasing importance of CMS programs to improving the health of the Indian communities.

## Reauthorization Is Important

***Health Disparities in Indian Country***
Indian Country must have access to modern systems of health care. Since the enactment of the IHCIA in 1976, the health care delivery system in America has evolved and modernized while the AI/AN system of health care has not kept up. Reauthorization of the IHCIA will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. S. 1057 authorizes concepts and methods of health care delivery for AI/AN in the same manner already considered standard practice by "mainstream" America. There is a critical need for health promotion and disease prevention activities in Indian Country and provisions of S. 1057 address

this need. Disease prevention and health promotion activities elevate the health status at both the individual and community level. Indian Country needs flexibility to run its health care delivery systems in a manner comparable to health care systems expected by "mainstream" America.

The Indian Health Care Improvement Act declares it is this Nation's policy to elevate the health status of the American and Alaska Native people to a level at parity with the general U.S. population. No other segment of the American population is more negatively impacted by health disparities than the AI/AN population and our people suffer from disproportionately higher rates of chronic disease and other illnesses.

We have demonstrated that 13 percent of AI/AN deaths occur in those younger than 25 years of age, a rate three times higher than the average US population. The US Commission on Civil Rights reported in 2003 that "American Indian youths are twice as likely to commit suicide...Native Americans are 630 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups."

In addition, according to the Indian Health Service, AI/ANs have a life expectancy six years less than the rest of the US population. Rates of cardiovascular disease among AI/AN are twice the amount for the general public, and continue to increase, while rates for the general public are actually decreasing.

Public health indicators, such as morbidity and mortality data, continue to reflect wide disparities in a number of major health and health-related conditions, such as Diabetes Mellitus, Tuberculosis, alcoholism, homicide, suicide and accidents. These disparities are largely attributable to a serious lack of funding sufficient to advance the level and quality of adequate health services for AI/AN. Recent studies reveal that almost 20 percent fewer AI/AN women receive pre-natal care than all other races and they engage in significantly higher rates of negative personal health behavior, such as smoking and the consumption of alcohol and illegal substances during pregnancy.

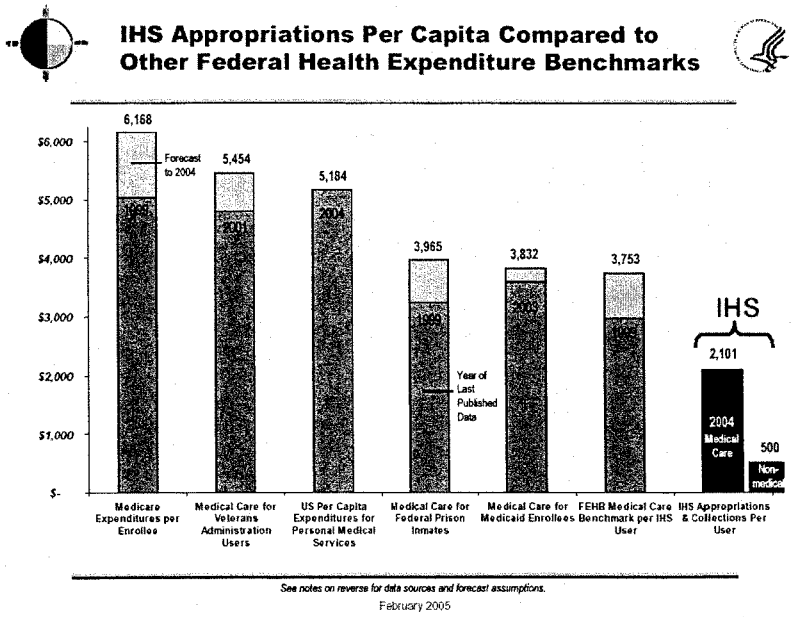
A travesty in the deplorable health conditions of AI/AN is knowing that the vast majority of illnesses and deaths from disease could be prevented if additional funding and contemporary programmatic approaches to health care was available to provide a basic level of care enjoyed by most Americans. It is unfortunate that despite two centuries of treaties and promises, American Indians endure health conditions and a level of health care funding that would be unacceptable to most other U.S. citizens.

## Funding Realities

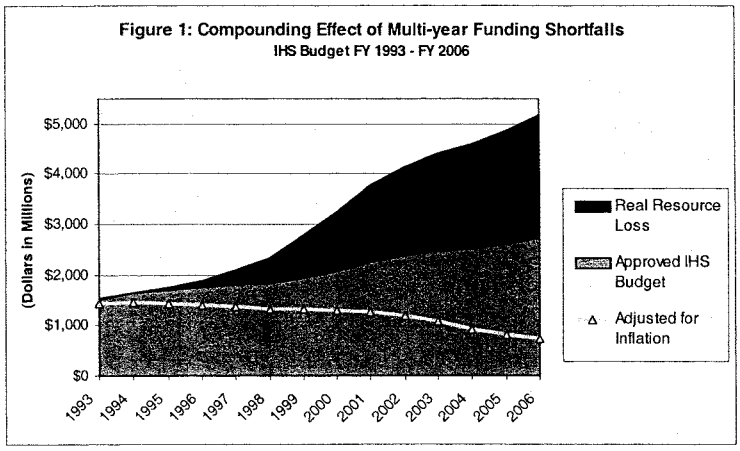
Indian Country continuously advocates for equitable health care programs and funding. Health care spending for AI/AN lags far behind spending for all other segments of society. For example, per capita expenditures for AI/AN beneficiaries receiving services in the IHS are approximately one-half of the per capita expenditures for Medicaid beneficiaries. In fact, the federal government spends nearly twice as much money for a federal prisoner's health care than it does for AI/AN.

When an AI/AN elder requires medical care, they may not receive it, or if they do, it could be at substandard levels.

Funding for the Indian Health Service (IHS) has not kept pace with population increases and inflation. While programs such as Medicare and Medicaid accrue mandatory annual increases to address inflation, the IHS does not receive comparable increases. According to the United States Commission on Civil Rights report entitled "A Quiet Crisis," between 1998 and 2003, industry experts estimate that medical costs grew approximately 10 to 12 percent annually, while IHS funding increases are less than 5 percent annually. Consequently, a large and expanding gap exists between needed and available services, or unmet needs, in Native American communities. The following chart, prepared by the IHS, further demonstrates this standard practice of funding disparities in federally supported health care programs.



The following graph illustrates the diminished purchasing power of the IHS budget over the past fourteen years. The graph demonstrates the compounding effect of multi-year funding shortfalls that have considerably eroded the IHS base budget. In 1993, the IHS health services accounts received $1.52 billion; and, had the accounts received adequate increases for inflation and population growth, that amount would be $5.2 billion today. The Northwest Portland Area Indian Health Board estimates that the IHS budget has lost over $2.46 billion over the last fourteen years.




***Trust Obligations of the Federal Government***

The federal responsibility to provide health services to AI/AN reflects the unique government-to-government relationship that exists between the Tribes and the United States. The importance of this relationship is reflected in the provisions of Article I, § 8, clause 3 of the United States Constitution, which gives the federal government specific authorities in its dealings with Indian Tribes.

Article VI, § (2) of the United States Constitution refers to all treaties entered into under the Authority of the United States as the "Supreme Law of the Land." Treaties between the federal government and our ancestors – negotiated by the United States government in return for the cession of over 400 million acres of Indian lands – created a fiduciary responsibility for the federal government to provide American Indians with health care services and adequate funding for those services. Additional Treaties, Statutes, U.S. Supreme Court decisions and Executive Orders have consistently reaffirmed this Trust responsibility.

The Snyder Act of 1921 has been the foundation for the many federal programs for Tribes instituted since its enactment, including programs targeting Indian health. It authorizes broad authority for Congress to appropriate funds to preserve and improve the health of AI/AN.

Since 1964, three public laws have dramatically changed the delivery of health care to the Tribes. First, the Transfer Act of 1954 removed responsibilities for health care of AI/AN from

the federal Department of the Interior to the, then, Department of Health, Education and Welfare (HEW).

Second, the Indian Self Determination and Education Assistance Act of 1975 changed forever the nature of relationships between Tribal organizations and the federal government and revolutionized the manner in which health services are delivered in Indian country. The Act provided guidance and direction to IHS to enable it to work with Tribes to develop Tribal based health systems in which Tribal organizations are authorized to operate their own health programs.

Approximately half of all appropriations to the IHS fund programs that are operated directly by Tribes administering health care systems offering local, accessible and coordinated services responding to the needs of individual Tribal members. In a 1998 NIHB study "Tribal Perspectives on Indian Self Determination and Self Governance in Health Care Management," 94 percent of the Tribal leaders and health system directors surveyed reported plans to enter into Self Determination or Self Governance agreements with the IHS. Tribally operated systems reported significantly greater gains in the availability of clinical services, community-based programs, auxiliary programs and disease prevention services. In most cases, Tribes contracting or compacting with IHS reported improved and increasingly collaborative relationships with the agency, with both IHS Area Offices and Tribal organizations working together to facilitate the transfer of program management.

Finally, with its comprehensive, far-reaching provisions, the Indian Health Care Improvement Act of 1976 created opportunities for enhancement of services to Tribes through innovative interventions that are responsive to the health needs of the Tribes and their members. Tribes and the IHS have intervened to achieve positive changes under the Act which includes: virtually every component of service delivery; health professions training, recruitment and retention; targeted disease prevention and treatment; funding of health systems; and mechanisms for integrating Tribal systems with federal programs, such as Medicaid and Medicare.

**PART**

We have worked hard over the last six years on the reauthorization of the IHCIA and hope that the 109th Congress will pass this important legislation which authorizes effective programs.

One of the ways to determine the effectiveness of federal programs is the Program Assessment Rating Tool (PART), developed by the Office of Management and Budget (OMB), which is used to evaluate programs and link performance to appropriations. The PART assessments review overall program effectiveness, spanning from how well a program is designed to how well it is implemented and what results are achieved. As such, the PART examines factors that the program or agency may not directly control but may be able to influence. For example, if a PART assessment identifies a statutory provision that impedes effectiveness, the agency may propose legislative changes to fix it. The PART is central to the Administration's Budget and Performance

Integration (BPI) Initiative because it drives a sustained focus on results. To earn a high PART rating, a program must use performance to manage, justify its resource requests based on the performance it expects to achieve, and continually improve efficiency; all goals of the BPI Initiative.

| Year | Program | Avg. Score | Rating |
|---|---|---|---|
| FY 2004 | Federally Administered programs | 78.0% | Moderately Effective |
| FY 2004 | Sanitation Facilities Programs | 84.8% | Moderately Effective |
| FY 2005 | Urban Indian Health | 70.5% | Adequate |
| FY 2005 | Resource & Patient Management System | 86.8% | Effective |
| FY 2006 | Health Care Facilities Construction | 95.8% | Effective |

The Indian Health Service (IHS) and tribes have been active participants in the PART reviews conducted by OMB and embrace the process as a means to provide critical outcome analysis for documenting improvements in the delivery of health care to AI/AN people. Since FY 2004, IHS has had five of its programs reviewed under PART. All of the IHS programs that have been rated under PART have at least an "adequate" rating with an average score of 83.2%. Moreover, the IHS has continually scored better than other agencies within the Department of Health and Human Services under PART. The IHS Health Facilities Construction program has received one of the highest scores in the federal government receiving 100% in three of the four PART categories for a combined score of 95.8%.

| Agency | Avg. Score |
|---|---|
| Indian Health Service | 83.2% |
| Centers for Medicare & Medicaid Services | 78% |
| Health Resource Services Administration | 64% |
| Federal Drug Administration | 58% |
| Depart of Defense* | 55% |
| Centers for Disease Control | 53% |
| Administration for Children & Families | 49% |
| Veterans Administration* | 47% |
| **HHS Total** (not including IHS) | 57.8% |

* Health Care Components only
Source: OMB, available at: www.whitehouse.gov/omb/budget/fy2006/pma/hhs.pdf

The IHS is currently working with Office of Management and Budget on a PART submission for its direct tribally operated health programs. The outcome of that PART review will not be

known until later in the year. However, based on the performance of past IHS submissions, it is anticipated that the direct tribally operated programs will be reviewed favorably by OMB.

While PART reviews are used to justify and substantiate funding requests in the appropriations process, the IHS has used the information to identify opportunities to improve its programs and operations. For example, the urban program is being reviewed by a task force of stakeholders specifically charged by the IHS Director to make recommendations for addressing the specific deficiencies identified by the PART assessment. The other IHS programs assessed under PART are also using the insights gained by the evaluation to make improvements internally.

The available evidence does not support that there are any design flaws associated with programs operating under the IHCIA. The success and effectiveness of IHCIA programs are further supported in the "results" of the PART assessments. From our perspective the IHS programs represent a success story for effectiveness. The IHS PART scores combined with system changes resulting from knowledge gained in the PART process speak to the effectiveness of using government resources to carry out health care services to Indian people. The effectiveness of the IHCIA and its programs are clearly demonstrated in the PART process and substantiates our strong position that reauthorization of the IHCIA should not include any regression from current law.

Again, thank you for providing me this opportunity to present testimony.

# NATIONAL STEERING COMMITTEE FOR THE REAUTHORIZATION of the INDIAN HEALTH CARE IMPROVEMENT ACT

The Honorable Byron Dorgan
Vice Chairman
Senate Committee on Indian Affairs
Washington, DC 20510-6450

September 16, 2005

Dear Vice Chairman Dorgan:

This letter responds to your correspondence of July 25, 2005 with regard to the written questions posed by Senator Patty Murray and Senator Maria Cantwell in follow up to the July 14, 2005 joint hearing on S.1057. We understand that the hearing record is closed at this time; however, we greatly appreciate the opportunity for the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act to share its views on these matters with the Committee.

Response to Senator Cantwell's Questions on the Need for Behavioral Health Services

1. *What tools do we currently have to address the tragedy of youth suicide among the Indian population?*

Culturally specific social marketing campaigns that are aimed at reducing mental health stigma in AI/AN communities through local community-based education and awareness could promote an increase in help-seeking behavior for youth who are experiencing mental health issues which may lead to suicidal thoughts or gestures. Social marketing can also be aimed at community members by providing practical tips for how to provide support and basic intervention to friends or family who may be expressing suicidal thoughts and education on when to call for professional help.

Early identification and outreach to at-risk youth through comprehensive community-based services is critical to addressing youth suicide. A systematic network made up of mental health, education, juvenile justice, child welfare, substance abuse and primary care service providers that provide coordinated and collaborative services in partnership with cultural or informal family supports to the child and the family is often referred to as a "system of care" approach. The key to this approach is that services are adapted to meet the individual needs of the youth and may include a combination of professional/clinical services and culturally-based interventions from the local community depending on the strengths of the individual youth and family (to include extended family and clan relationships). Since 1994 a total of 26 different AI/AN communities [see note below for detailed list] have developed local system of care

models to transform their children's mental health systems through grants and cooperative agreements. In general, these communities appear to have been able to address the issues of youth suicide, and the mental health issues that lead to youth suicide, in a way that provides early intervention, reduces the gaps between service systems and provides community-based follow-up care. Short term federal funding has made an impact in these communities and to varying degrees the efforts to transform the mental health system at the community level has sustained itself beyond the initial grant or cooperative agreement. Institutional support of these principals and practices through IHS behavioral health resources would assure that all AI/AN communities have access to this successful approach, not merely those who can successfully compete for limited funding awards.

Early suicide screening as part of a comprehensive system of care approach may be initiated as a self administered screening, such as the Columbia Teen Screen (www.teenscreen.org) or the National Institute of Mental Heath Diagnostic Interview for Children (NIMH DISC-IV), which can be administered by non-clinical providers. With the exception of any culturally incongruence at a local level, both of these screening tools would be fairly simple to integrate as part of a comprehensive system of care in AI/AN communities. To identify at-risk youth early, the screenings could be provided outside of the mental health system in a school, primary care, juvenile justice, or child welfare agency setting.

*2. How can we involve the community and families in the provision of behavioral health services?*

The AI/AN communities involved in the systems of care initiatives have a great deal of experience and expertise in this very issue of community and family involvement. It plays a primary role in the system of care approach and is also one of the goals mentioned in the President's New Freedom Commission on Mental Health report.

Community members (i.e. elders, clan leaders, traditional healers, concerned citizens, elected officials, business leaders, youth leaders, community advocates, and other service providers) and family members (those who care for, or are related to people who receive behavioral health services) have a unique and highly valuable perspective that can shape and guide the provision of behavioral health services to increase their effectiveness and relevance of services at the community level. In order to provide the community and families with a genuine "voice", their expertise and perspective must be valued by those in IHS that are formally charged with shaping behavioral health. One model of involvement would be the development of local community advisory boards, family advocacy groups and youth advisory groups that would meet regularly and have a level of authority and influence over the development of behavioral health services. This would involve community and family members at the local policy and program level to shape the overall provision of services. In order to maintain accountability of the services provided, involvement would also need to be increased at the direct service level through offering access to community-based advocates that could act on behalf of family members with service providers to ensure that the those receiving services are having their individual needs addressed in a way that is culturally relevant and acceptable. An overall paradigm shift to viewing community and family members as active partners in the planning and provision of behavioral health services, rather than simply the passive recipients of services from professionals is necessary and is imbedded in a system of care approach.

Developing an infrastructure that supports a partnership between formal behavioral health services and the community's culturally based services (i.e. traditional healing, cultural activities, mentorship) in the form of referrals, consultation and a general appreciation and respect of community-based interventions is another key.
Developing the skill, training and professional education of local AI/AN community members into formal behavioral health professions is an additional way of meeting this need. Establishing recruitment and staff development programs similar to the Rural Human Services programs in Alaska, where local community members are provided with training and opportunity along a career path. The concept of "growing your own" will eventually increase the number of AI/AN behavioral health professionals who are more likely to bring an understanding of the local community culture.

Community and family involvement would ideally be included at every level of the IHS behavioral health system, from the national level, to the regional level, to the service unit level, the service program level and service provider level. This could be accomplished by the principles identified above.

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***American Indian/Alaska Native communities that have developed local systems of care approaches for children's mental health:***

Child Mental Health Initiative (funded by SAMHSA Center for Mental Health Services)

1. Navajo Nation – NM (1994-99)
2. Passamaquoddy Tribe – ME (1997-2003)
3. Sacred Child Project – ND (1997-2003)
4. Saulte Ste. Marie Chippewa Tribe – MI (1998-2004)
5. Northern Arapaho Tribe – WY (1998-2004)
6. Oglala Sioux Tribe – SD (1999-2005)
7. Yukon Kuskokwim Health Corp. – AK (1999-2005)
8. United Indian Health Services – CA (2000-2006)
9. Fairbanks Native Association – AK (2002-2008)
10. Choctaw Nation – OK (2002-2008)
11. Urban Trails Project – CA (2003-2009)
12. Between 2-6 additional tribal sites are expected to be announced in September 2005 for funding (2005-2011)

Circles of Care Grant Program 1998-2001 (funded by SAMHSA Center for Mental Health Services)

1. Cheyenne River Sioux Tribe – WY
2. Feather River Tribal Health - CA
3. Shared Vision Project - MT
4. First Nations Community Healthsource – Albuquerque, NM
5. Oglala Sioux Tribe – SD

6. Choctaw Nation of Oklahoma
7. Urban Indian Health Board – Oakland, CA
8. Fairbanks Native Association- AK
9. Inter-Tribal Council of Michigan

Circles of Care II Grant Program 2001-2004 (funded by SAMHSA Center for Mental Health Services)

1. Tlingit and Haida Tribes - AK
2. Pascua Yaqui Tribe - AZ
3. Salt River Pima-Maricopa Indian Community - AZ
4. United American Indian Involvement – Los Angeles, CA
5. Blackfeet Indian Tribe - MT
6. Ute Indian Tribe - UT
7. Puyallup Tribal Health Authority – WA

Mental Health Community Safety Initiative 2003-2006 (funded by IHS Behavioral Health Programs)

1. Lower Elwha Klallam Tribe - WA
2. Nooksack Tribe - WA
3. Oklahoma City Indian Health Clinic Oklahoma City, OK

Circles of Care III Grant Program 2005-2008 (funded by SAMHSA Center for Mental Health Services

- Seven new sites will be announced in September 2005.

Response to Senator Cantwell's Question on the Indian Health Budget (IHS)

The President's FY 2006 budget request for the IHS was $3.8 billion, an increase of $63 million over FY05. This represents an approximate, aggregate increase of 2.1% over FY05. The National Indian Health Board and Tribes across the Country informed Congress that the Indian Health Service and Tribal governments providing health care services cannot begin to provide adequate health care with a 2.1% funding increase, especially considering inflation and an estimated increased user population of 28,000. Funding for the Indian Health Service has not kept pace with population increases and inflation. As Senator Cantwell aptly pointed out, while mandatory programs such as Medicaid and Medicare have accrued annual increases of 5 to 10 percent in order to keep pace with inflation, the IHS has not received these comparable increases. On behalf of Indian Country, NIHB requested that the House and Senate Appropriations Committee increase IHS funding by 10% over the FY05 level of $3.048 billion. In addition, it requested $200 million in new spending for health promotion and disease prevention activities in Indian Country. This brought the total Indian country request to $4,380 million for the Indian Health Service for FY06. As we all now know, the Committees did not meet this request: if they had, it would have been a good start.

When IHS funding does not keep place with inflation, losses in real dollars occur over time; therefore, despite nominal increases in funding, when those increases lie below the rate of inflation a relative loss in funding occurs. As a result, as the real, or actual, cost of providing

health care in Indian Country rises with medical inflation, the funding-below-inflation ensures a true loss in the ability of Indian Country to receive medical care is achieved. It logically follows that increases in American Indian and Alaska Native populations, combined with losses in IHS funding, result in substantial losses in health care buying power. This, in turn, accomplishes the staggering health disparities statistics routinely discussed about Indian Country, including the one Senator Cantwell included in her question in which she pointed out that the life expectancy for Indians living in Washington is approximately 4 years shorter than that of the rest of the population.

Response to Senator Cantwell's Questions on Medicare and Medicaid

1. "TrOOP" problem. It is a correct assessment that the Centers for Medicare and Medicaid Services (CMS) has determined that the value of drugs dispensed to Indian beneficiaries (without cost to the beneficiary) by IHS and tribal pharmacies will not count toward the true out-of-pocket costs, or "TrOOP". We share your dismay about this. Tribes strongly advocated to CMS that the value of these drugs should count toward the "TrOOP"; otherwise, the Indian Medicare beneficiaries served by our pharmacies will never qualify for the catastrophic coverage for which other Medicare beneficiaries can qualify. Unfortunately, our efforts to achieve a more sensible policy outcome at CMS failed and CMS has informed Tribal Leaders that it considers the matter closed. The only recourse Indian Country now has is for Congress to amend the law to expressly direct that drugs dispensed by IHS/tribal pharmacies will count toward "TrOOP."

2. Premiums under Medicare Part D. Senator Cantwell asked about the impact of the Part D premium feature on the Indian health system and its beneficiaries. There are three categories of premiums. First, CMS will pay the premiums for enrollment of "dual eligibles," defined as those Medicare beneficiaries who are enrolled in both Medicare and Medicaid. Second, other low-income beneficiaries can receive some assistance from CMS to pay their premiums. The part not subsidized would have to be paid by either the Indian beneficiary or the IHS/tribal program if he/she is to participate in Part D. Third, any Indian Medicare beneficiary who does not qualify for a full or part subsidy would either have the pay the premium him/herself, or have it paid for him/her by the program. Of course, we do not want any Indian beneficiary to have to pay any premium, as all Indians are entitled to have all health care costs covered by the Federal government. But in order for any person to enjoy the benefits of Part D, he/she must be enrolled in a Part D plan and either pay a premium, or have a premium paid on his/her behalf.

We believe that tribes should be allowed to use their IHS funds to pay premiums for their beneficiaries who do not qualify for full subsidies, but IHS has said there is not sufficient authority for such use of funds. To overcome this problem, we hope Congress will quickly pass S. 1239 that would expressly allow funds appropriated to IHS and other funds to be used for this purpose.

3. Co-pays under Medicare Part D. The Medicare Modernization Act (MMA) requires that every Medicare beneficiary, no matter how poor, must make co-pays for covered drugs.

These copays can be $1-$5, or even more, depending on the beneficiary's income level. IHS and tribal pharmacies do not charge their patients at all. Therefore, these pharmacies will be forced to absorb all co-pays that their beneficiaries would otherwise have to pay. The reimbursement the pharmacy would receive from the Part D Plan would reflect deduction of the applicable co-pay. Not only does this make extra work for all involved, the IHS pharmacy will thus have to subsidize this Medicare program in the amount of the copay.

4. Outreach/education to Indian Medicare beneficiaries. It is correct to say that the Medicare program is very confusing to beneficiaries: both Indian and non-Indian alike! While CMS has been working with IHS and the Tribal Technical Advisory Group to do informational training in Indian Country, the two formal training sessions CMS is sponsoring focus only on Indian health program staff, not on actual beneficiaries. It is the program staff that must do the hard work of finding and educating their Indian beneficiaries at the local level. This is an enormous and labor-intensive task for which our Indian health programs receive no additional funding for staff. We have no confidence that, despite their best efforts, all local programs will have the time and resources to reach all beneficiaries, explain this complex program to them (recall that many Indian elders do not speak English as a first language), and get eligible beneficiaries enrolled by the time this program starts on January 1, 2006.

We fear that Indian health programs will suffer sizeable loss of revenue, especially on their "dual eligibles." On January 1, those beneficiaries lose their Medicaid drug coverage and our pharmacies lose the Medicaid reimbursements they now collect. If all dual eligibles are not enrolled by then in a Part D plan, or the plan in which a beneficiary is enrolled has not admitted the IHS/tribal pharmacy to its network, we will not receive any reimbursement for drugs dispensed to that Indian beneficiary. It is very alarming that the Medicare Part D program, which is intended to help Medicare beneficiaries, will wind up harming the programs that serve *Indian* Medicare beneficiaries.

Response to Senator Murray's Question on IHCIA Prevention Provisions

As you may know, the Indian Health Service operates on a public health model that includes, among other things, programmatic efforts at *preventing* disease and encouraging a healthy lifestyle. It is our hope and objective that S. 1057 will enhance and further prevention efforts. This certainly is one of the goals of Title VII -- Behavioral Health. If you read this title, you will see that it contains a number of provisions aimed at prevention as well as early treatment and intervention.

Another part of the bill that is critical to disease prevention is found in the sanitation facilities provisions of Title III. Safe, potable water and appropriate waste disposal facilities are vital to prevention of diseases associated with contaminated water and inadequate sanitation. All Americans -- *including Indian people* -- are entitled to these measures that are so basic to a quality life. Unfortunately, however, there is a tremendous un-met need in Indian Country.

Title II also has a number of provisions that focus on prevention. See, for example, Sec. 203; 204 (diabetes prevention, treatment); Sec. 206 (research); Sec. 207 (cancer screening); Sec. 209 (epidemiology centers that track disease prevalence and thereby enable programs to respond to

diseases before they become a problem); Sec. 210 (school health education programs); Sec. 212 (prevention of communicable diseases).

Several of these programs are already authorized by current law. The major impediment now to really effective prevention efforts is lack of resources. Even if the IHCIA is amended to enhance prevention program language as set out in S. 1057, this, alone, will not achieve the level of prevention efforts that you and we recognize is needed. Unless Congress supplies more resources for these efforts, the best authorizing language in the world will not achieve the desired goal. **When Congress makes its appropriations decisions, it should keep in mind that *prevention* of disease is far less costly than *treatment* of disease. And a healthy individual has a far higher quality of life. This is what we want for all our Indian people.**

Response to Senator Murray's Question on Native American Veterans and Coordination of Health Benefits with the Indian Health Service

The long history of American Indians and Alaska Natives (AI/AN) serving in the United States Armed Forces should never be forgotten. The high percentage of American Indians and Alaska Natives in the military who have served in combat situations, as compared to the general population, results in AI/AN population with a disproportionately high level of "service-related" health needs, including behavioral health.

The first and obvious answer to addressing the health needs of American Indian and Alaska Native veterans is the need for additional funding to rectify the funding disparities that exist within the Indian Health Service and Veterans Health Administration (VHA). Because so many American Indian and Alaska Native veterans utilize the IHS and VHA services, the lower per capita expenditures for their respective user populations result in a limited level of care for AI/AN veterans. Despite the potential to receive health care from either the IHS or the VHA, AI/AN veterans still have unmet health care needs and suffer from high rates of chronic disease and behavioral health disorders. Despite the challenges that exist in serving the health needs of American Indian and Alaska Native veterans, opportunities to exist to enhance the delivery of health care through increased collaboration between the IHS and VHA that could be supported by Congress.

The IHS and VHA have determined that less than a third of the approximately 220,000 AI/AN veterans nationwide receive health care from VHA. Such numbers would likely increase if VHA facilities and services were located closer to areas with higher AI/AN populations, such as reservations, villages, communities, etc. Another potential barrier is the perception that the VHA will not appreciate, understand or accommodate the cultural needs of American Indians and Alaska Natives. Finally, the criteria for establishing eligibility for VHA services is much more stringent that IHS, which acts as a disincentive to access VHA services.

Over the last two and a half years, the Indian Health Service (IHS) and the Veterans' Health Administration (VHA) have collaborated via a memorandum of understanding (MOU) between the two federal agencies to promote greater cooperation and sharing to improve the health of American Indian and Alaska Native veterans. The collaborative activities of the IHS and VHA would benefit greatly from Congressional support of a task force comprised of AI/AN veterans,

Tribal leadership, federal representatives to conduct roundtables, field hearings, etc. culminating in the issuance of a report documenting the successes, barriers, and needs of the AI/AN veteran. The report would provide clear guidance as to the actions necessary to take care of our AI/AN veterans. Although the IHS/VHA collaboration includes some of these activities, adequate funding and support for such a comprehensive effort is currently not available.

On behalf of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act, thank you for this opportunity to share our views with you on these important questions. We look forward to working with you as we work to achieve reauthorization during this Congress. If you have any questions or would like additional information, please do not hesitate to contact us.

Sincerely,

Rachel A. Joseph
Co-Chair
National Steering Committee

Buford Rolin
Co Chair
National Steering Committee

cc: National Steering Committee, Members
National Indian Health Board, Board

**Submission to the Committee on Indian Affairs and the Committee on Health Education, Labor and Pensions US Senate on S 1057 The Indian Health Care Improvement Act Amendments of 2005.**

**Submitted by Professor Thomas B. Kardos, B.D.S., M.D.S., Ph.D., FFOP(RCPA)**

I, Thomas B. Kardos, am a professor of Oral Biology and Oral Pathology at the University of Otago, Dunedin, New Zealand.

I have a held senior management position in the Faculty when I was the Associate Dean for Academic Affairs in the Faculty of Dentistry. At the end of May this year, when my term ended, I did not seek reappointment. I am currently a member of the University's Committee for the Advancement of Learning and Teaching, the Distance Learning Reference Group and the Senate (academic administrative body of the University). As a registered specialist in oral pathology, and head of the discipline of oral biology, I teach in preclinical sciences across several programmes offered by the Faculty, i.e dentistry (dental students), dental hygiene, dental technology and dental therapy and contribute to the nationwide oral pathology diagnostic service. I am also involved in postgraduate supervison.

I am currently a registered dental practitioner (dentist) having qualified with a Bachelor of Dental Surgery (B.D.S.), and am also a registered oral pathologist, having completed a specialist qualification in Oral Pathology, Master of Dental Surgery (M.D.S.). In addition I have also completed a Doctor of Philosophy degree (Ph.D.) in experimental pathology. I was invited to become a member of the Faculty of Oral Pathology, Royal College of Pathologists Australasia (FFOP(RCPA)).

The teaching of dental hygiene, dental technology and dental therapy are integrated with the teaching of dentistry (dental students) across the Faculty of Dentistry. General dentists and dental specialists bring their expertise to these three programmes, in addition to staff with discipline specific qualifications. Hence students are exposed to a range of academic and clinical teachers. I have contributed to the education and training of Alaskan Dental Health Aide Therapists (DHATs) through classes in two preclinical papers (DAHP 101 and 102 (see attached)) and have chaired both the Board of Studies and Board of Examiners, that meet at least twice year.

The students that have completed the Diploma programme in dental therapy at Otago obtain a qualification that enables them to apply for registration to practice in New Zealand as a dental therapist. As the DHATs complete the same programme as all other students they are competent with clinical techniques and procedures within their scope of practice when they qualify.

I have had the opportunity to read the statement made by the President-Elect of the American Dental Association, Dr Robert M. Brandjord, presented to the Committee on July 14th. The submission identifies several key issues relating to the problem of delivering appropriate oral health care to those residents in the United States where there is a demonstrable need.

In my submission I wish to provide the Senate Committee with a background to the dental therapy programme offered at New Zealand's University of Otago and address,
a) the argument that attempts to relate the length of an academic programme to its quality,
b) the need to make the distinction between qualification (competence to practice) and registration or licensure (ability to practice within a community e.g. country or state and assurance of continuing competence), and
c) the need to recognize the invasive nature of preventable dental diseases and the costs to a community that can result from failure to intercept the progression of these diseases to involve the whole body and their impact on health.

Several attachments are included.
i) Letter from the Dental Council of New Zealand chairman, Dr Brent Stanely
ii) Scope of Practice for Dental Therapy
iii) Code of Practice for Dental Therapy
iv) Dental Hygiene - Dental Therapy Accreditation Protocol
v) Synopsis of papers offered for the Diploma in Dental Therapy
vi) Professional degree curricula - Harvard School of Dental Medicine and University of Alabama School of Dentistry.

**Background**

The University of Otago is internationally recognized for the calibre and quality of its graduates and research undertaken. Under the New Zealand Education Act 1989, Part 14, section 162, universities have all of the following characteristics:

(i) They are primarily concerned with more advanced learning, the principal aim being to develop intellectual independence:
(ii) Their research and teaching are closely interdependent and most of their teaching is done by people who are active in advancing knowledge:
(iii) They meet international standards of research and teaching:
(iv) They are a repository of knowledge and expertise:
(v) They accept a role as critic and conscience of society.

The University of Otago is the only provider of integrated dental education in New Zealand and places emphasis on the team approach to the delivery of oral health care (dentistry). The oral health team includes dentists, dental specialists in one of twelve disciplines, dental hygienists, dental technologists, dental therapists and dental assistants.
The Faculty can meet the requirements of professional education in dentistry as it has the experience and also the quality of clinical and preclinical staff to deliver appropriate and relevant academic content in a research-based environment. The integrated evidence-based programmes we offer are be able to meet the dental/oral health needs of various communities in NZ, and also internationally. As part of this our academic programmes provide new educational opportunities and clinical services for indigenous Maori, and Pacific Island Polynesian communities.

Graduates in Dentistry from New Zealand can practice throughout the world, although many countries require completion of a registration examination. All programmes currently offered in the Faculty of Dentistry have been accredited by the Dental Council of New Zealand. The review process includes benchmarking with Australia. (I understand, from our new Dean, that plans to introduce reciprocal accreditation of all undergraduate qualifications in dentistry (including dental therapy) with Australia, Canada and the United States of America are in progress.) The Faculty also offers programmes in continuing education and postgraduate education, including a postgraduate diploma in dental therapy.

Dental therapists are part of the oral health team in 40 countries throughout the world. In New Zealand, dental therapy is a profession that is a continuation of the School Dental Service that was introduced nearly 85 years ago. Nationally and internationally it has been shown that the dental therapist can provide a safe standard of oral health care as an extension to that of a dentist, without the potential complications arising from "*irreversible procedures*" eluded to in the ADA statement. In New Zealand there are about 600 dental therapists who are responsible for the care of approximately 850,000 patients (2003), in a population of close to 4 million. Despite this, and a workforce of 1700 dentists, the oral health needs of the community are not being met. In the absence of dental therapists the level of health, including oral health, in the country would be significantly compromised. Dental therapists have been in New Zealand for such a long time that there are few published studies addressing performance issues. The model has been exported to a wide range of countries

including Australia and Great Britain where these oral health professionals (along with dental hygienists) are called dental auxiliaries.

*a) the argument that attempts to relate the length of an academic programme to its quality,*

**Programmes**
The Faculty of Dentistry, at the University of Otago, offers the following undergraduate degrees, in addition to a range of postgraduate diplomas and degrees:
a) Bachelor of Dental Surgery, (BDS) the qualifying degree for dentists and encompasses five years of education and training, four years of which are in clinical disciplines. (In some countries, including the United States, this qualifying degree is a postgraduate programme, hence the reference by the ADA to an "eight-year programme" for dentists. The period engaged clinical activities to qualify equivalent to a BDS varies internationally, US published programmes are usually of three (Harvard School of Dental Medicine) or four years (University of Alabama School of Dentistry) duration. (See attached).
b) Bachelor of Health Sciences (endorsed in dental hygiene or dental therapy), and
c) Bachelor of Dental Technology.
ALL degree graduates complete a research project as part of their programme requirements, usually undertaken in their final year.

In addition the Faculty currently offers two-year undergraduate diploma qualifications in dental hygiene and dental therapy. These students complete a course of comprehensive clinical education and training, but are not expected to demonstrate the depth of understanding of the scientific basis of clinical practice as is expected of degree students, nor do they complete a research project. The diploma programme for dental therapists provides many more hours of clinical experience than that of a "typical" dental graduate. (See attached paper schedules). Students are required to complete prescribed papers that have a "points" value, in general the number of points equates with the number of hours of formal tuition in that paper per week. Formal tuition occurs over the academic year (two semesters each of 15 weeks duration) and their focussed course prepares them to be part of the oral health team, enhancing the efficiency and productivity of dentists at the same time as recognising the limitations of their scope of clinical practice. The programmes are accredited by the Dental Council of New Zealand, an agency independent of the University. The Dental Council has responsibility for the registration of all oral health practitioners. The statement that *"there is no independent verification of the competency for DHATs"* dental therapists (p 10) is not true.

All programmes offered by the University of Otago operate under the Health Practitioner's Competence Assurance Act, (2003) which has patient safety as a prime concern and requires registration and continuing professional education of all health professionals.

The submission presented by the ADA has identified papers offered in the diploma course, (p13) and compared this with what is described as a partial listing that *"schools must teach"*. The comparison is deliberately misleading as the content of each of the six papers listed for the diploma has not been included. (See attached) Furthermore no effort appears to have been made to determine competence of dental

therapists (in New Zealand or elsewhere in the world) nor the robustness of the programme offered at the University of Otago.

*b) the need to make the distinction between qualification (competence to practice) and registration or licensure (ability to practice within a community e.g. country or state and assurance of continuing competence),*

**Registration of Oral Health Professionals**
In 2004 the Health Practitioners' Competence Assurance Act (2003) came into effect. This legislation provides registration and competency requirements for Health Professionals, including those in Oral Health. The Act requires oral health practitioners to be responsible for their practice, participate in continuing professional development and to be able to demonstrate competence within their prescribed Scope of Practice. In addition Codes of Practice have also been developed in order to define professional relationships.

The Scope and Code of Practice for dental therapy are attached. (See attachments).

The legislation in New Zealand currently permits dental therapists to carry out a range of procedures on patients from six months of age right through to eighteen years of age. Their scope of practice requires compliance with a range of Codes and Acts (e.g. Health Information Privacy Code, Health and Disability Commissioner Act 1994, NZDTA Code of ethics and codes of practice). Dental therapists have an essential understanding of many of the principles that underlie oral health care and clinical treatment. Furthermore many of the diagnostic and clinical skills of the dental therapist are universal i.e. are not limited by the age of a patient. The scope of practice makes provision for the treatment of adult patients, BUT ONLY following the completion of additional education and training. It is noteworthy that it has been reported that in some communities paediatricians in the United States now receive training in the delivery of oral health care (Lewis, et al. 2000, Pediatrics **106**; E84). Dental therapists are able to provide oral health care, including undertaking procedures such as fillings and extractions, along with health promotion and education.

*c) the need to recognize the invasive nature of preventable dental diseases and the costs to a community that can result from failure to intercept the progression of these diseases to involve the whole body and their impact on health.*

**Dental Diseases**

Two preventable dental diseases are dental caries and gingivitis/ periodontitis. Dental caries may be defined as a localized loss of mineral from the tooth and can involve any of the dental tissues, enamel, dentine (dentin) or cementum. Under acidic conditions free protons, (hydrogen ions) produced from bacterial metabolism react with the mineral and bring about localised dissolution of the mineral. While the process is in the early stages and confined to dental enamel, caries is reversible, but with time the loss of mineral is such that a "cavity" forms. Prior to a cavity forming the process may be reversed by clinical intervention and the integrity of the tooth

preserved. For an oral health professional the prevention of "cavity" formation is a high priority.

Once a "cavity" has formed the integrity of the tooth cannot be restored without "drilling and filling" removal of the decayed tissue and replacement with a filling material. Initially the cavity is small but rapidly increases in size and results in destruction of the tooth tissue. Without clinical intervention the carious process will involve the dental pulp or the "nerve" of the tooth. PAIN is the principal presenting clinical symptom, usually a throbbing pain that is difficult to control with analgesics. If not intercepted the progression of dental caries is such that extraction is necessary. With pulpal involvement the bacteria can enter the blood stream and spread throughout the body in addition to giving rise to localised damage. When a localized abscess forms and bursts the dental pain is relieved, to some extent, but as the infection persists further tissue damage occurs. This may be localised e.g. osteomyelitis, or more generalised e.g. bacteraemia resulting in significant loss of health for the individual concerned and requiring expensive and often extensive medical intervention and treatment.

Gingivitis and periodontitis occur due the bacteria in the mouth breaking down the junction between the hard tissues of the tooth and the "gums". This junction is delicate and somewhat similar to that between a fingernail and the adjacent tissues in the region of the "quick", but more vulnerable to damage. Although the bacteria are different to those associated with caries, they also can enter the blood stream and the adjacent bone once the integrity of the junction has been lost. Loss of the supporting tissues also leads to loss of the tooth, usually requiring extraction.

Early intervention can stop the progress of these two rampant dental diseases. The challenge in NZ in the early 1900's was to find a mechanism by which a at risk group of patients, i.e. children, could be seen and their health, in particular their oral health status assessed and the diseases process (where present) arrested, usually through treatment (placement of fillings, or where necessary the extraction of teeth). A period of 6 month recalls was put in place and the health status of the community improved dramatically - through the services of the therapists (previously called school dental nurses).

The oral health status of a child can change dramatically over a year, even 6 months. Hence for any person or community regular monitoring of oral health status is essential. Some ninety years ago, in NZ, the importance of oral health and its contribution to general health was recognised and it was realised that there are simply not enough dentists to carry out this essential function, hence the introduction of dental therapists. In an ideal world, when caries and periodontal disease are controlled in a community, the dental therapists (and dental hygienists) would be involved with health promotion and education, prophylaxis and the application of topical agents to reverse early enamel caries. Regrettably, in New Zealand and in many countries throughout the world this state does not exist. Dental caries remains a major health problem. Even with comprehensive programmes of education large numbers of the population present with dental pain, arising from caries, and require treatment.

In a press release 24th Feb 2004, the World Health Organization identified that oral diseases such as dental caries and periodontitis are a global health problem in both

industrialized and developing countries. It was suggested that oral health systems need to be oriented to primary health care and prevention. (http://www.who.int/mediacentre/news/releases/2004/pr15/en/)

It is my opinion that the New Zealand experience has shown that utilization of the dental therapists, as part of the oral health team has gone a long way towards reducing inequalities in oral health in the community. They work in partnership with the dental profession (dentists). As individuals their performance (as with all health practitioners in New Zealand, under the Health Practitioners' Competence Assurance Act) is under regular review in order to ensure patient safety.

21 July 2005

DCNZ
Dental Council
of New Zealand
Te Kaunihera Tiaki
Niho o Aotearoa

Dr Tom Kardos
Department of Oral Sciences
School of Dentistry
University of Otago
P O Box 647
DUNEDIN

Dear Tom

**Re: Dental Therapy Practice**

I understand that you have been asked to submit written testimony on the issue of dental therapy practice and training to the US Senate Committees of Indian Affairs and Health, Education, Labour and Pensions on S.1057 The Indian Health Care Improvement Act Amendments of 2005. You have asked for the Dental Council of New Zealand's comments on this issue.

We would make the following observations:

- Dental therapists are an integral and valued part of New Zealand's public health dentistry system providing basic oral health care, including irreversible procedures, within the attached well defined scope of practice to children and adolescents up to age 18. It is illegal for dental therapists to practise outside their registered scope of practice.

- Dental therapists can practice independently for the care of children and adolescents up to age 18 years. Although the practice of dental therapy does not require the physical presence of a dentist, a team approach is in place. To protect the health and safety of members of the public a professional relationship must exist between dental therapists and dentists for access to clinical advice and prescription medicines and to enable dental therapists to take radiographs. This consultative professional relationship must be supported by a written professional agreement between a dental therapist and dentist/s. Further detail is contained in the attached Code of Practice on The Professional Relationships Associated with the Practice of Dental Therapy

- Since 18 September 2004 and the introduction of the Health Practitioners Competence Assurance (HPCA) legislation dental therapy has become a regulated (licensed) profession falling within the ambit of the Dental Council of New Zealand (which is also responsible for regulating the professions of dentistry, dental hygiene and dental technology)

- There are currently 639 dental therapists, 1701 dentists and dental specialists, 390 dental hygienists and 338 clinical dental technicians registered and practising in New Zealand.

- The HPCA requires all New Zealand qualifications, which are prescribed for registration as a health practitioner to be accredited and monitored. As such the

dental therapy training programmes at the two New Zealand universities which provide this training were subjected to a rigorous accreditation process and were subsequently approved by the Dental Council as prescribed qualifications for dental therapy registration. Details of the accreditation requirements and standards (which are joint standards with Australia) are attached.

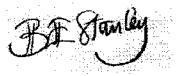
- Currently there are 16 dental therapists registered to provide dental therapy services (within the boundaries of the attached dental therapy scope of practice) to adults in a team situation with clinical guidance provided by a dentist. Prior to the passage of the HPCA these dental therapists were providing care to adults under supervision in hospital dental departments and iwi (tribal) settings. To accommodate those already working in this area the Dental Council 'grandparented' them into this additional scope of adult dental therapy practice. The prescribed qualification for registration in this additional scope of practice is now a Dental Council accredited qualification in adult dental therapy care. To date no such qualification has been submitted to the Dental Council for accreditation as a prescribed qualification.

- Applicants for dental therapy registration in New Zealand who hold other than a prescribed (accredited) qualification for registration must sit and pass a rigorous registration examination process (written examinations of 6 hours and clinical examinations over 4 days).

- As a regulated profession high standards of education, continuing professional development and accountability apply to dental therapy. Like dentists, dental therapists are subject to continuing competency requirements (continuing professional development, peer group learning activities and compliance with Dental Council Codes of Practice) as well as formal complaints and disciplinary processes. Since the Dental Council has assumed responsibility for the regulation of dental therapists on 18 September 2004 two complaints from members of the public have been received, neither of which reached the threshold for either a competence review or disciplinary action.

In conclusion, dental therapists in this country are well-trained and integral members of the dental team and are highly valued by the public. The dental therapy model works well in the New Zealand context, within the context of the quality assurance and accountability mechanisms described above. For information we would note that dental therapists are also used widely in Australia and Trans Tasman legislation conveys mutual recognition of registration between Australia and New Zealand. We have only commented on the New Zealand situation and would not presume to comment on the applicability of this model to other jurisdictions.

Yours sincerely



Brent Stanley
Chair
DENTAL COUNCIL OF NEW ZEALAND

DCNZ

Dental Council of New Zealand
Te Kaunihera Tiaki Niho o Aotearoa

# Dental Council of New Zealand

**Health Practitioners Competence Assurance Act 2003**

## Notice of Scopes of Practice and Prescribed Qualifications

ISSUED BY THE DENTAL COUNCIL PURSUANT TO SECTIONS 11 AND 12 OF THE HEALTH PRACTITIONERS COMPETENCE ASSURANCE ACT 2003

## Dental Therapists

### Scope of General Dental Therapy Practice

The scope of practice for dental therapists is set out in the documented "Detailed Scope of General Dental Therapy Practice" produced and published from time to time by the Dental Council of New Zealand.

Dental therapy practice is a subset of the practice of dentistry, and is commensurate with a dental therapist's approved education, training and competence.

Dental therapists provide oral health assessment, treatment, management and prevention services for children and adolescents up to age 18. Disease prevention and oral health promotion and maintenance are core activities.

Dental therapists and dentists have a consultative working relationship, which is documented in an agreement between the parties.

### Detailed Scope of Practice for General Dental Therapy Practice

The Dental Council of New Zealand defines the practice of dentistry as the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

Dental therapy practice is a subset of the practice of dentistry, and is commensurate with a dental therapist's approved education, training and competence.

Dental therapists and dentists have a consultative working relationship, which is documented in an agreement between the parties.

In collaboration with dentists and other health care professionals, and in partnership with individuals, whanau and communities, dental therapists provide oral health assessment, treatment, management and prevention services for children and adolescents up to age 18. Disease prevention and oral health promotion and maintenance are core activities.

Dental therapy practice involves:

- Obtaining medical histories and consulting with other health practitioners as appropriate
- Examination of oral tissues, diagnosis of dental caries and recognition of abnormalities
- Preparation of an oral care plan
- Informed consent procedures

- Administration of local anaesthetic using dentoalveolar infiltration, inferior dental nerve block and topical local anaesthetic techniques
- Preparation of cavities and restoration of primary and permanent teeth using direct placement of appropriate dental materials.
- Extraction of primary teeth
- Pulp capping in primary and permanent teeth
- Preventive dentistry including cleaning, polishing and scaling (to remove deposits in association with gingivitis), fissure sealants, and fluoride applications
- Oral health education and promotion.
- Referral as necessary to the appropriate practitioner/agency

Dental therapy practice includes teaching, research and management given that such roles influence clinical practice and public safety.

**Prescribed Qualifications**

- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution) and approved experience in the provision of dental therapy services within the scope of dental therapy practice; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago; or
- Bachelor of Health Science (Oral Health), Auckland University of Technology; or
- Undergraduate dental therapy degree or diploma from an Australian Dental Council accredited educational programme; or
- Undergraduate dental therapy degree or diploma, or a undergraduate dental degree; and a pass in the DCNZ Dental Therapy Registration Examination.

## ADDITIONAL SCOPES OF PRACTICE FOR DENTAL THERAPY PRACTICE

### Scope for Pulpotomies in Dental Therapy Practice

Performing pulpotomies on primary teeth.

**Prescribed Qualifications**

- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; and evidence of successful completion of the University of Otago training module in pulpotomies; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and evidence of successful completion of the University of Otago training module in pulpotomies; or
- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Science (Oral Health), Auckland University of Technology and registration in the Scope of General Dental Therapy practice.

### Scope for Radiography in Dental Therapy Practice

Taking periapical and bitewing radiographs[1].

**Prescribed Qualifications**

- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; and an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04; or
- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice and evidence of successful completion of one of the following radiography training courses:
  - Radiography for Dental Therapists, Canterbury District Health Board
  - Dental Radiography Training Programme, Auckland Regional Dental Service

[1] The Radiation Protection Act 1965 requires non-licensed persons who take x-rays to do so under the supervision or instructions of a person who holds a license under that Act.

- Dental Radiography Training Module, Waikato District Health Board
- Dental Radiography Training Module, Otago District Health Board
- Dental Radiography Course, Hutt Valley District Health Board
- Dental Radiography Course, Department of Health
- Dental Radiography Course, Massey
- Radiography for Dental Therapists, Wellington Polytechnic; or

- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04; or

- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and evidence of successful completion of one of the following radiography training courses:

  - Radiography for Dental Therapists, Canterbury District Health Board
  - Dental Radiography Training Course, Auckland Regional Dental Service
  - Dental Radiography Training Module, Waikato District Health Board
  - Dental Radiography Training Module, Otago District Health Board
  - Dental Radiography Course, Hutt Valley District Health Board
  - Dental Radiography Course, Department of Health
  - Dental Radiography Course, Massey
  - Radiography for Dental Therapists, Wellington Polytechnic; or

- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or

- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago and registration in the Scope of General Dental Therapy practice; or

- Bachelor of Health Science (Oral Health), Auckland University of Technology and registration in the Scope of General Dental Therapy practice.

## Scope for Diagnostic Radiography in Dental Therapy Practice

Taking and interpreting periapical and bitewing radiographs[2].

**Prescribed Qualifications**

- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; evidence of successful completion of a radiography training course or an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04; and approved experience in interpreting periapical and bitewing radiographs under the direction and supervision of a dentist who can attest to competency; or

[2] The Radiation Protection Act 1965 requires non-licensed persons who take x-rays to do so under the supervision or instructions of a person who holds a license under that Act.

- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; evidence of successful completion of a radiography training course or an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04 and approved experience in interpreting periapical and bitewing radiographs under the direction and supervision of a dentist who can attest to competency; or
- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago) and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Science (Oral Health), Auckland University of Technology and registration in the Scope of General Dental Therapy practice.

## Scope for Stainless Steel Crowns in Dental Therapy Practice

Preparing teeth for, and placing stainless steel crowns on primary teeth.

**Prescribed Qualifications**

- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; and evidence of successful completion of the University of Otago or AUT training module in stainless steel crowns; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and evidence of successful completion of the University of Otago or AUT training module in stainless steel crowns; or
- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Science (Oral Health), Auckland University of Technology and registration in the Scope of General Dental Therapy practice.

## Scope for Adult Care in Dental Therapy Practice

Providing care to adult patients within the general dental therapy scope of practice (and/or any additional scope) in a team situation with clinical guidance[3] provided by a practising dentist/s.

**Prescribed Qualifications**

- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and a DCNZ accredited qualification in adult dental therapy practice[4]; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and a DCNZ accredited qualification in adult dental therapy practice[4]; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago; registration in the Scope of General Dental Therapy practice and a DCNZ accredited qualification in adult dental therapy practice[4]; or
- Bachelor of Health Science (Oral Health), Auckland University of Technology; registration in the Scope of General Dental Therapy practice and a DCNZ accredited qualification in adult dental therapy[4].

***For applications received before 19/9/04***

- Certificate in Dental Therapy (issued by the Department of Health or a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under the direction and supervision of a dentist, who can attest to competency; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under the direction and supervision of a dentist, who can attest to competency; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago; registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under direction and supervision of a dentist, who can attest to competency; or
- Bachelor of Health Science (Oral Health), Auckland University of Technology; registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under the direction and supervision of a dentist, who can attest to competency.

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[3] Clinical guidance means the professional support and assistance provided to a dental therapist by a practising dentist or dental specialist as part of the provision of overall integrated care to the adult patient group. Dental therapists and dentists/specialists normally work from the same premises providing a team approach. Clinical guidance may be provided at a distance but appropriate access must be available to ensure that the dentist or specialist is able to provide guidance and advice, when required and maintain general oversight of the clinical care outcomes of the adult patient group.

[4] Currently no training programmes have been accredited.

DCNZ

Dental Council
of New Zealand
Te Kaunihera Tiaki
Niho o Aotearoa

Code of Practice

# The Professional Relationships Associated with the Practice of Dental Therapy

Approved by DCNZ August 2004

## 1 Introduction

The Dental Council of New Zealand defines the practice of dentistry as the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

Dental therapy practice is a subset of the practice of dentistry, and is commensurate with a dental therapist's approved education, training and competence. The scope of practice of dental therapy is described by the Dental Council of New Zealand pursuant to s11 of the Health Practitioners Competence Assurance Act (2003) and is included in this code of practice in Appendix 1.

This code of practice aims to protect the health and safety of members of the public by describing the professional relationship that must exist between dental therapists and dentists in the practice of dental therapy in New Zealand.

## 2 Practice of dental therapy for children and adolescents up to age 18 years

Dental therapists can practice independently for the care of children and adolescents up to age 18 years within the scopes of practice described for dental therapy. The practice of dental therapy does not require the physical presence of a dentist or other health practitioner.

Dental therapists and dentists have a consultative working relationship that is supported by a written professional agreement between a dental therapist and a dentist or dentists.

### 2.1 Responsibility of dental therapists

Dental therapists assess, plan and provide dental care within the boundaries of their education, training and competence. They are responsible for ensuring the patient and caregiver is provided with access to sufficient information to make an informed choice about treatment and to provide informed consent. Decisions and actions taken independently by dental therapists are their personal responsibility. Accountability for the standard of decisions and care undertaken independently remains with the dental therapist.

#### *2.1.1 Timely advice*

Dental therapists are responsible for seeking additional professional advice when the assessment, planning or provision of dental care extends beyond their knowledge or skills. Dental therapists have a duty of care to recognise the need to seek additional professional advice and to seek advice in a timely manner.

The primary source of additional professional advice will be the dentist/s with whom each dental therapist has a professional agreement. However, this relationship does not preclude dental therapists from seeking additional professional advice from other health practitioners where appropriate or necessary. Dental therapists must ensure they keep accurate records of the advice sought and obtained.

It is not possible or appropriate to describe an exhaustive list of situations that will require dental therapists to seek timely advice from a dentist. However, examples may include:

1. Interpretation of medical histories, including cardiac malformations and decisions regarding the need for antibiotic prophylaxis, histories of bleeding disorders, or the presence of medical conditions that may lead to immunosuppression.
2. Information or clinical support to assist in the assessment or management of unusual disease activity or presentations. Timely advice may include treatment options outside of the scope of practice of dental therapy to assist in the provision of informed consent, information about preventive therapies to control disease, or clinical guidance with care planning when extensive restorative care and/or extractions may be required

3. Information to assist in the management of patients with disabilities including information about the disability and its implications for dental care or patient management.
4. Information to assist in the management of active dental disease including pulpal pathology or periodontal disease.
5. Interpretation of dental radiographs.
6. Information to assist in the assessment and management of dental anomalies, missing teeth, supernumerary teeth or developing malocclusions.

While dental therapy education and training equips dental therapists to identify these circumstances, decisions regarding appropriate patient management may require additional advice from a dentist, and may require further information to be sought from other health practitioners.

Dental therapists must ensure that they have discussed their practice with the dentist/s from whom they will seek professional support and advice, and dental therapists and dentists entering into a professional agreement must ensure that their professional opinions and standards are consistent.

#### *2.1.2 Referral*

Dental therapists must refer patients requiring care beyond their scope of practice, and patients unable to be managed within their practice, to a dentist or to another health practitioner. It is the responsibility of the dental therapist to recognise the need to refer a patient's care and to ensure that the referral is appropriately documented. The dental therapist must ensure that the patient and/or their guardian are aware of the need to seek additional care from a dentist, dental specialist or other health practitioner.

Referral of patient care does not have to be made to the dentist/s with whom the dental therapist has a professional agreement. Dental therapists and dentists must remain aware of the requirements of the HDC Code of Health and Disability Services Consumers' Rights Regulation 1996, and in particular Right 7 (8), which provides for patients to express a preference as to who will provide services and to have that preference met where practicable.

However, the professional agreement must document an understanding of the management of referrals by the dental therapist.

### 2.2 Responsibility of dentists

Dentists providing professional advice to dental therapists through a formal professional agreement must be prepared to work collegially and collaboratively in the provision of patient care and be able to provide dental therapists with timely and accurate advice appropriate to the practising environment.

Other dentists providing professional advice, information or opinions have a duty of care to ensure that the advice is accurate and appropriate. Dentists will be responsible for the advice and information they provide.

The dental therapist and the dentist may hold joint accountability for the standard of decisions and care undertaken by a dental therapist after seeking professional advice about the assessment, planning and/or provision of dental care for individual patients or groups of patients.

#### *2.2.1 Knowledge and skills appropriate to the clinical environment*

Dentists providing professional advice to individual dental therapists, or groups of dental therapists in small practice environments such as private practice, iwi or community health settings must ensure they have an appropriate understanding of the knowledge, skills and experience of the dental therapists with whom they are working and of the practice of dental therapy in a practice-based environment.

Dentists providing professional advice to large groups of dental therapists in a public health environment, such as the school dental service, must have sufficient skill and experience to be able to provide timely and accurate advice appropriate to the environment of a public health programme. This skill and experience should include knowledge of the principles of public health, the practice of paediatric dentistry, and the practice of dental therapy within a community-based programme.

Dentists must be familiar with the scopes of practice for dental therapy, relevant codes of practice and particularly the requirements of this code of practice.

#### *2.2.2 Timely advice*

Dentists providing professional advice should be available to speak to the dental therapist seeking advice on the same working day as the advice is sought. Collective professional support, provided by a group of dentists, should ensure that continuous professional support remains available throughout periods of absence of one or more of the dentists. If this is not possible, arrangements must be made to cover periods of absence with another dentist and this arrangement must be agreed with the dental therapist. Dentists providing professional support individually must make arrangements to cover periods of absence with another dentist and agree this arrangement with the dental therapist. Dentists must ensure they keep accurate records of the advice given.

#### *2.2.3 General dentists and dental specialists*

Dentists can provide professional support individually or collectively and both general dentists and dental specialists can provide professional support to dental therapists through a written professional agreement. Dental therapists engaged in general dental therapy practice will require professional support from a dentist or dentists that are competent in the full scope of general dentistry.

Dental specialists may be registered either in general dentistry and dental specialty scopes of practice, or in the scope of practice of their dental specialty only. Dental specialists must only provide professional support within their own scope(s) of practice.

For example an orthodontist registered in the scope of practice of orthodontics, but not general dentistry, could not provide a professional agreement to cover the full scope of practice of a dental therapist. The dental therapist would require an additional dentist or dental specialist registered in the general dentistry scope of practice to be a party to the professional agreement.

## 3 Adult dental care

Dental therapists undertaking dental care for adult patients (all patients aged 18 years and over) must be registered with the Dental Council of New Zealand for the scope of practice adult dental care in dental therapy practice. The requirements for registration in this scope of practice are outlined in this code of practice in Appendix 1. This scope of practice is additional to and separate from the scope of practice for general dental therapy practice.

Dental therapists participating in adult patient care must do so in a team situation with clinical guidance provided by a practising dentist/s. Clinical guidance means the professional support and assistance provided to a dental therapist by a practising dentist or dental specialist as part of the provision of overall integrated care to the adult patient group. Dental therapists undertaking adult dental care must document a professional agreement with the dentist/s providing clinical guidance and general oversight of the clinical care outcomes of the adult patient group.

While dental therapists and dentists engaged in a team approach to the provision of dental care for adults normally work from the same premises, the practice of dental therapy does not require the physical presence a dentist or other health practitioner. Clinical guidance may be provided at a distance, but appropriate access must be available to ensure that a dentist is able to provide guidance, timely advice, and to maintain general oversight of the clinical care outcomes of the adult patient group.

Oversight is defined within the Health Practitioners Competence Assurance Act 2003 as professional support provided to a health practitioner by a professional peer for the purposes of professional development. In the context of adult dental care in dental therapy practice, a registered dentist must provide general oversight of the dental therapist's practice.

Dental therapists with an adult scope of practice may take responsibility for tasks within the assessment, planning or treatment of adult patients, provided those tasks remain within the education, training and competence of a dental therapist and within the general dental therapy scope of practice and /or additional scopes.

Dental therapist responsibility for adult dental care will vary depending upon the practising circumstances of the dentist/s and dental therapist, and the patient group under care. In circumstances where the dentist and dental therapist practice from the same physical location and are frequently practising together the dentist may undertake the assessment and planning of care, and delegate specific items of care to be managed by the dental therapist.

Alternatively, when a dental therapist undertakes examinations for patients between periodic assessments by a dentist, or when a dental therapist undertakes care for adult patients in a community-based clinic that is remote from the dentist, the dental therapist may take responsibility for the assessment and planning of care within the education, training and competence of the dental therapist, and for the provision of items of care within the scopes of practice of dental therapy. An arrangement of this nature would require that all conditions outside the education, training and competence of the dental therapist are referred for assessment, and if necessary management, by a dentist.

Delegations of responsibility may be made in the professional agreement or delegations may be made in a specific context for the care of individual patients. However, the delegations of responsibility must be documented either through the professional agreement or through the patient's dental notes and written care plan. The patient's dental records must clearly identify which practitioner(s) is responsible for the differing aspects of care within a care plan.

For example, the professional agreement may state that the dentist/s delegate responsibility for the assessment and planning of care and for undertaking clinical procedures within the education, training and competence of the dental therapist and the scope/s of practice of dental therapy. In another circumstance all delegations may be made through the clinical notes with specific items of care within the scope/s of practice of dental therapy delegated to the dental therapist.

The dental therapist and dentist/s may hold joint accountability for the standard of decisions and care undertaken in adult dental care provided through a team relationship. If responsibility for the assessment and planning of care is delegated, the dentist/s must be satisfied that the dental therapist has appropriate knowledge and skill to act appropriately on the information, and the dentist must have systems in place to monitor the clinical care outcomes of the adult patient group.

The responsibility for the outcomes of clinical care provided to adult patients remains with the dentist/s providing clinical guidance and maintaining general oversight of the clinical care outcomes of the adult patient group.

Dental therapists, dentists and organisations considering arrangements to manage the care of adult patients with a team approach utilising dental therapists and dentists are encouraged to consult with the Dental Council of New Zealand to establish the appropriateness of the clinical arrangements prior to commencing clinical practice.

## 4 Scopes of Practice including Radiography in Dental Therapy Practice or Diagnostic Radiography in Dental Therapy Practice

Dental therapists cannot be licensed to take x-rays under the Radiation Protection Act (1965) and dental x–ray machines must be owned and under the safe care of a licensed person. Only a registered dentist may be granted a licence for dental diagnosis under the Act.

It is therefore legally necessary for all dental therapists whose scopes of practice includes radiography in dental therapy practice or diagnostic radiography in dental therapy practice to work under the supervision or instructions of a registered dentist for this aspect of their practice.

The dentist must be named in the dental therapist's professional agreement and the agreement must clearly document that the dental therapist is undertaking dental radiography under the supervision or instructions of the dentist. Where a professional agreement names multiple dentists for professional advice, a single dentist must be clearly identified with the responsibility for dental radiography.

Dental therapists practising with the scope of practice radiography in dental therapy practice will require a dentist, or a dental therapist with the scope of practice diagnostic radiography in dental therapy practice, to read the radiographs and provide a report. Dentists or dental therapists who read or audit films have a responsibility to provide reports in a written format and in a timely manner such that the provision of timely care to patients is not compromised.

It should be noted that the scopes of practice for dental radiography in dental therapy practice are limited to periapical and bitewing radiography. Dental radiography in dental therapy practice cannot be extended to wider dental radiography through a professional agreement.

## 5 Access to prescription items

Only medical practitioners, dentists, midwives and designated prescribers are permitted to prescribe medicines to people.

Some specific exclusions to the definition of a medicine are made in the Medicines Regulations, and are of relevance to dentistry and the practice of dental therapy. These exclusions include substances used to fill dental cavities and substances declared by the regulations not to be a medicine for the purposes of the Medicines Act 1981. A small number of substances that in most other circumstances are prescription medicines, are excluded from this status by the Medicines Regulations 1984 when used by a dental therapist. Appendix 2 describes the status of some substances commonly used in the practice of dental therapy.

Dentists are permitted under the Medicines Regulations 1984 to prescribe, administer and/or supply prescription medicines for patients under their care. Dentists are also permitted under the Medicines (Standing Order) Regulations 2002 to issue a standing order (written instruction) for the administration or supply of prescription medicines or controlled drugs to patients by people engaged in the delivery of health services without a prescription. A standing order does not enable prescribing by other people engaged in the delivery of health services, just the direct administration or supply of the medicines.

Dental therapy practice includes the administration of local anaesthetics and the application of topical fluorides for the prevention of dental caries. The clinical procedures undertaken as part of dental therapy practice may also require the administration of prescription medicines to their patients prior to, or following clinical procedures. A common example is antibiotic prophylaxis for patients with at risk cardiac anomalies.

Controlled drugs are not administered or supplied by dental therapists as part of the practice of dental therapy.

It is the responsibility of dental therapists to ensure that patients under their care have access to appropriate medicines for the safe provision of dental care.

Despite the exemption of some medicines in common usage in dental therapy practice from the list of prescription medicines (Appendix 2), it will still be necessary for a dental therapist to have a formal relationship with a dentist for the purchase of medicines, and to enable the administration or supply of, any substance that is not exempted.

It is essential that a dental therapist's professional agreement provides an agreed process for the purchase and supply of prescription medicines that will be administered directly to patients. This may be achieved in two different ways.

1 A standing order is issued that covers a group of dental therapists that are employed by, under the managerial control of, or employed within an environment where a dentist is authorised to issue a standing order by a group of practitioners or a group of people permitted to supply or administer a medicine under a standing order.

2 An individual dental therapist's professional agreement establishes a standing order for the administration and supply of prescription medicines under the authority of a dentist who is the dental therapist's employer, exercising managerial control of the dental therapist or employed within an environment where a dentist is authorised to issue a standing order by a group of practitioners or a group of people permitted to supply or administer a medicine under a standing order and is a signatory to the professional agreement. Where a professional agreement names multiple dentists for professional advice, a single dentist must be clearly identified with the responsibility for the standing order.

It is the responsibility of dentists entering into professional agreements with dental therapists to ensure that medicines supplied to dental therapists for administration or supply to patients are the subject of an appropriate standing order and that the medicines are being administered and/or supplied in a safe and effective manner and appropriately documented.

The medicines allowed to be administered and/or supplied directly to patients under a dentist's standing order must be clearly specified and along with the circumstances in which these medicines may be supplied
Information on standing orders can be downloaded from Ministry of Health website www.moh.govt.nz (use the search facility to locate the document "*Guidelines for the Development and Operation of Standing Orders*").

**5.1 Prescribed medicines**

Patients managed by dental therapists must have access to appropriate prescriptions for medicines dispensed on prescription that are required to be taken in conjunction with the practice of dental therapy.

Dental therapists and dentists who are party to professional agreements must ensure a clear process for patient access to appropriate prescriptions. A dentist who is a signatory to the professional agreement may not always provide prescriptions. It may be more appropriate for the prescription to be provided by another practitioner (doctor or dentist) who is more directly involved in the clinical care of the patient, given that safe prescribing practice requires an understanding of the patient's history and clinical presentation.

However, if a prescription is to be sought from a practitioner other than a signatory to the professional agreement, the dental therapist must have sufficient information and knowledge to assess its appropriateness. A dental therapist must seek the advice of a dentist who is signatory to his/her professional agreement if in doubt.

Antibiotics for prophylaxis against infective endocarditis are a particular example of prescription medicines that will be required in conjunction with dental therapy practice. It is particularly important to ensure the accuracy and appropriateness of antibiotics prescribed for the prophylaxis of infective endocarditis. Practitioners outside of the dental professions frequently do not appreciate the specific nature of the recommended medicines, dosages and timing. A dental therapist relying upon a practitioner who is not a signatory to the professional agreement to provide antibiotic prophylaxis accepts responsibility for the correct antibiotic regimen being provided for the dental care and for providing dental care with appropriate antibiotic cover.

The current standard of care for the prevention of infective endocarditis associated with dental treatment is described in Technical Report No 76 published in July 1999 by the National Heart Foundation of New Zealand.

The publication is titled:

*Prevention of infective endocarditis associated with dental treatment and other medical interventions.* Ellis-Pegler RB et al. National Heart Foundation of New Zealand: Auckland, July 1999.

This publication can be downloaded from the New Zealand National Heart Foundation website www.heartfoundation.org.nz

## 6 Documented professional agreement

Every dental therapist must have a written professional agreement with a dentist or dentists who will be the primary source of timely professional advice and access to prescription medicines. The professional agreement will also document responsibility for dental radiography practice and arrangements for adult dental care when a dental therapist's practice includes these scopes of practice.

A professional agreement is individual to a dental therapist. Groups of dental therapists cannot be covered by a collective professional agreement.

The professional agreement must be contained in a written agreement that clearly describes:

1. The purpose of the professional agreement.
2. The name of the dental therapist.
3. The name/s of the dentist/s who will provide professional support and advice to the dental therapist under the terms of the professional agreement and the Dental Council of New Zealand's Code of Practice – The Practice of Dental Therapy.
4. The scope or scopes of practice that the dental therapist is registered to practice with the Dental Council of New Zealand.
5. Any limitation of the dental therapist's competencies within the scopes of practice
6. The responsibility of the dental therapist to seek timely professional advice
7. The responsibility of the dentist/s to provide timely advice including how the dentist/s can be contacted and alternative arrangements
8. The management of patients requiring referral beyond the dental therapist's scope of practice
9. Access to prescribed medicines for the practice of dental therapy
10. The need for the dental therapist and all dentists named in the agreement to maintain a current Annual Practising Certificate with the Dental Council of New Zealand and a requirement for any party to notify the others if at any time an Annual Practising Certificate is declined or amended in a manner that would materially affect the agreement.

For dental therapists registered with the scope of practice radiography in dental therapy practice or diagnostic radiography in dental therapy practice:

11. An individual dentist that will provide supervision or instruction for the practice of radiography

For dental therapists registered with the scope of practice adult care in dental therapy practice

12. The name of the dentist/s providing clinical guidance and general oversight of the clinical care outcomes of the adult patient group
13. The delegations of responsibility for adult patient care

Appendix 3 contains sample written agreements.

## APPENDIX 1

**Appendix 1**

**Scope of Practice for General Dental Therapy Practice**

**Description**
The Dental Council of New Zealand defines the practice of dentistry as the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

Dental therapy practice is a subset of the practice of dentistry, and is commensurate with a dental therapist's approved education, training and competence.

Dental therapists and dentists have a consultative working relationship, which is documented in an agreement between the parties.

In collaboration with dentists and other health care professionals, and in partnership with individuals, whanau and communities, dental therapists provide oral health assessment, treatment, management and prevention services for children and adolescents up to age 18. Disease prevention and oral health promotion and maintenance are core activities.

Dental therapy practice involves:
- Obtaining medical histories and consulting with other health practitioners as appropriate
- Examination of oral tissues, diagnosis of dental caries and recognition of abnormalities
- Preparation of an oral care plan
- Informed consent procedures
- Administration of local anaesthetic using dentoalveolar infiltration, inferior dental nerve block and topical local anaesthetic techniques
- Preparation of cavities and restoration of primary and permanent teeth using direct placement of appropriate dental materials.
- Extraction of primary teeth
- Pulp capping in primary and permanent teeth
- Preventive dentistry including cleaning, polishing and scaling (to remove deposits in association with gingivitis), fissure sealants, and fluoride applications
- Oral health education and promotion.
- Referral as necessary to the appropriate practitioner/agency

Dental therapy practice includes teaching, research and management given that such roles influence clinical practice and public safety.

**Qualifications**
- Certificate in Dental Therapy (issued by the Department of Health) and approved experience in the provision of dental therapy services within the scope of dental therapy practice; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution) ; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago; or
- Bachelor of Health Sciences (Dental Therapy), AUT; or
- Undergraduate dental therapy degree or diploma from an Australian Dental Council accredited educational programme; or
- A pass in the DCNZ Dental Therapy Registration Examination

## APPENDIX 1

**Additional Scopes of Dental Therapy Practice**

**Scope for Pulpotomies in Dental Therapy Practice**

**Description**
Performing pulpotomies on primary teeth

**Qualifications**
- Certificate in Dental Therapy (issued by the Department of Health); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; and evidence of successful completion of the University of Otago training module in pulpotomies; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; and evidence of successful completion of the University of Otago training module in pulpotomies; or
- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Dental Therapy), AUT and registration in the Scope of General Dental Therapy practice

**Scope for Radiography in Dental Therapy Practice**

**Description**
Taking periapical and bitewing radiographs[1]

**Qualifications**
- Certificate in Dental Therapy (issued by the Department of Health); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; and an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04; or
- Certificate in Dental Therapy (issued by the Department of Health); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice and evidence of successful completion of one of the following radiography training courses:
  - Radiography for Dental Therapists, Canterbury District Health Board
  - Dental Radiography Training Programme, Auckland Regional Dental Service
  - Dental Radiography Training Module, Waikato District Health Board
  - Dental Radiography Course, Hutt Valley District Health Board
  - Radiography for Dental Therapists, Department of Health; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; and an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and evidence of successful completion of one of the following radiography training courses:
  - Radiography for Dental Therapists, Canterbury District Health Board
  - Dental Radiography Training Programme, Auckland Regional Dental Service
  - Dental Radiography Training Module, Waikato District Health Board
  - Dental Radiography Course, Hutt Valley District Health Board
  - Radiography for Dental Therapists, Department of Health; or
- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago) and registration in the Scope of General Dental Therapy practice ; or
- Bachelor of Health Sciences (Dental Therapy), AUT and registration in the Scope of General Dental Therapy practice

[1] The Radiation Protection Act 1965 requires non-licensed persons who take x-rays to do so under the supervision or instructions of a person who holds a license under that Act.

## APPENDIX 1

**Scope for Diagnostic Radiography in Dental Therapy Practice**

**Description**
Taking and interpreting periapical and bitewing radiographs [2]

**Qualifications**
- Certificate in Dental Therapy (issued by the Department of Health); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; evidence of successful completion of a radiography training course or an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04; and approved experience in interpreting periapical and bitewing radiographs under the direction and supervision of a dentist who can attest to competency; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice; evidence of successful completion of a radiography training course or an exemption certificate issued by the New Zealand Medical Radiation Technologists Board current as at 18/09/04; and approved experience in interpreting periapical and bitewing radiographs under the direction and supervision of a dentist who can attest to competency; or
- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago and registration in the Scope of General Dental Therapy practice ; or
- Bachelor of Health Sciences (Dental Therapy), AUT and registration in the Scope of General Dental Therapy practice

**Scope for Stainless Steel Crowns in Dental Therapy Practice**

**Description**
Preparing teeth for, and placing stainless steel crowns on primary teeth

**Qualifications**
- Certificate in Dental Therapy (issued by the Department of Health); registration in the Scope of General Dental Therapy practice; approved experience in the provision of dental therapy services within the scope of dental therapy practice; and; and evidence of successful completion of the University of Otago training module in stainless steel crowns; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and evidence of successful completion of the University of Otago training module in stainless steel crowns; or
- Diploma in Dental Therapy, University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago and registration in the Scope of General Dental Therapy practice; or
- Bachelor of Health Sciences (Dental Therapy), AUT and registration in the Scope of General Dental Therapy practice

[2] The Radiation Protection Act 1965 requires non-licensed persons who take x-rays to do so under the supervision or instructions of a person who holds a license under that Act.

## APPENDIX 1

**Scope for Adult Care in Dental Therapy Practice**

**Description**
Providing care to adult patients within the general dental therapy scope of practice (and /or any additional scope) in a team situation with clinical guidance[3] provided by a practising dentist/s.

**Qualifications**
- Certificate in Dental Therapy (issued by the Department of Health); registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under the direction and supervision of a dentist, who can attest to competency; or
- Diploma in Dental Therapy (issued by a New Zealand educational institution); registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under the direction and supervision of a dentist, who can attest to competency; or
- Bachelor of Health Sciences (Endorsement in Dental Therapy), University of Otago; registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under direction and supervision of a dentist, who can attest to competency; or
- Bachelor of Health Sciences (Dental Therapy), AUT; registration in the Scope of General Dental Therapy practice and approved experience in the provision of oral healthcare to adults under the direction and supervision of a dentist, who can attest to competency.

The prescribed qualifications above will be withdrawn as at 19 September 2004. Thereafter the prescribed qualification for registration in the additional dental therapy scope of adult care will be an accredited qualification in adult dental therapy practice, issued by a New Zealand educational institution.

[3] Clinical guidance means the professional support and assistance provided to a dental therapist by a practising dentist or dental specialist as part of the provision of overall integrated care to the adult patient group. Dental therapists and dentists/specialists normally work from the same premises providing a team approach. Clinical guidance may be provided at a distance but appropriate access must be available to ensure that the dentist or specialist is able to provide guidance and advice, when required and maintain general oversight of the clinical care outcomes of the adult patient group.

## APPENDIX 2

### Appendix 2

### Prescription medicine exclusions

Some specific exclusions to the definition of a medicine are made, and are of relevance to dentistry and the practice of dental therapy. These exclusions include substances used to fill dental cavities and substances declared by the regulations not to be a medicine for the purposes of the Medicines Act 1981.

Not all substances that appear to be prescription medicines and involved in the practice of dental therapy are in fact prescription medicines when used by a dental therapist, as defined by the Medicines Regulations 1984. This Appendix describes the status of some substances commonly used in the practice of dental therapy.

Of particular note are:

***Lignocaine***
Lignocaine for injection is a prescription medicine except when used as a local anaesthetic in practice by a registered nurse or podiatrist or by a dental therapist.

***Prilocaine***
Prilocaine for injection is a prescription medicine except when used as a local anaesthetic in practice by a dental therapist.

***Felypressin***
Felypressin in the vasoconstrictor most commonly used with prilocaine in Citanest local anaesthetic. Felypressin is a prescription medicine except when used as a local anaesthetic in practice by a registered dental therapist.

Note no other commonly used local anaesthetics have exemptions from being a prescription medicine when used in practice by a registered dental therapist.

***Fluorides***
Fluorides are prescription medicines when present in medicines for external use other than pastes, gels or powders for cleaning the teeth that contain more than 2.5% of elemental fluorine except when used in practice by a registered dental therapist.

Duraphat varnish contains 5% sodium fluoride [50mg/ml], and 2.26% elemental fluoride.

***Adrenaline***
Adrenaline is a prescription medicine in medicines containing more than 1% and adrenaline is a restricted medicine in medicines containing 1% or less and more than 0.02%.

Adrenaline as a vasoconstrictor in local anaesthetics is usually at a concentration of 1:80,000 (0.00125%) or 1:100,000 (0.001%).

Adrenaline contained in recommended medical emergency kits is at 1:1000 (0.1%) and is therefore a restricted medicine

## APPENDIX 3

# Professional Agreement between a Dental Therapist and Dentist/s for the Practice of Dental Therapy in New Zealand

**Purpose of the professional relationship**

This is an agreement outlining the professional relationship between an individual dental therapist and a dentist or dentists.

The parties understand that dental therapy practice is a subset of the practice of dentistry that is defined by the scopes of practice and Code of Practice - The Practice of Dental Therapy approved by the Dental Council of New Zealand.

Dental therapists and dentists have a consultative working relationship that is supported by a written professional agreement.

The parties to this agreement understand that a professional agreement is a requirement of the Dental Council of New Zealand Code of Practice - The Practice of Dental Therapy and that their responsibilities and potential liabilities arising from the professional relationship outlined by this agreement are detailed in the Dental Council of New Zealand Code of Practice - The Practice of Dental Therapy. The agreement may be subsequently amended where necessary and appropriate.

This agreement is made between

_____
(name of the dental therapist)

registered with the Dental Council of New Zealand

and

Dr _____
(name of the dentist/ dental specialist)

Dr _____
(name of the dentist/ dental specialist)

Dr _____
(name of the dentist/ dental specialist)

Dr _____
(name of the dentist/ dental specialist)

dentist/s or dental specialists registered with the Dental Council of New Zealand.

## APPENDIX 3

**Definition of terms**

Dental therapists, dentists and dental specialists are all health practitioners registered with the Dental Council of New Zealand.

Scope of Practice is defined by the Health Practitioners Competence Assurance Act 2003 and

(a) means any health service that forms part of a health profession and that for the time being described under section 11; and

(b) in relation to a health practitioner of that profession means 1 or more of such health services that the practitioner is, under an authorisation granted under section 21, permitted to perform, subject to any conditions for the time being imposed by the responsible authority.

**Scopes of practice**

I _____ am a dental therapist
(name of the dental therapist)
registered with the Dental Council of New Zealand for the practice of general dental therapy.

I am also registered with the following additional scopes of practice *(tick appropriate boxes)*

☐ Pulpotomies in dental therapy practice

☐ Radiography in dental therapy practice OR ☐ Diagnostic radiography in dental therapy practice

☐ Stainless steel crowns in dental therapy practice

I confirm that I am competent in all duties defined within these scopes of practice with the exception of:

_____

_____

_____

**Roles and responsibilities of the dental therapist**

As a dental therapist I am responsible for assessing, planning and providing dental care to children and adolescents up to age 18 years within the boundaries of my education, knowledge and technical skills. I understand that decisions and actions taken independently in my clinical practice are my personal responsibility.

I understand that I am responsible for seeking additional professional advice when the assessment, planning or provision of dental care extends beyond my knowledge or skills and that I have a duty of care to seek additional professional advice in a timely manner.

My primary source of additional professional advice will be the dentist/s named in this professional agreement. However, this relationship does not preclude me from seeking additional professional advice from other health practitioners where appropriate or necessary.

## APPENDIX 3

**Roles and responsibilities of the dentist**

I am / We are dentist/s or dental specialist/s registered with the Dental Council of New Zealand in the scope of practice of general dentistry and/or in a specialist scopes of practice. I/We confirm that I am / we are competent in these scopes of practice and willing to provide professional support and advice for the dental therapy practice of the dental therapist named in this agreement.

I/We understand that I am / we are responsible for providing professional advice and that I / we have a duty of care to provide this professional advice to the best of my / our ability and to be available in a timely manner to provide advice. I/we understand that I/we will be the primary source of additional professional advice but that this relationship does not preclude the dental therapist named in this agreement from seeking additional professional advice from other health practitioners where appropriate or necessary.

I/we can be contacted for this advice in the following manner

☐ By telephone at the following number/s _____

☐ On site at the same location

☐ **Other** _____

**Referral of patients beyond the scope of practice or unable to be managed within the practice**

We agree that patients requiring care beyond the relevant scopes of practice in dental therapy, or unable to be managed within the dental therapist's practice, will be referred to a dentist or to another appropriate health practitioner.

**Access to prescription items**

I _____ confirm that I have arranged
(name of the dental therapist)
access to the prescription medicines necessary for direct administration or supply in my practice of dental therapy.

This access will be provided by:

A separate standing order issued by _____
(insert name of dentist and/or organisation)

OR

A standing order established with Dr _____ in conjunction with this professional agreement
(insert name of dentist)

I confirm that for patients requiring a prescribed medicine I will consult with a dentist party to this agreement or will refer the patient to another practitioner permitted to prescribe and familiar with the patient's clinical care.

## APPENDIX 3

**Practice of radiography in dental therapy practice or diagnostic radiography in dental therapy practice**
*(if included in registered scopes of practice)*

I _____ confirm that for the practice of
(name of the dental therapist)
radiography in dental therapy practice I am practising under the supervision or instruction of Dr
_____ (insert name of dentist)

I, Dr _____ confirm that I am licensed under the Radiation
(insert name of dentist)
Protection Act 1965 to use irradiating apparatus for dental radiographic diagnosis and that all dental x–ray machines to be used by the dental therapist named in this agreement are owned and under the safe care of a licensed person.

**Parties to the agreement**

This agreement is made between

| _____ | _____ | _____ |
|---|---|---|
| (name of the dental therapist) | (signature of the dental therapist) | (Date) |

dental therapist registered with the Dental Council of New Zealand

and

| Dr _____ | _____ | _____ |
|---|---|---|
| (name of the dentist/ dental specialist) | (signature of the dentist/ dental specialist) | (Date) |
| Dr _____ | _____ | _____ |
| (name of the dentist/ dental specialist) | (signature of the dentist/ dental specialist) | (Date) |
| Dr _____ | _____ | _____ |
| (name of the dentist/ dental specialist) | (signature of the dentist/ dental specialist) | (Date) |
| Dr _____ | _____ | _____ |
| (name of the dentist/ dental specialist) | (signature of the dentist/ dental specialist) | (Date) |

dentist/s or dental specialists registered with the Dental Council of New Zealand.

We individually agree to ensure continued compliance with the requirements to hold an Annual Practising Certificate with the Dental Council of New Zealand and to notify all of the other parties to this agreement if at any time an Annual Practising Certificate is declined or amended in a manner that would materially affect the agreement.

## APPENDIX 3

**Adult dental care**

I _____ am a dental therapist registered with the
(name of the dental therapist)
Dental Council of New Zealand for the practice of general dental therapy and I am also registered with the additional scope of practice adult care in dental therapy practice.

I understand that to practise adult care in dental therapy practice I must practise in a team situation with clinical guidance provided by a practising dentist/s.

I will be undertaking adult care in a team relationship with the dentists who are signatories below.

I/We, Dr _____ and Dr _____
(name of the dentist/ dental specialist) (name of the dentist/ dental specialist)

understand that the dental therapist named in this agreement will be undertaking care for adult patients in a team relationship with me / us and agree to

a) provide clinical guidance and
b) maintain general oversight of the clinical care outcomes of patients under the care of

_____
(name of the dental therapist)

I / we agree that I / we will delegate specific items of care for the dental therapist to undertake through written instructions contained in the care plan and clinical notes of the individual patients

OR

I / we agree that I / we provide the following general delegations of responsibility

a) assessment and planning of care within the education, training and competence of the dental therapist
b) undertaking clinical procedures within the scope of practice of general dental therapy

All conditions outside the education, training and competence of the dental therapist must be referred for assessment, and if necessary management, by a dentist.

**Parties to the agreement**

This agreement is made between

| _____ | _____ | _____ |
|---|---|---|
| (name of the dental therapist) | (signature of the dental therapist) | (Date) |

dental therapist registered with the Dental Council of New Zealand

and

| Dr _____ | _____ | _____ |
|---|---|---|
| (name of the dentist/ dental specialist) | (signature of the dentist/ dental specialist) | (Date) |

| Dr _____ | _____ | _____ |
|---|---|---|
| (name of the dentist/ dental specialist) | (signature of the dentist/ dental specialist) | (Date) |

dentist/s or dental specialists registered with the Dental Council of New Zealand.

We individually agree to ensure continued compliance with the requirements to hold an Annual Practising Certificate with the Dental Council of New Zealand and to notify all of the other parties to this agreement if at any time an Annual Practising Certificate is declined or amended in a manner that would materially affect the agreement.

# DCNZ Guidelines for Accreditation of Programmes Offered in Dental Therapy and Dental Hygiene

## 2004

## Introduction

The Dental Council of New Zealand, established under the Health Practitioners Competence Assurance Act 2003, is responsible for protecting the health and safety of the public by providing the mechanisms to ensure that all oral health professionals are competent and fit to practise their profession. The Dental Council is also charged with:

- Prescribing the qualifications required for registration in dental scopes of practice and for that purpose accrediting and monitoring educational institutions and degrees, courses of study or programmes
- Ensuring that new registrants are competent to practice
- Setting programmes to ensure the ongoing competence of registered health practitioners
- Setting standards of clinical and cultural competence and ethical conduct.

The Dental Council of New Zealand and the Australian Dental Council have established a joint accreditation process for Australasian dental schools and programmes. Accreditation by the Dental Councils of New Zealand and Australia is the process by which the Councils recognise a dental educational programme, including its facilities, as having met the defined Australasian requirements.

The information requested in this pro-forma, together with attached documents, forms the basis of the accreditation visits to be held in 2004. This pro-forma is based on Australian Accreditation documentation and the documentation used for the accreditation of the BDS programme in New Zealand.

The review process will be conducted in a positive and constructive manner, with the best interests of dentistry foremost in the minds of the reviewers. It is intended that the review should be largely a self-assessment process by the educational providers themselves, with a site visit by the review team to interact with staff and students, discuss issues arising from the documentation, and to view the facilities and operations of the educational provider.

This pro-forma provides a number of guidelines that direct responses by asking specific question and requesting specific documentation. Responses should be kept brief and to the point. Extra information may be provided as an appendix.

The curricula for Dental Therapists and Dental Hygienists should produce caring professionals who are able to work unsupervised within a dental team, adapt to change and continue to educate themselves throughout their careers in order to promote the health of others. Most importantly, the new graduate should be competent to practice within their scope of practice on registration.

To achieve this aim the curriculum should extend beyond explicit learning objectives related to clinical dental therapy and dental hygiene practice to include opportunities for developing social responsibility and for personal growth. Therefore the curriculum should provide an appropriate focus on the three areas: content, society and student development. These areas should be integral to the Programme and a continuous part of student activity within clinical practice. They should also permeate the whole of the curriculum and be evident as being evaluated in assessment throughout the course.

Content area includes:

- mastery of theory related to society and health and clinical dental therapy and hygiene practice;
- command of clinical skills; .
- critical thinking;
- problem solving; and the
- desire to continue learning.

Social responsibility includes:

- civic responsibility;
- vocational preparation;
- ethical values and behaviour; and
- empathy and compassion for others.

Student development includes:

- self-esteem and personal growth;
- creative expression;
- cultivation of personal talents and interest areas; and
- health and safety.

It is not the intention of the Accreditation process to assess each of these focus areas individually. Rather the Dental Therapy and/or Dental Hygiene Programmes should identify pertinent examples as it addresses the guidelines and/or include information in the SWOT analysis.

The intention is to identify the diversity of teaching and learning approaches in the Schools within the continuum of dental education, recognising that this diversity can strengthen the educational system, provided that each provider continually evaluates its own methods.

The review process should enable the strengths and weaknesses of each programme to be identified. It is intended that this should be the result of a thorough and honest self- assessment. An integral part of this process will be completion of a SWOT analysis.

The information requested in this pro-forma must be provided to the DCNZ well before the scheduled visitation so that members of the visiting team can meet and discuss the responses. The convenor of the visiting team may then ask for clarification of certain responses or for additional information prior to the visit. The visits will be arranged in liaison with the Dean/Head of School. They will be carried out in a positive constructive atmosphere.

The responses from the School will form the basis of the accreditation report with comments from the visiting team added for each of the guidelines. The aim is for each School to have substantial ownership of the process, both in terms of collating the information and also in relation to the final document.

## Outcomes of the Accreditation Process

On the advice of the Accreditation Committee, the ADC will select one of the following options for each specialist program put forward for accreditation:

1. **Full accreditation** covers the full five years until the next round of accreditation. At its discretion, the Council may require an annual report from each program convenor indicating the current status of the program and particularly detailing any significant alteration from the program that was accredited originally.

2. **Full accreditation subject to conditions** covers five years but is subject to the condition that certain actions detailed in the accreditation report are realised within a specified time frame. The ADC or DCNZ may require the submission of further materials for review and reserves the option to re-visit the School. A written statement detailing compliance with the ADC report is the minimum requirement.

3. **Provisional accreditation.** This will cover a variable period but generally not longer than that required to allow current candidates to complete their specific program. It is reserved for the situation where major deficiencies in a program are identified including the non-provision of requested materials. Provisional accreditation is allocated as a positive step in bringing a program to an acceptable standard and may reflect deficiencies identified in any area reviewed during the accreditation process. It should not be viewed, either internally or externally, as a negative statement.

4. **No accreditation.** Used in only the most exceptional circumstances where deficiencies in a program are such that it is felt graduates would be unable to achieve the required levels of scholarship and expertise. Every effort is made to avoid this situation and active consultation would involve the University, State Dental Board, DCNZ and/or specialist consultants.

5. **New program accreditation.** Any level of accreditation may be used in this category which covers both entirely new programs and heavily restructured programs. Some conditions would usually be identified and the School required to respond to these within a specified time frame. The aim of this category is to streamline the progress to full accreditation.

## Guidelines

**Definition of Terms**

For clarity and consistency the following terms will be used throughout this document:

- Programme. Courses of educational and training for dental therapists and/or dental hygienists
- School. The educational facility responsible for the delivery of the Programme
- Educational Institutions. The university or college of which the School is part.

This pro-forma seeks information about 20 areas, each of which is described by a guideline. The guidelines indicate the desirable standards against which the School will be assessed, and the context in which the DCNZ will make any recommendations or suggestions. For each of the areas to be considered by review teams, together with their associated guidelines, a series of questions and requests is provided to direct responses.

Particular attention should be paid to the wording of the guidelines. For instance, a guideline may take the form of either a "must" or "should" statement. The wording signifies the importance of that particular guideline for accreditation as follows:

Must: - compliance with the guideline is considered to be essential or mandatory.
Should: - compliance with the guideline is highly desirable.

While the same guidelines are applied for both new and established programmes, it is recognised that it may be difficult for those introducing new programmes or substantial changes to supply all of the information requested, and allowance will be made for this.

Any issues which a School finds are not addressed under the guidelines may be included in the SWOT analysis (item 18).

The guidelines are as follows:

| Guideline 1 |
| --- |
| There must be a clearly defined educational philosophy for the Dental Therapy and/or Dental Hygiene Programmes. It is recognised that diversity of teaching and learning approaches can strengthen the educational system provided that the School continually evaluates its own methods. |

| Guideline 2 |
| --- |
| All programmes must address the recommendations and suggestions made at previous internal or external course reviews. This is an important determinant of the process as it demonstrates a School's awareness of the need for continual improvement. |

| Guideline 3 |
| --- |
| The Programme must exist as a distinct course of study within the Educational Institution. Students must have the same rights and privileges as other students of the Educational Institution. |

Guideline 4

The Programme must have adequate continuing financial resources, management structure and administration, and support staff to enable its objectives to be achieved.

Guideline 5

The design, size and general state of buildings and classrooms, library, laboratories, clinical and educational facilities and their relevant equipment must allow the Programme to achieve its educational objectives. Modern audio-visual material and methods of information retrieval should be available.

Guideline 6

The number of staff and staff/student ratios must be adequate to achieve educational objectives. The qualifications and experience of the staff must be sufficient to cover adequately all of the aspects of dental hygiene and/or dental therapy practice. Schools must provide a staff development programme for all of its staff

Guideline 7

Admission into the Programme must be based on published selection criteria, which must be available to advisors and applicants, and applied equitably during the selection process. Admissions processes must be continually evaluated to assess their effectiveness. The School must identify pathways of articulation from Programmes onto other courses of education and training offered by itself and other institutions where applicable.

Guideline 8

The aim of the curriculum should be to facilitate the education and training of Dental Hygienists and/or Dental Therapists. It should produce caring professionals who are able to work within a dental team, adapt to change and continue to educate themselves throughout their careers in order to promote the health of others.

Dental Hygienist and Dental Therapists must be competent to practise within the DCNZ prescribed scope of dental therapy or dental hygiene practice on the day they graduate. They should be understanding of and responsive to, the oral health needs and rights of the community, eg. HDC Code of Rights.

The Programme's curriculum will be assessed with reference to the educational philosophy and objectives of the Educational Institution. The curriculum must be well balanced and recognise the social context of health care, the changing patterns in the prevalence of dental disease as well as advances in the practice of dentistry.

The curriculum must ensure that students develop an understanding of the importance of contemporary social issues, the principles of social justice and ethical behaviour.

Particular attention must be given to the interrelationship of subjects, especially to the application of the social and the basic sciences to clinical practice, so that the programme comprises a related body of knowledge rather than one of discrete and separate subjects. The accreditation process is not intended to prescribe curriculum content and the time devoted to a subject area. Given the above statements regarding diversity and integration of subjects this would be both impracticable and contradictory. Therefore, it is the responsibility of Schools to organise their own teaching

programmes which will then be judged in terms of achievement of the stated aims of the Programme rather than conformity to a standardised pattern, ie. outcome or competence based.

Teaching and assessment must be designed to develop students who can assume responsibility for their own learning.

Clinical supervision by staff must be adequate to ensure that acceptable standards of patient care are maintained, including accurate and complete record-keeping.

Evaluation processes must be in place to ensure that acceptable standards of patient care are maintained.

Guideline 9

The Educational Institution and its clinics must be safe for students, staff and patients. The clinics must provide adequate general dental patient care in a setting conducive to education and research.

Guideline 10

At graduation, students must be capable of competent practice in a team situation. They must be provided with suitable patients and facilities during the Programme to enable them to develop this competence.

Guideline 11

A clearly stated, valid and reliable system of formative and summative student assessment must be used to determine progression and graduation of students.

Guideline 12

There must be student representation on appropriate committees, and student grievances and concerns must be identified and addressed. Counselling and health services should be available to all students.

Guideline 13

There should be integration of the Dental Therapy and/or Dental Hygiene Programme with the BDS programme where possible so that students learn to work as members of a dental health team. Where possible students should have an opportunity to interact with students in other health education programmes to foster effective communication between disciplines.

Guideline 14

The Programme must have functional relationships with at least one District Health Board or other providers of oral health care such as community clinics. The relationship must enable students of dental therapy or dental hygiene to provide oral health care for patients appropriate to that required to achieve the educational objectives described by the provider.

Guideline 15

The Programme should have functional relationships with other departments of the Educational Institution, with the various dental professions and their organisations, and with the community in order to promote dentistry and provide learning opportunities for students.

Guideline 16

There should be a demonstrated commitment to establish research related to dental therapy and/or dental hygiene practice and oral health promotion. Where possible this research should involve students.

Guideline 17

The School must perform ongoing evaluation of the outcomes of its programmes to determine whether it is meeting its objectives. Results of the evaluation process must be used to improve the Programme.

Guideline 18

Each School must identify its own strengths, weaknesses, opportunities for improvement and threats to the quality of its Programme.

Guideline 19

The educational institution must demonstrate that the principles of Mana Maori and of the Treaty of Waitangi are upheld throughout the programme.

Guideline 20

Each School must formulate strategies and a timetable for improvement of its Programme based on the self-assessment process undertaken for accreditation.

## Areas for consideration

1. Overview of the Programme
2. Responses to recommendations and suggestions from the last accreditation process
3. The administrative relationship of the Programme to the School/University.
4. Programme administration and budget
5. Physical facilities and resources
6. Staff and staff development
7. Admissions policies and procedures
8. The curriculum
9. Clinic administration
10. Preparation for practice
11. Student assessment and examinations
12. Student support and representation
13. Relationship with allied dental education programmes
14. Interface with other service providers
15. Interface with educational institution, profession and community
16. Research and postgraduate and continuing education
17. Evaluation procedures and outcomes
18. SWOT analysis
19 Mana Maori
20 Strategies and timetables for improvement
21 Appendices

Schools should address each of the above areas in formulating their response. It is intended that the visiting team will add its comments at the end of each of the sections and that the School's self-evaluation, together with the visitors' comments, will form the final documentation. It is intended that appendices should be kept to a minimum, but that copies of relevant documentation would be available to the visiting team prior to the visits being undertaken. The questions and qualifiers provided under each of the guidelines are meant to help direct Schools' responses. Schools can use their own discretion in determining the layout of their responses, but they should use the guidelines as headings to their documentation, use at least an ll-point font and provide an electronic and hard copy of their submission.

It is intended that each member of the visiting team will have a copy of the School's responses, together with a copy of the course guide. One copy of each of the other requested documents should be available for the convenor of the visiting team to peruse.

Name of School: _____

Address Of School: _____

Name of Programme Head: _____

Telephone No: _____

Facsimile No: _____

Email: _____

Name of Head/Dean _____

Telephone No: _____

Facsimile No: _____

Email: _____

Name of Vice-Chancellor: _____

Telephone No: _____

Facsimile No: _____

Email: _____

Date submitted to Joint DCNZ/ADC Accreditation Committee: _____

Please return to:

The Registrar
Dental Council of New Zealand
Level 8
PO Box 10 448
WELLINGTON

## 1. Overview of Programme

**Guideline 1**
**There must be a clearly defined educational philosophy for the Programme. It is recognised that diversity of teaching and learning objectives can strengthen the educational system provided that each programme continually evaluates its own methods.**

Please provide an overview of the Programme to be considered for accreditation, including:

- The date when the Programme was / will be introduced
- A description of the School's and/ or Programme's educational philosophy and objectives
- Attach a copy of the University's charter, school's mission statement and strategic plan in relation to the programme being assessed.

## 2 Responses to recommendations and suggestions from the last accreditation process

**Guideline 2**
**All Programmes must address the recommendations and suggestions made at previous internal or external course reviews. This is an important determinant of the process as it demonstrates a School's awareness of the need for continual improvement.**

Describe how the recommendations and suggestions from other review processes have been addressed.

## 3. The administrative relationship of the School to the Educational Institution

**Guideline 3**

**The Programme must exist as a distinct course of study within the Educational Institution. Students must have the same rights and privileges as other students of the Educational Institution.**

Describe the administrative relationship of the Programme within the School or Educational Institution. Include as an appendix an administration flowchart.

Does the Programme have the same status and responsibility as other comparable departments/units in the School/Institution? If no, explain.

Is there equal/ appropriate representation on joint committees with representatives of other health programmes?

Do dental therapy/dental hygiene students have the same rights and privileges as other students of the Educational Institution? If no, explain.

## 4. Programme administration and budget

**Guideline 4**

**The Programme must have adequate continuing financial resources, management structure and administration, and support staff to enable its objectives to be achieved.**

Describe the committee structures used for the management of the Dental Therapy /Dental Hygiene Programme. A flow-chart may be used. Include names of staff with academic or administrative responsibilities.

Describe the decision-making process within the School in relation to academic and resource issues.

Do the resources available to the Dental Therapy /Dental Hygiene Programme enable it to fulfil its educational objectives?

If "service" departments outside the Programme present subjects or courses, indicate how financial arrangements are negotiated for each of these subjects.

Describe additional sources of funding generated by the Programme other than educational funding.

How are the clinic operations funded?

Please provide a copy of the Programme's and/or School's strategic plan and business plan.

## 5. Physical facilities and resources

**Guideline 5**
**The design, size and general state of buildings and classrooms, library, laboratories, clinical and Educational Institutions facilities and their relevant equipment must allow the Dental Therapy and/or Dental Hygiene Programme to achieve its educational objectives. Modern audio-visual material and methods of information retrieval should be available.**

Describe the facilities available for teaching and learning, eg: lecture theatres, tutorial rooms, laboratories, and clinical facilities including the number of dental units.

Describe library and computer facilities.

Are there any areas where physical facilities need to be improved in order to enhance your programme?

## 6. Staff and staff development

**Guideline 6**

**The number of staff and staff/students ratios must be adequate to achieve educational objectives. The qualifications and experience of the staff must be sufficient to cover adequately all of the aspects of dental hygiene and/or dental therapy practice. Schools must provide a staff development programme for all of its staff.**

Attach, as an appendix, a list of all full-time, half-time and part-time academic staff within the programme, including their main teaching responsibilities.

List any current vacancies and how long they have been vacant and the plans for filling these positions.

Describe any difficulties the programme has had in recruiting suitable qualified academic staff.

Describe the School's plan for recruitment of academic staff including procedures for appointment and promotion.

What opportunities are available for staff to further their professional development?

## 7. Admissions policies and procedures

**Guideline 7**

**Admission into the Programme must be based on published selection criteria, which must be available to advisors and applicants, and applied equitably during the selection process. Admissions programmes must be continually evaluated to assess their effectiveness. The School must identify pathways of articulation from Programmes onto other courses of education and training offered by itself and other institutions where applicable.**

Describe the admissions process for your programme, including information about pre- requisites, quotas, categories and numbers of applicants, special schemes, bridging programmes.

Describe how your admissions process is administered and evaluated.

Please provide outcomes of your evaluation if available.

Describe any appeals process relating to the admissions process.

Attach a copy of the information provided for prospective applicants.

Has the admissions process ever been changed? If so, describe how and why.

Do the admissions procedures include a clear overview of the further career pathways available?

What mechanisms are available to provide flexibility for career change?

Please detail any special entry schemes for Maori and Pacific Island students. How is this advertised?

Describe the support supplied to students entering under special entry schemes.

What is your schools policy in relation to the admission of disabled students? What support is available?

Provide numbers on the proportion of NZ residents in the Programme.

Provide numbers on the proportion of students who have English as a first language in the Programme.

Describe the policies and prerequisites for full fee paying non-resident students.

Do you accept transfer students into later years of the course? If so, describe the methods of selection and number of students accepted over the past three years.

Provide, as an appendix, a table showing the numbers of students in each year for the past three years, including gender and the numbers failing or held back.

Describe how the Dental Hygiene/Dental Therapy Programme relates with other programmes (eg. science degrees, and other programmes which might produce potential dental students or accept students who do not complete the dental programme).

What are your School's requirements in relation to immunisation of new students against infectious diseases?

What are your schools policies in relation to students with bloodborne infectious diseases?

Describe how the Dental Therapy and/or Dental Hygiene Programmes articulate with other programmes (such as BDS, post graduate programmes, science degrees and any other programme which educates dental therapists/hygienists or permit transfers).

## 8. The Curriculum

**Guideline 8**

**The aim of the curriculum should be to facilitate the education and training of Dental Hygienists and/or Dental Therapists. It should produce caring professionals who are able to work within a dental team, adapt to change and continue to educate themselves throughout their careers in order to promote the health of others.**

**Dental Hygienist and Dental Therapists must be competent to practise within the DCNZ prescribed scopes of dental therapy or dental hygiene practice on the day they graduate. They should be understanding of and responsive to, the oral health needs and rights of the community, eg. HDC Code of Rights.**

**The Programme's curriculum will be assessed with reference to the educational philosophy and objectives of the Educational Institution. The curriculum must be well balanced and recognise the social context of health care, the changing patterns in the prevalence of dental disease as well as advances in the practice of dentistry.**

**The curriculum must ensure that students develop an understanding of the importance of contemporary social issues, the principles of social justice and ethical behaviour.**

**Particular attention must be given to the interrelationship of subjects, especially to the application of the social and the basic sciences to clinical practice, so that the programme comprises a related body of knowledge rather than one of discrete and separate subjects. The accreditation process is not intended to prescribe curriculum content and the time devoted to a subject area. Given the above statements regarding diversity and integration of subjects this would be both impracticable and contradictory. Therefore, it is the responsibility of Schools to organise their own teaching programmes which will then be judged in terms of achievement of the stated aims of the Programme rather than conformity to a standardised pattern, ie. outcome or competence based.**

**Teaching and assessment must be designed to develop students who can assume responsibility for their own learning.**

**Clinical supervision by staff must be adequate to ensure that acceptable standards of patient care are maintained, including accurate and complete record-keeping.**

**Evaluation processes must be in place to ensure that acceptable standards of patient care are maintained.**

Describe how the curricula reflects the DCNZ prescribed scopes of dental therapy or dental hygiene practice.

Describe the process whereby the Programme's curriculum is reviewed and how changes are implemented. What is the process within the Institution for considering changes to courses? For programmes undergoing major structural change, indicate areas of overlap between the old and new programmes.

The following list indicates those subjects/topics that might be expected to be included in a dental therapist/hygienist programme. They may be present with varying emphasis and may not stand alone as separate subjects. The content of these subjects should be at least at the level to support dental therapy and/ or dental hygiene practice.

For each of these subjects/topics indicate how/where they are included within the curriculum, and how they are co-ordinated and integrated both horizontally and vertically throughout the course. If this information is clearly presented in the course guide, then refer to the appropriate pages. In addition, indicate how students learn to provide total patient care within their scope of practice by integrating information relating to the various clinical disciplines. It is recognised that School's may use different terminology to describe these subjects.

- anatomy -gross and microscopic; oral anatomy
- behavioural sciences, including communication; models of learning, human development and behaviour change, social and cultural effects
- bicultural issues – Hauora Maori and the Treaty of Waitangi
- community oral health services .
- dental diseases
- dental materials .
- dental occlusion
- dental radiography
- emergency procedures, CPR
- epidemiology
- ethics and jurisprudence
- general histology
- general microbiology , immunology and oral pathology
- general pathology
- general physiology
- infection control
- local analgesia
- diet and oral health
- operative dentistry
- oral biology (histology , embryology , microbiology and physiology)
- oral diagnosis
- oral health promotion
- orthodontics
- paediatric dentistry
- pain control
- periodontology
- pharmacology
- preventive dentistry
- prosthodontics, fixed and removable, including implants .public health policy
- research methodology , computer skills, and critical appraisal of the literature
- special needs dentistry , including gerodontology , medically compromised, disabled
- responsibilities in vocational practice (team dentistry, safe practice, occupational health and safety, legislation governing practice, including scopes of practice)
- tooth deposits and stains

Copies of the course guide or handbook provided to students describing the course content should be made available to each of the members of the visiting team.

The course guide should include the name of subject co-ordinators, aims and objectives of subjects, topics covered, contact hours for lectures, laboratories, tutorials, clinics, etc., assessment processes, required texts and manuals, recommended reading.

List the "service" departments involved in contributing to teaching, including staff within those departments responsible for course presentation.

Provide timetables for each of the years of the course indicating clearly time commitments/student in each of the years.

Describe any elective courses offered to students.

## 9 Clinic Administration

**Guideline 9**

**The educational institution and its clinics must be safe for students, staff and patients. The clinics must provide adequate general dental patient care in a setting conducive to education and research.**

Describe how the dental clinics are managed. An administrative flowchart may be used.

Please provide copies of policies and/or protocols relating to the following:

- ❑ infection control
- ❑ medical emergencies
- ❑ eligibility of patients for treatment
- ❑ assignment of patients to students
- ❑ recalls
- ❑ patient records
- ❑ development, approval and review of patient treatment plans
- ❑ technical laboratory support
- ❑ waste management
- ❑ radiation protection
- ❑ occupational health and safety
- ❑ auditing of patient care
- ❑ clinical supervision
- ❑ other

Is there a shortage of patients for any clinical procedures? If so, give details.

Where do students gain their clinical experience, eg. placements outside the Programme, etc? (refer to 14 also)

Provide details of the patient group, and outline the degree of students' exposure to children, adolescents and adult patients.

Do the students experience integrated treatment planning and management of patients? If so when and how?

What provisions are made for maintenance of equipment and replacement of equipment?

What measures does the programme have in place to increase student awareness of ergonomic issues and measures to prevent work related musculosketal disorders?

## 10 Preparation for Practice

**Guideline 10**

**At graduation, students must be capable of competent practice in a team situation and within the DCNZ prescribed scopes of dental therapy or dental hygiene practice. They must be provided with suitable patients and facilities during the Programme to enable them to develop this competence. A designated dentist will be available to provide clinical guidance.**

Do the students gain adequate experience in all areas of dental therapy and/or dental hygiene practice prior to graduation?

Do dental therapy students gain adequate experience of providing care to children and adolescent patients prior to graduation?

What experience do dental therapy students gain of providing care to adult patients prior to graduation?

If formal requirements are indicated to students, provide the range performed by students in each of the Programme years and to which patient groups. If there are no formal requirements, but rather guidelines, indicate average number of procedures undertaken by students in each year and ranges, ie. highest and lowest numbers. Include the competencies they are required to display as a result of clinical experience.

Describe how the curriculum attempts to facilitate the integration by students of both scientific and clinical concepts. Evaluation processes and outcome results relating to this aspect of the curriculum can be given under Guideline 17.

Describe any other programmes your School offers to prepare students for practice on graduation.

Have the graduates of your Programme been surveyed about their perceptions of the quality of their training and preparation for clinical practice? If so, provide results.

Have employers of your graduates been surveyed about the quality of your graduates? If so, provide details.

## 11 Student assessment and examinations

**Guideline 11**

**A clearly stated, valid and reliable system of formative and summative student assessment must be used to determine progression and graduation of students.**

Describe the School's philosophy of assessment of students.

Describe the methods of assessment in each of the subject/courses (if this is clearly described in the course guide, refer to appropriate pages).

Indicate the relationship or links between the School's assessment process and its objectives and teaching approaches.

Are students encouraged to self-assess? If so, give details.

Provide details of redemption/supplementary exams.

Are any special arrangements made for repeating students?

Describe the role of external examiners. Provide copies of external examiners reports from the past two to three years.

What mechanisms are available for student appeals relating to assessment?

Does your School use special "barrier examinations" to prevent students from progressing unless a satisfactory performance is achieved? If so, in what areas and how?

Does your School provide staff and students with an assessment policy? If so, provide a copy.

Provide examples of previous exam question papers for each year level of the course.

Include, as an appendix a table showing progression rates, withdrawals, deferrals and failures for all years over the past three years.

## 12 Student support and representation

**Guideline 12**

**There must be student representation on appropriate committees, and student grievances and concerns must be identified and addressed. Counselling and health services should be available to all students.**

What is the nature of student representation on School committees?

How are students encouraged to join and participate in student and professional organisations?

What mechanisms are in place to ensure early contact with stress management and prevention and awareness of high-risk behaviour and symptoms of impairment?

Give details of the counselling/psychiatric treatment facilities available to students including comment on its accessibility, confidentiality and degree of separation from the School.

What role modelling and mentoring schemes are in operation? Give details.

What health services are available for students?

What financial aid provisions are there for students?

What mechanisms are in place to ensure early identification, assistance and follow-up of students experiencing difficulties, eg. academic, social, cultural, health etc?

How does the school deal with impaired students? e.g. drugs, alcohol, mental illness?

What remedial support is available for students, eg. study skills?

Are there specific language support programmes available for students?

What mechanisms are available to enable students to comment on their course and teaching staff?

Give details of student facilities including lockers, common room, etc.

How are students protected from discrimination?

How are students protected in the case of error or adverse outcomes?

What mechanisms are available to consider grievances from students?

## 13 Relationship with allied dental education programmes

**Guideline 13**

**There should be integration of the Dental Therapy and/or Dental Hygiene Programme with the BDS programme where possible so that students learn to work as members of a dental health team. Where possible, students should have an opportunity to interact with students in other health education programmes to foster effective communication between disciplines.**

Are there any other dental education programmes in your institution? If yes, describe how they relate to the Programme.

If applicable, describe the interaction between the students in any other NZ training programme with the students in your Programme. Give details if appropriate.

How do dental therapy and/or dental hygienist students interact with other members of the dental team throughout the course?

How do students interact with other health professionals (apart from dental students) throughout the course?

## 14 Interface with other service providers

**Guideline 14**

**The Programme must have functional relationships with at least one District Health Board or other providers of oral health care such as community clinics. The relationship must enable students of dental therapy or dental hygiene to provide oral health care for patients appropriate to that required to achieve the educational objectives described by the provider.**

Describe the relationship between the educational programme and the DHB. Does the relationship enable achievement of the identified educational objectives?

Are there any difficulties or areas of tension in this relationship?

Describe any other programmes that provide your students with opportunities to gain experience in hospitals or other settings.

How much time do students spend outside the educational institution and in what settings?

Describe how the educational programme interacts with local community health programmes. Provide examples.

## 15 Interface with the education institution, profession and community

**Guideline 15**

**The Programme should have functional relationships with other departments of the Educational Institution, with the various dental professions and their organisations, and with the community in order to promote dentistry and provide learning opportunities for students.**

Describe how the Programme interacts with other departments.

Describe how the Programme interacts with the various dental professions.

Are there any difficulties or areas of tension in these relationships?

Describe how the Programme promotes oral health promotion within the community.

Describe how the Programme interacts with Australian programme providers.

## 16 Research and postgraduate and continuing education

**Guideline 16**

**There should be a demonstrated commitment to establish research related to dental therapy and/or dental hygiene practice and oral health promotion. Where possible this research should involve students.**

What are the research strengths of your Programme and School?

How are students made aware of research activities in your Programme/School?

How may students become involved in research activities in your Programme/School?

What evidence is there that research activities of your Programme/School contribute to or complement the course being provided?

Has your Programme undertaken any dental education research? If so, give details.

What is the relationship between teaching staff in your Programme and research in Oral Health Sciences?

Provide a brief overview of postgraduate programmes offered and how they are linked to the dental therapy or dental hygiene courses.

Is the programme involved in running CPD programmes?

## 17 Evaluation procedures and outcomes

**Guideline 17**

**The School must perform ongoing evaluation of the outcomes of its Programme to determine whether it is meeting its objectives. Results of the evaluation process must be used to improve the Programme.**

Provide details of the evaluation processes used in the Programme to assess the quality of its teaching and learning, including outcome results.

Consider:

- student evaluation of individual subjects
- student evaluation of the curriculum overall
- student evaluation of academic staff
- student evaluation of part-time tutors
- staff evaluation of students
- peer review of teaching (PET)
- external examiners reports
- course experience questionnaires (CEQs)
- evaluation by graduates -e.g., how well-prepared are they?
- evaluation by employers of graduates
- other

Does your Programme have a teaching portfolio? If so, provide a copy.

## 18 SWOT analysis

**Guideline 18**

**Each School must identify its own strengths, weaknesses, and opportunities for improvement and threats to the quality of its Programme.**

Include a brief discussion of current active issues in dental education in New Zealand, with particular reference to therapy and hygiene education.

What are the perceived strengths of your dental therapy and/or dental hygiene course?

What are the weaknesses?

What opportunities are presenting themselves?

What threats exist?

## 19 Mana Maori

**Guideline 19**

The educational provider must demonstrate that the principles of Mana Maori and of the Treaty of Waitangi are upheld throughout the programme.

Describe how the guideline is given effect in the recruitment and support of Maori students. Does the school, for example, employ Maori personnel skilled in supporting Maori students?

Describe the school's relationships with local Iwi and Hapu in ways, which illustrate plans to increase Maori participation within the profession and ways to ensure cross cultural understanding.

How does the School ensure the highest rate of retention of Maori students?

Describe how the guideline is given effect in scholarship, teaching and research.

Describe how the guideline is given effect in achieving a Maori focus in the programme objectives.

Is there a role explicitly devoted to Maori dental health developments within the School?

Does the School's strategic planning include a timetable and budget for achieving Maori focused objectives?

## 20 Strategies and timetables for improvement

**Guideline 20**

**Each School must formulate strategies and a timetable for improvement of its Programme based on the self-assessment process undertaken for accreditation.**

Provide details of the School's strategies for improvement of the Dental Therapy and/or Dental Hygiene Programme, including a timetable for implementation.

## 21 Appendices

1. Flowchart of School's relationship to University
2. Flowchart of administrative structure of School
3. Flowchart of committee structure of School
4. Roles and membership of committees
5. Budgets for the last three years
6. Strategic plan
7. Business plan
8. Staff – names, CVs
9. Staff documents
10. Table of student numbers
11. Information on admissions
12. Entry on curriculum in Calendar
13. Course handbooks
14. Description of courses
15. Timetables
16. Administrative flowchart of dental clinics
17. Policies, protocols of clinic administration
18. External examiners reports
19. Assessment policy
20. Previous examination questions
21. Progression rates, withdrawals, etc
22. Summaries of evaluations
23. Teaching portfolio

# DAHP 101 - General Health Sciences (8 points)

DAHP101 *General Health Sciences* is a one-year course for Dental Hygiene and Dental Therapy Diploma students in their first year that aims to provide a broad, basic understanding of health sciences disciplines that the underlie the provision of health care. The course is presented as five modules covering, Cell Biology, Chemistry, Physics, Biochemistry, Microbiology and Immunology. This two-semester course includes lectures and laboratory sessions.

### Anatomy
This module is designed as a general introduction to the tissues and systems of the human body, at all levels from cells to gross anatomy. Anatomy is the largest module in the DAHP 101 course, running for the entire first semester. The anatomy module has a significant practical component including a section on histology and virtual dissection.

### Cell Biology
Introduction to the structure and function of the living cell. Includes brief introduction to the biological macromolecules proteins (enzymes), nucleic acids, lipids and carbohydrates; structure and function of the major eukaryotic organelles: plasma membrane, nucleus, nucleolus, mitochondria, ribosomes, vacuoles, lysosomes, Golgi apparatus; how cells are connected to form tissues; cell specialisation; cell division.

### Chemistry
An introduction to chemistry and its links with the oral health sciences. Atoms, elements, the periodic table, mixtures, compounds, bonds, solids, liquids and gases. Symbols, formulae, naming conventions. Reactions, the mole, equilibrium. Electrolytes, concentrations, solubility, acids, bases, salts, buffers, oxidation, reduction. Hydrocarbons, their formulae and naming. Alcohols, ethers, amines, aldehydes, ketones and carboxylic acids.

### Biochemistry
Bases, RNA, DNA, structure. Replication, transcription, translation. Amino acids, peptides, structure. Fibrous proteins (keratins, collagen), globular proteins (myoglobin) Functions of proteins including: oxygen storage and transport, immunoglobulins and enzymes. Absorption and digestion of carbohydrates, lipids and proteins, energy, chemical components of food and work Essential metabolic pathways (glycolysis, pyruvate oxidation and citric acid cycle/respiration. ATP, mitochondria, electron transport and oxidative phosphorylation). Vitamins. Hormonal regulation of fuel metabolism, starvation, diabetes mellitus. Lipid metabolism, cardiovascular disease. Food and Nutrition Guideline for NZ.

### Microbiology
Introduction to microbiology. Includes principles of sterilisation and disinfection; prevention of cross-infection; introduction to bacteriology (prokaryotes), gram-positive and gram-negative bacteria, cell structure, antibiotics, prokaryotic genetics and gene exchange, antibiotic resistance; pathogens and virulence factors; introduction to mycology and pathogenic fungi; introduction to virology.

### Immunology
Introduction to the human immune system; innate immunity including antimicrobial factors in saliva; acquired immunity including humoral immunity, stimulation of antibody production, structure and function of antibodies, classical and alternative complement cascades; cell-mediated immunity; the principles of vaccination; allergic reaction; clinical aspects of immunology.

### Physics
Introduction to waves, oscillations, types of waves, superposition, waves at boundaries (transmission, reflection, refraction) attenuation, sound, electromagnetic spectrum, radioactivity. Electric potential, electron beams. Production and uses of ultrasound and X-rays.

### Enabling competencies:

Competent to apply knowledge and understanding of the development, structure and function of the human body and its nutrition to the study of dental hygiene or dental therapy.

Demonstrate knowledge of the cardiopulmonary, digestive, skeletal and nervous systems and their function.

Demonstrate knowledge and understanding of the control of the cardiovascular system and the role of the cardiovascular system in homeostasis and following injury.

Demonstrate knowledge of the influence of nutrition on health and the sources of nutrients e.g. proteins, carbohydrates, fats, minerals and vitamins, as they relate to health, and the information that is given to patients. Demonstrate knowledge of the influence of cultural background on diet.

Demonstrate knowledge and understanding of the principles of sterilization, disinfection and the prevention of cross infection

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Demonstrate knowledge and understanding of the immune system and host responses to micro-organisms.

Demonstrate detailed knowledge the principles of inorganic chemistry and physics as they apply to dental therapy and dental hygiene.

# DAHP 102 - Oral Health Sciences (10 points)

DAHP102 *Oral Health Sciences* is a one year course for Dental Therapy and Dental Hygiene Diploma students in their first year. This two semester course introduces the student to general anatomy relevant to the practice of dental hygiene and dental therapy. An emphasis of course is head and neck anatomy, oral biology and oral pathology, including modules on oral medicine and oral microbiology, are prerequisites to the clinical examination and diagnosis of oral health and the recognition of oral and dental diseases in patients. The course consists of four major modules:

1. Anatomy and Histology
2. Microbiology
3. Oral Biology
4. Oral Medicine and Pathology

### 1. Anatomy and Histology

The module provides knowledge of the integrated anatomy, histology and physiology of the head and neck including clinical examples to reinforce the relevance of those systems to clinical practice. In addition emphasis is placed on the cardiovascular and respiratory systems with regard to the management of medical emergencies in dental practice.

### 2. Microbiology

This module aims to provide basic knowledge of the process of infectious disease, the microbiological ecology of the oral cavity and pathogenic plaque and further to provide a biological basis for understanding the process of dental caries and periodontitis and measures of infection control in clinical practice.

### 3. Oral Biology

This module aims to provide an understanding of the development, structure and function of the craniofacial complex and its components, and to provide knowledge of the biology of the oral environment in health, and an also introduction to the pathogenesis of common oral and dental diseases relevant to dental therapy and dental hygiene practice.

### 4. Oral Medicine and Oral Pathology

This module aims to provide knowledge of the pathogenesis of common oral diseases relevant to dental therapy and dental hygiene practice with emphasis on recognition, clinical implications, referral and modes of treatment.

### Enabling competencies:

Apply knowledge and understanding of the development, structure and function of the craniofacial complex to the study and practice of dental hygiene and dental therapy.

Demonstrate a knowledge of skull and jaw anatomy and how these influence masticatory function.

Demonstrate understanding of the blood supply and lymphatic system of the oral cavity and face.

Demonstrate detailed knowledge of the anatomy of the oral cavity to provide the foundation for the administration of local anaesthetics.

Demonstrate knowledge and understanding of the development and structure of oral and dental tissues and their interactions with the environment.

Demonstrate an understanding of basic concepts and key processes in the discipline of Pathology.

Demonstrate an understanding of the most common disease processes affecting the dental and oral tissues.

Demonstrate an understanding of the basic principles of infection and sterilization based on an understanding of the epidemiology of infectious disease in the dental surgery.

# DTHR 101 - Clinical Dentistry (22 points)

DTHR 101 *Clinical Dentistry* is a full-year paper that introduces students into the clinical environment and routines relevant to dental therapy practice. In the first semester emphasis is placed on operative procedures (cavity design, preparation and restoration) using simulation techniques on phantom heads. The principles of local analgesia, radiography and diagnosis and treatment planning are also introduced. In the second semester clinical and operative procedures are commenced on selected patients.

## List of topics covered

1. Communication skills including informed consent
2. Dental surgery assisting
3. Clinical cross infection control
4. Diagnosis and treatment planning
5. Operative dentistry. Cavity design (Class I - V), cavity preparation and restoration.
6. Dental diseases, their prevention and clinical management. Diet analysis, plaque control and topical fluorides.
7. Radiography
8. Local analgesia and pain control
9. Dental materials in dental therapy practice
10. Introduction to patient management

## Enabling competencies:

Demonstrate knowledge and understanding of the clinical environment and the procedures used to minimize cross infection. Principles of sterilization and their application.

Demonstrate an understanding of diagnosis and treatment planning, and the clinical techniques used for caries prevention, local analgesia, radiography, cavity preparation and the placement of restorations within the scope of dental therapy practice.

Demonstrate an understanding of the anatomy and physiology of pain and the ways in which local anaesthetics modify the sensation of pain.

Perform clinical techniques of fluoride treatment, tooth protection, and manage preventative and restorative care for selected patients.

Demonstrate a knowledge of the components of interpersonal communication and how they may be modified by culture, medication, anxiety or fear. Demonstrate an ability to identify anxiety in patients and implement procedures by which this anxiety can be reduced.

Demonstrate knowledge of the epidemiology of periodontal disease and the principles of "safe practice" in the delivery of oral health care for the patients.

Demonstrate an awareness of the limitations of dental therapy practice and knowledge and application of the procedures for patient referral.

# DAHP 201 - Society and Health (6 points)

DAHP201: *Society and Health* is a full year paper intended to develop an understanding of the basic concepts of community and society and their implications for health and oral health.

The paper comprises three modules:

**Module 1: New Zealand Society and Health**

i) New Zealand Society
ii) Maori oral health
iii) Sociology of health and illness

**Module 2: Health Promotion Theory and Practice**

i) Health promotion concepts and principles
ii) Health education
iii) The prevention of oral disease in populations

**Module 3: Oral Health Care**

i) The New Zealand health system
ii) Allies in health
iii) Quality in oral health care

**Enabling competencies:**

Demonstrate knowledge and understanding of the principles and social content of education in New Zealand Society and its relationship to tikanga Maori.

Demonstrate knowledge and understanding of the models and concepts of social sciences applied to the delivery of social services and oral health care.

Demonstrate an understanding of the implementation of the Treaty of Waitangi and health legislation for the provision of oral health care in New Zealand society.

Demonstrate knowledge and understanding of health issues, beliefs and practices as they relate to various ethnic groups in New Zealand, with emphasis on Maori and Pacific Islanders.

Demonstrate knowledge and understanding of the principles of epidemiology and biostatistics and their application to the delivery and promotion of public oral and dental health.

Demonstrate knowledge of the organization of the health system in New Zealand; strategic planning for the delivery of oral health services, the funding of oral health services and performance indicators.

# DTHR 202: Advanced Clinical Dentistry (24 points)

DTHR 202 is a full-year paper where students undertake the diagnosis (including medical histories), treatment planning and treatment of a wide range of patients in a closely supervised clinical environment.. In the first semester new operative procedures such as pulpotomy, complex restorations and the placement of stainless steel crowns are learnt using simulation techniques, and the principles of exodontia (tooth extraction), and the management of traumatic injuries are also covered. The management of children and adolescents with special needs (including those on medication) and recognition of conditions beyond the scope of dental therapy practice (e.g. clinical oral pathology, periodontology, exodontia and orthodontia) are emphasized and the procedures for referral implemented.

## List of topics covered

1. Operative management of dental caries including complex restorations on permanent and primary teeth and stainless steel crowns on primary teeth)
2. Medical histories and pharmacology.
3. Management of deep carious lesions.
4. Pulpotomy for the primary dentition
5. Extraction of primary teeth
6. The dental therapist's role in the management of traumatic injuries
7. The dental therapist's role in the referral of orthodontic patients
8. Clinical practice for children with special needs (e.g. medically compromised children and children with disabilities)
9. Recognition of clinical oral pathology including anomalies of tooth development and eruption
10. Behaviour management and dental caries in the teenage years.

## Enabling competencies:

Demonstrate knowledge and understanding of the principles of radiography and an ability to interpret radiographs to assess oral health or disease.

Describe the clinical and radiographic anatomy of any erupted tooth and its supporting structures, in particular with regard to the principles of exodontia.

Demonstrate competence in the operative management of dental caries (including; diagnosis, treatment planning, cavity design, cavity preparation and placement of restorations, pulpotomy, complex restorations and stainless steel crowns).

Demonstrate competence in exodontia.

Demonstrate an understanding of the complications that can arise from exodontia and explain the principles of post-operative care to patients.

Demonstrate knowledge of the procedures for the management of post-operative complications arising from exodontia.

Demonstrate knowledge and understanding of the principles of oral health prevention and the promotion of health.

Ability to apply and justify criteria by which outcomes of oral health care are assessed.

Demonstrate understanding of the principles of management of patient anxiety and describe how anxiety levels are influenced by the behaviour of dental therapists and environmental factors.

# DTHR 203: Dental Therapy Practice (10 points)

DTHR 203: *Dental Therapy Practice* is a full-year paper that is intended to enable students to become familiar with all aspects pertaining to the organization and support necessary to practice Dental Therapy. This includes knowledge of the scope of Dental Therapy practice, the work environment, records (including computer records), work experience, and the legal requirements of Dental Therapy practice.

## Enabling competencies:

Demonstrate knowledge of the role of the dental therapist in dental practice in New Zealand, and the role of the dental therapist in public health.

Demonstrate knowledge and understanding of the principles of dental clinic management and appraisal in order to deliver optimal dental therapy care.

Demonstrate knowledge and understanding of the principles of education and communication to explain to the patient or their care giver informed consent procedures in order to obtain informed consent.

Demonstrate knowledge and application of the principles of the Health and Disabilities Consumers Code of Rights and the Health Practitioner's Competence Assurance Act as they apply to the practice of Dental Therapy.

Demonstrate an understanding of the roles of all oral health workers and their relationships with dental therapists.

Demonstrate knowledge of the principles of patient data entry and management of software packages to maintain comprehensive patient records.

Demonstrate knowledge and understanding of the strategic role of dental therapists and their legal responsibilities in the delivery of oral health care in New Zealand.

Demonstrate knowledge of the ethical responsibilities of dental therapists in relation to their treatment and referral of patients.

Demonstrate knowledge and application of the principles of patient and practice audit and review.

**Testimony of**
**Don Kashevaroff**
**Tribal Self-Governance Advisory Committee Chair**
**President, Seldovia Village Tribe**
**President and Chairman, Alaska Native Tribal Health Consortium**

**Senate Committee on Indian Affairs**

**July 14, 2005**

**Hearing Regarding**
**Indian Health Care Improvement Act Amendments of 2005**
**Home Health, Dental Health Aide Therapists,**
**FTCA Protection and Negotiated Rulemaking**

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## INTRODUCTION

Mr. Chairman and members of the Committees on Indian Affairs ("SCIA") and Health, Education, Labor and Pensions ("HELP"), thank you for the opportunity to testify on S. 1057, the Indian Health Care Improvement Act ("IHCIA") Amendments of 2005, which will revise and amend the IHCIA. The commitment of the SCIA to ensuring the passage of this important legislation has only been surpassed by that of Tribal leaders and American Indian and Alaska Native ("AI/AN") Tribes throughout the United States.

I appear today as the Chair of the Tribal Self-Governance Advisory Committee ("TSGAC"). The TSGAC consists of Tribal leaders convened by the Indian Health Service ("IHS") to address the health needs of all eligible AI/ANs, especially those served by the Tribal health programs operated through self-determination contracts and self-governance compacts under the Indian Self-Determination and Education Assistance Act ("ISDEAA").

My testimony also reflects my own experience as an Aleut and beneficiary of services provided directly by the IHS and by Tribal health providers, as well as the knowledge I have gained by serving AI/ANs in many capacities, including as President of my own 400 member Federally recognized Tribe – the Seldovia Village Tribe; President and Chair of the Board of the Alaska Native Tribal Health Consortium ("ANTHC") – the largest self-governance program in the United States, serving over 130,000 Alaska Natives; Director of the Alaska Native Health Board ("ANHB"); and Co-Chair of the IHS Tribal-Urban Budget Workgroup. Each of these roles contributes to my understanding of the importance of the bill being considered here today.

ANTHC carries out all non-residual IHS Area Office functions in the Alaska Area. These include a wide range of community health programs, Community Health Aide training and support, administrative support for the Community Health Aide Certification Board, training of personal care attendants and other allied health care providers, development of behavioral health aide training and standards, epidemiology and public health research, cutting edge telehealth development and operation, and construction of sanitation and health facilities in rural Alaska.

ANTHC also co-manages the Alaska Native Medical Center ("ANMC") with Southcentral Foundation ("SCF"). ANMC is the premier tertiary care hospital in the Indian health system and is the only certified Level II Trauma Center in Alaska. In addition to the fine primary care and behavioral health services SCF provides at ANMC, ANTHC provides emergency services and a wide range of specialty care, including internal medicine, ophthalmology, orthopedic, otolaryngology, surgery, cardiology, hematology, and oncology. SCF and ANTHC collaboratively provide women's health and dental services at ANMC. Ancillary services, including pharmacy, laboratory, and imaging services, are also available.

The breadth of these programs contrasts strikingly with the experience we have at the Seldovia Village Tribe where until 4 years ago only contract health services ("CHS") were available to pay for limited care from private physicians for members who could not travel in to Anchorage to receive direct care at ANMC. For all the differences in scope of services, however, we share with ANTHC, and other Tribal health programs throughout the Indian health system, the most important characteristic of self-determination and self-governance Tribes – that of determination, of assessing the health needs of our people and redesigning and expanding our programs to improve the available care. Since the Seldovia Village Tribe assumed its program from IHS, it has established a clinic, providing an expanding range of culturally appropriate primary, preventive and wellness services. It also began offering community health services, including programs to encourage children and teens to develop healthy lifestyles and discourage substance abuse. Just last week, the Seldovia Village Tribe opened the doors of its new clinic and anticipates expanding its services to include behavioral health and dental services.

Similarly, ANTHC has made numerous changes to the programs it administers to better address the needs of Alaska Natives. To cite just a few examples, ANMC developed a pediatric intensive care unit, adding a perinatologist and two pediatric intensive care specialists to the medical staff. Our Division of Environmental Health and Engineering changed the foundation of its service delivery so that it was aligned with the Tribal regions, where it builds health and sanitation facilities and provides a wide range of environmental health services. ANTHC developed and expanded more responsive community health services, including its traditional food safety program, which monitors the level of contaminants in subsistence food sources. ANTHC increased its emphasis on injury prevention and preventive care measures, including HIV prevention and tobacco cessation programs. At the same time ANMC reorganized its specialty departments to increase access for patients traveling to Anchorage, the AFHCAN project developed telehealth technology that allowed more Natives living in rural areas to receive care in their own villages.

I mention these accomplishments not to convince you about the worth of the ISDEAA. I know the achievements of Tribes operating programs under the ISDEAA are well known to the members of the SCIA. I describe them instead to provide a backdrop for the importance of the amendments proposed to the IHCIA.

**HOME HEALTH**

S. 1057 amends the IHCIA in ways that reflect the recognition that fundamental changes have occurred in health care delivery since the last significant consideration of the IHCIA in the 1980s. Since then health care delivery has been transformed.

- Throughout the nation, hospitals used to be the centerpiece of health care delivery, but now the focus is on delivering care in homes and communities. This change results from the development of new modalities in health care delivery, the need to address more chronic conditions of an aging population, and the recognition that the cost of institutionally based care is simply unaffordable. These are all factors that apply equally in the AI/AN community and Indian health system.

- The health status of AI/ANs remains lower than that of other populations in the United States, but the causes of morbidity and mortality have changed. It is no longer neo-natal mortality and communicable diseases that rank among the highest causes of death, but rather diseases like cancer, heart disease, and diabetes – all conditions that can be affected by life style and, which must ultimately be addressed through strong prevention and early intervention programs. In the meantime, there are huge challenges in meeting the treatment needs with those who are afflicted.

- In the Indian health system, reliance on third-party reimbursement and other funding sources has become increasingly important since appropriations to IHS fail even to keep up with inflation, let alone to address population growth, the cost of new pharmaceuticals, and increased morbidity. Third-party payors limit the number of hospital days for which they will provide reimbursement believing that better, more appropriate care can be achieved in non-hospital settings at a substantially lower cost. States have obtained "waivers" from Medicaid allowing expanded non-hospital based services where they can demonstrate cost savings.

  This is important from two points of view in the Indian health system. First, to the extent home based care is not embraced, for those AI/AN patients with Medicaid, Medicare or other third-party coverage reimbursement is not available for days of hospital care in which the patient could have received adequate care in another lower cost setting. Secondly, the IHS and Tribal facilities are bearing the cost of the most expensive level of care, when if the resources were deployed in other types of care substantial savings could be achieved.

- Due to the successes in the Indian health system AI/ANs are living longer, and, now need a wider range of services including home health, personal care attendants, assisted living, and, in some cases, nursing home care. At ANMC about twenty-five percent of bed days could be in a less acute setting if the resources existed to support our patients through

skilled nursing, home care, personal care attendants, assisted living, and, near the end of life, hospice. These resources would include specially trained health professionals such as personal care attendants, case managers and others who can meet the needs of AI/ANs in their homes and villages under the direction of physicians, rather than relying solely on facility based care.

- Home- and community-based care also provides opportunities for AI/AN elders to receive the most culturally competent care. The constraints of hospital based care are many. For AI/AN elders, having to choose between leaving their home and community to receive care and doing without that care is very difficult. Leaving home often means being surrounded by providers who do not speak the elder's language, eating non-traditional foods, and losing contact with family who may live far from the hospital. Providing a wide range of supportive and skilled services at home delays or forestalls the need for hospitalization and shortens the stays when they must occur.

Indian health programs throughout the country are working to address these dynamics. More express authority in the IHCIA will assist the Indian health system and provide clearer direction that Congress is serious about its commitment to supporting the Indian health system in delivering the best mix of services to AI/ANs in the most cost effective way.

This is a very cost effective approach, as well. The Indian health system is still plagued with old, out-of-date facilities that desperately need replacement. At the same time, due to continued high birth rate and changing patterns of disease and longer life spans, the demands on even new hospitals to increase the number of beds is relentless. Even ANMC, one of the newest facilities, will fall short by 20 beds by 2015 given current trends. The need for expansion can be affected substantially, however, by investments in home care and other levels of community-based care that are expressly described in S. 1057. *See, e.g.,* Section 201(a)(5)(A) and (H), Section 205, and Section 213. The comprehensive range of care described in S. 1057 is critical to meeting the evolving needs of AI/ANs.

**DENTAL HEALTH AIDE THERAPISTS**

Section 121 of the IHCIA, 25 U.S.C. § 1616*l*, expressly authorized the Alaska Community Health Aide Program ("CHAP") through which village residents have been trained since the 1960's to provide health services. These health services have always included dental services. The CHAP has been a critical factor in making health care services available to 85,000 Alaska Natives who otherwise would be without any direct access without, in most cases, having to be flown to another community. Community health aides and practitioners are certified by a Federal board that also adopts standards for training and for certification.

In 2002 the CHAP Certification Board *Standards and Procedures* were amended to provide for certification of a specialized class of community health aides called dental health aides. This was done to address a crisis in dental disease among Alaska Natives and a lack of adequate

providers to address the problem. Among the four classes of dental health aides authorized to be certified upon completion of all of the requirements are dental health aide therapists ("DHATs"). A person may not be certified as a DHAT without completing a two year college dental training curriculum that includes 2400 hundred hours of classroom and clinical experience, of which about 760 hours are spent in a clinic treating patients. Upon successful completion of this training and a preceptorship in which the DHAT must demonstrate under the direct supervision of a dentist the ability to perform each of the procedures for which she will be certified to the same standard as is expected of a dentist, the DHAT may be certified to practice in villages under the general supervision of a dentist.

Six village residents were selected initially by the Yukon-Kuskokwim Health Corporation ("YKHC") and Maniilaq Association to obtain DHAT training. Training is currently being provided at the University of Otago in New Zealand because no United States dental school offers mid-level dental training despite its demonstrated success in reducing unmet need in 42 countries, including Canada, Australia, Great Britain, New Zealand, and Hong Kong. They are all back from training now and are in various stages of their preceptorships and certification. Another cohort of trainees began a year ago and will complete training another year from now.

Tribes in Alaska and around the country have been taken aback by the vehement opposition by the American Dental Association ("ADA") to the certification and practice of DHATs. Their opposition is couched in concerns about quality of care and concern about prevention, but fundamentally appears to be focused on preventing any form of mid-level practice, even in the most remote locations where the alternative is no dental care at all, or seeing a dentist once a year when one can be flown in to the village to conduct a clinic.

The reasons for the program and the legal underpinnings of it are well-explained in a letter written by the Sonosky, Chambers Law Firm LLP on behalf of a number of Alaska Native health programs to the Alaska Attorney General. A copy of this is attached. Also attached are a one page briefing on the issue and a letter from the Director of IHS regarding the services provided by DHATs.

S. 1057 provides for a study of the work of DHATs and limits certification of DHATs in IHS Areas outside Alaska for the four years allocated to complete the study and report to Congress. This is reasonable. Alaska Tribal health programs are completely committed to open evaluation of the work of DHATs, which in Canada has been found to be the equivalent of dentists within the DHAT's scope of practice.

Other witnesses will be addressing this issue in more detail during this hearing. I chose to include it in my comments, both as a representative of ANTHC and the TSGAC, because we believe the issues that underpin this program are so important to achieving the objectives of the IHCIA and of self-governance. IHS and Tribal health programs have been able to have positive impacts because they have looked creatively at health delivery issues and found ways to overcome institutional and funding barriers. There will never be enough dentists to provide

routine dental care in Alaska Native villages or in other Indian communities. The populations are too small to support a resident dentist and the locations too isolated to attract them. Mid-level practitioners made a substantial contribution to overcoming limitations in access to primary health care despite early opposition and fears expressed by physicians. We are convinced that DHATs will prove equally important in solving the dental crisis that plagues AI/ANs. Being able to evaluate health delivery issues and make these decisions after examining the best information is central to the IHS and to self-governance.

**FEDERAL TORT CLAIMS ACT COVERAGE**

We understand that the Administration, and in particular the Department of Justice ("DOJ"), has expressed concerns about the scope of Federal Tort Claims Act ("FTCA") coverage available under existing law and the impact the amendments in S. 1057 might have on such coverage. These concerns have not been expressed directly to the TSGAC or other bodies of Tribal leaders and, thus, Tribal leaders are somewhat at a loss about how to respond. I believe it may be helpful to provide some background about FTCA and the critical importance it plays in the opportunity to making the limited health care dollars available through appropriations to IHS and other funding sources go as far as possible.

Throughout the ISDEAA, Congress has taken care to assure that programs assumed by Tribes will continue to receive the same level of direct and indirect Federal support as when they were directly operated by the IHS. Direct program funding for the programs must "not be less than the appropriate Secretary would have otherwise provided for the operation of the programs." 25 U.S.C. § 450j-1(a)(1). Tribes are guaranteed access to certain "in kind" supports on essentially the same basis as the IHS (*e.g.*, access to Federal sources of supply and interagency motor pool vehicles, etc.) By these provisions, Congress intended "to assure that there is no diminution in program resources when programs, services, functions or activities are transferred to tribal operation," and to ensure that Tribes would not be compelled "to divert program funds to prudently manage the contract, a result Congress has consistently sought to avoid." S. Rep. 103-374, at 9 (1994).

Among the "in kind" supports made available to Tribal organizations is the right to be regarded as an agency of the United States for FTCA purposes with respect to tort claims that arise from carrying out their ISDEAA agreements.

Congress initially extended the FTCA tort claim coverage to ISDEAA contractors on a limited basis, following the failure of the Secretary of the Interior to meet his legal obligation to procure liability insurance on their behalf, Pub. L. 100-472, § 201(c) (1988), and pending the Secretary's investigation of the feasibility of procuring such insurance or providing alternative protection. When the Secretary failed to investigate the cost and availability of liability insurance, Congress made the FTCA coverage permanent:

> The Committee has included language to make the extension of the Federal Tort Claims protection to P.L. 638 contractors permanent. It is unfortunate that the Department did not respond in a timely manner to the Committee's direction last year to undertake a study to show if other means of meeting the legal requirement for the Secretary [of the Interior] to provide liability coverage for tribal contractors would be preferable. However, since the Department delayed taking action to respond to this directive, the Committee has no choice but to provide the required liability coverage on a permanent basis by extending the Federal Tort Claims Act coverage.

H.R. Rep. No. 101-789, Oct 2, 1990 at 72. *See also* S. Rep. 101-534, Oct. 16, 1990 at 65 ("This step is necessary due to the failure of the Bureau to conduct the necessary study and analysis of alternatives requested by the Committees.")

Through § 314 of Pub. L. 101-512 and other laws, Congress extended to Tribal contractors the same protective provisions of the FTCA that limit the United States' exposure in its own FTCA litigation. In 1987, when Congress began enacting the series of public laws that extended FTCA and other protections to Tribal contractors, it was especially concerned that ISDEAA has inadvertently shifted extraordinary risk of liability to the Tribal contractors by effectively requiring each one

> to waive its immunity from suit up to the policy limits of its insurance, and then to be subjected to litigation without any of the protective and very restrictive provisions which apply to litigation under the Federal Tort Claims Act.

S. Rep. 100-274 at 2646.

The legislative history indicates that Congress understood that Pub. L. 101-512 and its predecessors simply restored the status quo by making the Federal government responsible for any legal liability associated with the performance of Federal functions.

> It is clear that tribal contractors are carrying out federal responsibilities. The nature of the legal liability associated with such responsibilities does not change because a tribal government is performing a Federal function. The unique nature of the legal trust relationship between the Federal Government and tribal governments requires that the Federal Government provide liability insurance coverage in the same manner as such coverage is provided when the Federal Government performs the function. Consequently, section 201(c) of the Committee amendment

> provides that, for purposes of the Federal Tort Claims Act, employees of Indian tribes carrying out self-determination contracts are considered to be employees of the Federal Government.

S. Rep. 100-274, Dec. 21, 1987 at 2645.

Further, Congress recognized the high cost of liability insurance that Tribes were forced to bear, but from which the Government was exempt:

> Further, tribal governments must carry liability insurance, premiums for which have skyrocketed in the last few years, just as they have for other units of government. The Federal Government, because it is covered under the provisions of the Federal Tort Claims Act, does not have to incur the cost of purchasing such insurance.

S. Rep. 100-274, Dec. 21, 1987 at 2628 (regarding discussion of indirect costs). The Government also recognized the high cost of "tail coverage."

> A patient claiming an injury in connection with the provision of direct services is limited to the remedies available under the Federal Tort Claims Act in any action against the United States. This provision is intended to cover claims against a tribal contractor for acts or omissions that occurred prior to the bill's enactment but for which the statute of limitations has not yet expired. Under current law, the contractors are required to carry malpractice insurance coverage for such past claims. This so-called "tail liability" coverage is even more expensive than coverage for current claims.

S. Rep. 100-274, Dec. 21, 1987 at 2646.

In 1994 the Congressional Budget Office reported to Congress that the extension of the Federal government's liability to include malpractice and other health-care related claims against subcontractors for Tribal organizations that perform Indian Health Service functions under self-determination contracts would have "no significant effect on the federal budget." S.Rep. 103-374 at 15. The GAO concluded that "[i]n aggregate the percentage of tribal claims approved [by the DOJ] and the amount awarded are comparable with the resolution of other FTCA claims at the Department of Health and Human Services." Statement of Barry T. Hill, testimony before the SIAC, Tuesday July 31, 2001.

Limiting the coverage of FTCA protection would require Tribal contractors and compactors to incur the substantial and extraordinarily burdensome expense for liability insurance, legal representation, and legal liability. If these costs are not born by the DOJ, they will simply shift to the IHS. The IHS will be legally obliged to provide adequate contract support funds to cover these expenses. If it failed to do so, funds would have to be diverted from direct services. The result: AI/ANs will suffer from diminished health care services, contrary to Congress' intent and to their great detriment:

> As originally enacted, the Self-Determination act authorized either Secretary to require [] tribal contractors to obtain liability insurance. The Act also precluded insurance carriers from asserting the tribe's sovereign immunity from suit.
>
> In practice, the costs of such liability insurance have been taken from the amount of funds provided to the tribal contractor for indirect costs. The Committee is concerned that tribal contractors have been forced to pay for liability insurance out of program funds, which in turn, has resulted in decreased levels of services for Indian beneficiaries.

S. Rep. 100-274, Dec. 21, 1987 at 2645. Limiting the FTCA coverage provided by Pub. L. 101-512 and other laws would not only harm the AI/ANs, but could amount to a breach of the Federal government's trust responsibility:

> The United States has assumed a trust responsibility to provide health care to Native Americans. The intent of the Committee is to prevent the Federal government from divesting itself, through the self-determination process, of the obligation it has to properly carry out the responsibility.

S. Rep. 100-274, Dec. 21, 1987 at 2646.

Tribes did not ask for changes in the scope of FTCA coverage even though there are areas where the FTCA coverage of ISDEAA contractors could be improved; nor does S. 1057 propose any changes. While ANTHC, for example, currently expends considerable resources to procure malpractice insurance to cover any "gaps" that may exist in FTCA protection, the cost of full malpractice insurance would be exorbitant, easily running five times as much (or about as much as it costs to pay several full time specialty physicians to provide services for an entire year). ANTHC would have to make corresponding reductions in direct services. Reductions in FTCA coverage are wholly unacceptable, as is trying to limit the delivery of necessary health services to AI/ANs merely because there might be more exposure.

I look forward to hearing the testimony of the Justice Department representative and reading their written testimony. To the extent it triggers the need to provide additional information, I will submit additional testimony or be glad to respond to supplementary questions Committee members may have.

**NEGOTIATED RULEMAKING**

S. 1057 provides for negotiated rulemaking regarding most sections of Title I and Titles II, III, and VII. Rulemaking under the Administrative Procedures Act ("APA") is provided for other sections and for Titles IV and V. *See* Section 802. In the past, the Administration has expressed reservations about negotiated rulemaking. Tribal leaders took the Administration concerns to heart and proposed the compromise in which only certain parts were subject to negotiated rulemaking. We hope that the limitations on the scope of negotiated rulemaking have resolved the concerns.

The TSGAC has especially strong views on this topic given the enormous success of the negotiated rulemaking to implement Title V of the ISDEAA. The provisions found in Section 802 mirror those applicable to that effort, except that a somewhat longer period has been provided for given the number of issues.

Negotiated rulemaking is a critical component of a true government-to-government relationship. The issues that must be addressed in rulemaking are at the heart of a Tribal program's ability to deliver health care services for AI/ANs. In the course of the negotiated rulemaking process, true understanding among Tribes and with IHS is achieved. These insights have positive impacts that go beyond the final rules, and which also assure that the rules will be based on a more complete understanding of the variability in health delivery challenges that face Tribes and across the nation. The role of Tribes should not be limited to that of any other citizen responding to proposed regulations. To produce a good outcome there must be the give and take that worked so well with regard to the self-governance regulations.

**OTHER ISSUES**

**Findings.** The TSGAC was disappointed that S. 1057 did not include some of the findings recommended by the National Steering Committee ("NSC") and included in earlier versions of this bill considered in the last Congress. We strongly believe that the Congress should acknowledge expressly the cession of more than 400,000,000 acres of land in exchange for promises made to AI/ANs and their Tribes and all too often broken. We hope the Committee will amend the bill to include the language found in S. 556, Sections 2(2) through (4).

**Avoiding Regression.** Fundamental to the consideration of S. 1057 must be a close examination to determine whether any provision of it causes a "regression" in authority compared to current law. We believe there are some instances where that occurs. For instance, in Section 403 (current law Section 206), Indian health programs may only bill third-party payors for reasonable

charges as determined by the Secretary. Tribes have advocated for substituting "reasonable charges" for "reasonable expenses" in order to reflect more common health care industry practice, however we are very concerned about inserting the Secretary into the process. The Department of Health and Human Services has no mechanism for making such determinations regarding literally thousands of potential charges or for the periodic amendment of them. This change would have the effect of reducing Tribal autonomy, increasing bureaucracy, and limiting desperately needed revenue.

We are continuing to closely evaluate the bill and may submit additional remarks before the close of the comment period on other provisions.

**CONCLUSION**

Thank you again for the leadership you are showing in trying to move this important legislation forward. We especially appreciate the willingness of the Health, Education, Labor and Pensions Committee members to sit in on a joint hearing with the Indian Affairs Committee. We hope this level of collegial consideration will finally lead to passage.

Thank you also for offering me the honor of testifying on these important issues. If there is any other information I can provide, or that other members of the TSGAC, staff of ANTHC, or of the Seldovia Village Tribe can offer, please let me know.

For more information, contact:
Don Kashevaroff, President & Chairman
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DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Indian Health Service
Rockville MD 20852

OCT 1 2 2004

Ms. H. Sally Smith
Chairperson, Bristol Bay Area
Health Corporation
P.O. Box 130
Dillingham, AK 99576

Dear Chairperson Smith:

The Indian Health Service (IHS) has been asked for its views about the language added to section 121(b) of the Indian Health Care Improvement Act (IHCIA) Reauthorization bill, H.R. 2440, as reported out of the House Resources Committee last week. We are disappointed by the decision of the House Resources Committee to accept the proposal of the American Dental Association (ADA). If enacted by the full Congress, the change to section 121(b) would roll back the existing legal authority of the IHS and Tribes. It would impede progress in implementing an innovative strategy to respond to the crisis in dental health among American Indian and Alaska Native (AI/AN) people.

The ADA has been a good friend to the IHS and Tribes. The U.S. Department of Health and Human Services' (HHS) U.S. Public Health Service (PHS) and the IHS share common goals with the ADA: to ensure that our patients receive quality health care from qualified providers and to increase the access to oral health care. However, on this occasion, the IHS and the ADA differ on the best way to achieve these goals.

The ADA objects to only one category of the dental health aide component of the Community Health Aide Program (CHAP). The organization wants to prevent dental health aide therapists, the highest level of dental health aides, from treating caries and performing pulpotomies and extractions. The ADA's concern is that these procedures should not be performed by anyone other than a licensed dentist because no other level of practitioner could be adequately trained.

The dental health aide therapy program was modeled after extremely successful programs in New Zealand (operating since 1921) and Canada (operating since 1974). The World Health Organization documents 42 countries with some variant of a dental therapist, including Australia, Canada, China (Hong Kong), Great Britain, Malaysia, Singapore, and Thailand. The first six Alaska Natives, who live in remote villages in Alaska, will complete their 2-year training at the Otago University of Dentistry in New Zealand in November 2004. Six additional students began their training in February 2004, and another class is scheduled to start this winter. I am convinced that this training will prepare dental therapists to perform these procedures and that the Alaska Tribal health leaders have developed thorough measures to ensure the continuance of the high quality care they provide.

The ADA has proposed that it establish a volunteer network of dentists who would make periodic visits to Alaska Native villages to supplement the services the Tribal dentists can offer and the other services of the dental health aides. While the offer is very much appreciated and would help, the IHS shares the view of the Alaska Tribal health leaders that it will not begin to respond to the need nor achieve the continuity of culturally appropriate care that AI/AN people deserve.

Decades of inadequate access to dental care, along with other factors that contribute to the generally disparate health condition of AI/ANs compared to the general population, have led to a true epidemic of dental caries among Alaska Natives. The rate is 2-1/2 times that of the general public. The situation is further exacerbated by a chronic shortage of dentists. Alaska Tribal health programs are currently experiencing a persistent 25 percent vacancy rate among dentists along with an annual 30 percent turnover rate.

The HHS has worked closely with the ADA since it first expressed concern about the dental health aide program. In October 2003, the HHS provided a lengthy written briefing on this matter and met with the ADA. Since then, there have been meetings and discussions on a regular basis, including meetings in which I have participated and meetings in Alaska with Alaska Tribal Leaders. Unfortunately, these have not led to a compromise on which we can agree.

The IHS continues to strongly support the dental health aide program component of the CHAP and opposes any restriction on the authority of the IHS to certify dental health aides. We look forward to continuing to work with the National Steering Committee to achieve passage of the IHCIA this year and to work with the ADA to resolve the organization's concerns without accepting the proposed restrictions on this important program.

Sincerely yours,

Charles W. Grim, DDS

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

cc: Ms. Rachel Joseph

## S. 1057, Reauthorization of the Indian Health Care Improvement Act

### Dental Health Aide Therapists: The Solution to a Crisis

**The "Hidden" Epidemic!** The rate of dental decay among children in Alaska in 2-1/2 times the national rate. One-third of school children miss school because of dental pain and 25% report avoiding laughing or smiling because of the way their teeth look. Dental caries are epidemic in Alaska Native villages.

| American Indian/Alaska Native | | |
|---|---|---|
| Children (age) | Have Had Caries | Untreated Caries |
| 2-4 | 79% | 68% |
| 6-14 | 87% | 66% |
| 15-19 | 91% | 68% |

**Continuing to Lose Ground!** In 1991, a dental manpower study was conducted in Alaska. It found that if the IHS/Tribal health system doubled the number of dentists, it would take 10 years to eliminate the unmet need for dental services. But, there have been no funding increases, nor an increase in the number of dentists willing to live in Alaska Native villages. For the 85,000 Alaska Natives who live in the 200 villages without road access, the only time dental services are available is when a dentist flies to the village to conduct a dental clinic or the patient is evacuated by plane to a regional dental clinic. Alaska Tribal Health Programs experience a 25% vacancy rate among dentists and a 30% average annual turnover rate.

**What is the Alaska Dental Health Aide Program?** The Alaska Dental Health Aide (DHA) Program is a specialty practice area under the Community Health Aide Program (CHAP). It is authorized under section 121 of the Indian Health Care Improvement Act, 25 U.S.C. § 1616*l*. CHAP is operated by Alaska tribal health programs carrying out programs of the Indian Health Service (IHS) under the Indian Self-Determination and Education Assistance Act, P.L. 93-638. The focus of the DHA Program is on prevention, pain and infection relief, and basic restorative services.

**Four Levels of Dental Health Aides**

**Primary DHA:** education, dental assisting, preventive services
**Expanded Function DHA:** expanded duty dental assistants in dental clinics
**DHA Hygienists:** dental hygiene services
**DHA Therapists (DHAT):** oral exams, restorations, stainless steel crowns, extractions in villages

**How Are DHATs Trained?** Due to opposition from the American Dental Association, there are no DHAT training programs in the United States yet. DHATs are being educated at the University of Otago in New Zealand. The two year program is includes 2400 hours of classroom and clinical experience, of which about 760 hours are spent in a clinic treating children. DHATs perform more clinical procedures within their scope of practice while in college than the average American dental school graduates.

**How Are DHAT Services Regulated?** DHATs must be employees of an IHS funded tribal health program. After their formal education is complete, DHATs must complete at least a twelve week preceptorship under the direct supervision of a dentist. DHATs must meet the same standard of care as a dentist for each procedure for which she will be certified. DHATs must be certified by the Federal CHAP Certification Board before they can practice in a village. DHATs must satisfy annual continuing education requirements and must be recertified every two years. Evaluation of the performance of the new DHATs is ongoing and will be expanded.

**Does It Work?** The World Health Organization documents 42 countries with some variant of a DHAT, including Australia, Hong Kong, Great Britain, and Canada. After Canada initiated its program, the ratio of extractions to restorations dropped from over 50% to less than 10%. Double blind studies comparing the work of Canadian dental therapists and federal dentists reveal the quality of restorations by therapists to equal that of he dentists. Physician's assistants and nurse practitioners had a major impact on access to general medical care. So, can DHATs on dental health.

**What Does S. 1057 Do?** Sec. 121 in the bill does not amend CHAP in Alaska. It does provide for a study of DHAT implementation over the next four years, reports to the Congress on the outcome, and it prohibits DHATs from being certified outside Alaska during the period of the study.

**For More Information:** The Department of Health and Human Services, IHS, the American Association of Public Health Dentistry, and many foundations and groups concerned about dental health and access have endorsed the DHAT program. It has been the subject of many papers and articles. For more information or an opportunity to see the program, contact:

Paul Sherry, CEO (psherry@anthc.org), Alaska Native Tribal Health Consortium, 907-729-1900;
Trudy Anderson, President, (tanderson@anhb.org) Alaska Native Health Board, 907-562-6006; or
Myra Munson (myra@sonoskyjuneau.com), Sonosky, Chambers, Sachse, Miller & Munson, LLP, 907-586-5880.

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*ALASKA BAR
**ALASKA AND WASHINGTON BAR

**MAY 10, 2005**

**HAND-DELIVERED**

Attorney General David W. Màrquez
Department of Law
P.O. Box 110300
Juneau, Alaska 99811-0300

Re: Dental Health Aide Program

Dear Attorney General Màrquez:

Our firm represents Alaska tribes and tribal health organizations that operate federal health care programs throughout Alaska.

We understand that the State Board of Dental Examiners (the "Dental Board") requested legal advice from your office concerning the federal Community Health Aide Program's dental health aide component. Because of the critical importance of this program in combating the growing epidemic of dental disease in rural Alaska, and because the Dental Board's request to your office indicates a serious and unfortunate misunderstanding of the program, we provide these comments to you.

Your office has previously opined that the State of Alaska's occupational licensing laws — in particular those administered by the Dental Board — apply to providers employed by tribal health care organizations.[1/] With due respect to your office's previous opinion, we believe it was based on errors of fact and a profound misunderstanding of the applicable federal law.[2/] We respectfully suggest that this opinion be revisited and revised, for the reasons expressed in this letter.

## 1.0 Identity and Interest of Commenters

We submit these comments on behalf of:

- Alaska Native Tribal Health Consortium ("ANTHC") – co-operating the Alaska Native Medical Center ("ANMC"), providing all non-residual Indian Health Service ("IHS") Area Office functions, including administrative support for the Community Health Aide Program Certification Board and training of dental health aides;

- Arctic Slope Native Association — operating the Samuel Simmonds Memorial Hospital in Barrow and serving the villages of the North Slope;

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1/ 1993 Inf. Op. Att'y Gen. (Dec. 6; 663-93-0492). The most striking error of fact and law in this opinion is the predicate of its analysis: that the employees of tribal health care organizations "are not contractors with or employees of the federal government and, therefore, are not exempt from state licensing statutes." *Id.*, at 1. In fact, our clients are direct contractors of the federal government's Indian Health Service and, as discussed *infra.*, their employees carry out essential federal programs. We have found no authority whatsoever to support your office's conclusion that employees of federal contractors are treated differently than the contractors themselves for federal preemption purposes.

2/ Federal preemption of the State's occupational licensing laws does not depend on whether the employees are "direct contractors," as your office's 1993 opinion asserts, but on whether licensing by the State will interfere with a federal program or activity. *See generally, Leslie Miller v. Arkansas*, 352 U.S. 187 (1956), *applied in United States v. Commonwealth of Virginia*, 972 F.Supp. 1008 (E.D. Va. 1997) (State's private investigator and security officer licensing laws do not apply to individuals performing background checks for the FBI; federal preemption applies to bar enforcement because "the state statute forms an obstacle to the accomplishment and execution of Congressional objectives"); *discussed in Gartrell Construction Inc. v. Aubry*, 940 F.2d 437 (9th Cir. 1991), *citing*, *Electric Const. Co. v. Flickinger*, 485 P.2d 547 (Arizona), *cert. denied*, 404 U.S. 952 (1971) (subcontractors of federal contractors exempt from state licensing laws, even when not working in a "federal enclave" such as a military base); *and cited in Airport Const. and Materials, Inc., v. Bivens*, 649 S.W.2d 830 (Ark. 1983) (applying *Leslie Miller* to overrule State attempt to require construction contractor licenses; finding impermissible burden "if instrumentalities of the United States must desist from performance of their duties until they satisfy a state officer of their competence, [*i.e.*, when] qualifications are added to those which the federal government has pronounced sufficient.").

- Chugachmiut — operating the North Star Health Clinic in Seward, and providing dental services in Seward, Tatitlek, Chenega and Nanwalek;

- Maniilaq Association ("Maniilaq") – operating the Maniilaq Health Center in Kotzebue and serving 12 villages;

- Norton Sound Health Corporation ("NSHC") – operating the Norton Sound Regional Hospital, and serving 15 villages;

- Southeast Alaska Regional Health Consortium ("SEARHC") – operating the Mt. Edgecumbe Hospital and the Juneau Medical-Dental Clinic, and serving villages and communities throughout Southeast Alaska;

- Tanana Chiefs Conference ("TCC") – operating the Chief Andrew Isaac Health Center in Fairbanks and serving 42 villages; and

- Yukon-Kuskokwim Health Corporation ("YKHC") – operating the Yukon-Kuskokwim Delta Regional Hospital, and serving 58 villages.

Our clients carry out programs of the federal Indian Health Service (IHS) under the Alaska Tribal Health Compact and individual funding agreements with the Secretary of the U.S. Department of Health and Human Services. Our clients' health care services, including dental services, are provided to eligible Alaska Natives and American Indians with federal health care funds received pursuant to Title I (self-determination) and Title V (self-governance) of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.[3/]

As the Alaska Supreme Court has observed, providing health care services to American Indians and Alaska Natives is a uniquely federal obligation.[4/] Congress has repeatedly and expressly confirmed this obligation – and not just recently, but over the course of the last two centuries. The unique federal obligation to provide health services to American Indians and Alaska Natives is required by treaties and by statutes, and has no

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3/ 25 U.S.C. 450 *et seq.*("ISDEAA"). In addition to direct IHS funding, as IHS funded entities, Alaska tribal health providers are eligible Medicare and Medicaid providers. *See*, 42 U.S.C. § 1395qq (Medicare) and 42 U.S.C. § 1396j (Medicaid).

4/ *Fairbanks North Star Borough v. Denâ Nenâ Henash*, 88 P.3d 124, 143 (Alaska 2004) ("ISDEAA 'has the purposes of improving the provision of *federal services* by making them more responsive to tribal needs, and improving the functioning of tribes through increased self-governance."); *see*, 25 U.S.C. § 1601(b) (IHS has the responsibility to foster the "major national goal . . . to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level.").

parallel in state law:

> Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.[5/]

Federal health care services are primarily provided to Alaska Natives through the Alaska tribal health network, including our clients. The Alaska Native Health System as a whole, has a patient base of roughly 120,000 individuals. It operates seven major hospitals, nearly two hundred village clinics, and a wide variety of physical and behavioral health care facilities in all regions of the State, both urban and rural.

### 2.0 Role of Tribal Health Providers in Dental Care

Tribal health providers are not only the principal providers of dental care in rural Alaska — in most rural areas, they are the only providers of dental health care whatsoever.

There is an epidemic of dental disease in rural Alaska. Changes of diet over the last several decades have led to a huge increase in dental problems among rural residents. Long-standing difficulties in obtaining regular, preventative dental care have exacerbated these problems. As the State of Alaska's Department of Health and Social Services ("DHSS") Commissioner Joel Gilbertson recently noted,

> [m]ore that 100,000 people live in rural Alaska. For decades they have faced serious problems obtaining dental care. Most rural villages see a visiting dentist once or twice a year. Children get priority for care, but even their needs are not fully met. Adults rarely get to see a dentist except in emergencies. The oral caries (decay) rate for Alaska Natives is 2 ½ times the

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5/ 25 U.S.C. § 1601(a); *see also* S. Rep. No. 100-274, 100th Cong. 2d Sess (1988), *reprinted in* 1988 U.S.C.C.A.N. 2620; *see also*, 25 U.S.C. § 1602. IHS has increasingly relied on tribes and tribal health organizations to carry out IHS health programs pursuant to ISDEAA. This has "put the administration and management of the health programs in the hands of tribal governments and provides them the flexibility to tailor their health program to meet the diverse and unique needs of their constituents. Significant improvements have been made in the administration of tribal health programs and in the quality, quantity and accessibility of services provided to the service population." *See*, http://www.ihs.gov/NonMedicalPrograms/SelfGovernance/index.asp, Indian Health Service, Office of Tribal Self-Governance.

> national average. It has been increasingly difficult for Alaska's rural health centers to attract and retain full time dentists. There are fewer graduates from U.S. dental schools, and more Alaska dentists are reaching retirement age.[6/]

The Commissioner's recitation of the problem summarizes more specific statistics that are truly alarming:

> Preliminary data from the 1999 Indian Health Service Oral Health Survey in dental clinics indicate the following for Alaska Native children using dental clinic services (not necessarily representative of all Alaska Native children):
>
> - 77% of 2-4 year olds have dental caries experience in their primary teeth.
> - 95% of 6-8 year olds have dental caries experience in their primary or permanent teeth.
> - 83% of 15 year olds have dental caries experience in their permanent teeth.
> - 60% of 2-4 year olds have **untreated dental caries** in their primary teeth.
> - 66% of 6-8 year olds have **untreated dental caries** in their primary or permanent teeth.
> - 67% of 15 year olds have **untreated dental caries** in their permanent teeth.
> - 51% of 35-44 year olds have **untreated dental caries** in their permanent teeth.[7/]

These disease rates are appalling. Dental health among rural Alaskans, particularly children, is in a state of crisis. The objectives established by the Congress in 1992 to promote dental health among American Indians and Alaska Natives have not been

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6/ DHSS Commissioner Joel Gilbertson, *Anchorage Daily News*, 02/24/05.

7/ *Healthy Alaskans 2010 - Volume 1*, 13-4 (emphasis added.) We note that in rural areas of Alaska, virtually the only access to dental services is through IHS/tribal dental clinics, thus these numbers are likely to be highly representative of that population, which is, not coincidentally, the population proposed to be served by dental health aides.

met by any stretch of the imagination:

> **(20)** Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 45 percent among children aged 6 through 8 and no more than 60 percent among adolescents aged 15.
>
> **(21)** Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children aged 6 through 8 and no more than 40 percent among adolescents aged 15.
>
> **(22)** Reduce to no more than 20 percent the proportion of individuals aged 65 and older who have lost all of their natural teeth.
>
> **(23)** Increase to at least 45 percent the proportion of individuals aged 35 to 44 who have never lost a permanent tooth due to dental caries or periodontal disease.
>
> **(24)** Reduce destructive periodontal disease to a prevalence of no more than 15 percent among individuals aged 35 to 44.
>
> **(25)** Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth.
>
> **(26)** Reduce the prevalence of gingivitis among individuals aged 35 to 44 to no more than 50 percent.[8/]

It is painfully obvious that relying on the dentist-only model of service delivery for rural Alaska has failed. Nor is there any reason to think it can succeed.[9/] The vast

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8/ 25 U.S.C. § 1602(b)(20) – (26).

9/ The *Healthy People 2010 Objectives* for the nation are even more ambitious than the 1992 objectives cited above. They include:

- reduction in the proportion of young children with dental caries experience in their primary teeth to 11% (21-1a) [in 1999 77% among 2-4 year old Alaska Natives];
- reduction in the proportion of children with dental caries experience in the primary and permanent teeth to 42% (21-1b) [in 1999 95% among 6-8 year old Alaska Natives];
- reduction in the proportion of adolescents with dental caries experience in their

(continued...)

majority of Alaska dentists are engaged in private practice in urban and suburban areas such as Anchorage, the Mat-Su Valley, Fairbanks and Juneau. Few, if any, of these dentists are willing to travel to villages to provide services.[10/] The cost of providing services in villages is high; travel is unpredictable, time-consuming and expensive; and the ability of the rural population to pay for private dental services is low. Private dentists in Alaska earn comfortable incomes in urban practices.[11/] They have no economic incentive to provide dental health services in rural areas and, for the most part, they do not.[12/]

We are aware that the American Dental Association and Alaska Dental Society have expressed a willingness to develop a "volunteer" visiting dentist program for rural Alaska. Our clients have participated in this program's developmental meetings and some will take advantage of the program should it become available. While well-intentioned, however, the proposed volunteer effort does not begin to address the underlying need for continuity of care and ready, reliable, repeated access to dental health services. As one Maniilaq dentist noted, the ADA's "Caries SWAT Team" might have some positive short term benefits, but those benefits will be extremely limited:

> [O]nce they have filled and extracted all of the diseased teeth the disease ceases to exist and no one will get any more caries right? Or are they planning on coming up every year and spending an entire month in each village? As it is by the end of June I will

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9/ (...continued)

permanent teeth to 51% (21-1c) [in 1999 83% among 15 year old Alaska Natives];

- reduction in the proportion of young children with untreated dental decay in their primary teeth to 9% (21-2a) [in 1999 60% among 2-4 year old Alaska Natives];
- reduction in the proportion of children with untreated dental decay in primary and permanent teeth to 21% (21-2b) [in 1999 66% among 6-8 year old Alaska Natives];
- reduction in the proportion of adolescents with untreated dental decay in their permanent teeth to 15% (21-2c) [in 1999 67% among 15 year old Alaska Natives];
- reduction in the proportion of adults with untreated dental decay to 15% (21-2d) [in 1999 51% among 35-44 year old Alaska Natives].

10/ *Cf.*, 68 *Journal of Dental Education*, No. 1, at 10 (most dentists unwilling to serve publically insured patients; less than 10% of dentists participate in programs to assure oral health care for poor children; "[m]any dentists just do not want publically insured patients...").

11/ The American Dental Society reports the average net income of dentists in 2002 was between $174,350 and $291,250. *ADA 2003 Survey of Dental Practice.*

12/ *See, e.g.*, letter from Yukon-Kuskokwim Health Corporation President Gene Peltola to Senator Ted Stevens, 09/17/04 ("very few of these dentists come to live in rural Alaska where our dental crisis is most acute").

> have done 6 weeks in our largest village and there [are] still tons of disease and as usual I put in at least 10 hour days out there.[13/]

Our clients are skeptical that the proposed "volunteer dentist" effort will continue indefinitely, or even long enough to make any noticeable impact on dental health. When the initial enthusiasm disappears, as it will, it will prove difficult to recruit volunteer dentists to leave their practices and families and travel to remote locations, especially during the winter months. Good dental care requires continuity: regular examinations; repeated oral hygiene education; early and prompt treatment of problems. Sporadic visits from volunteer dentists cannot provide that essential continuity of care.

Additionally, our clients note that the difficulties in scheduling and the costs of "care and feeding" volunteer dentists will be high. Most villages do not have hotels, restaurants or other visitor facilities. Those that exist are often closed in the winter. Visitors from urban areas are often ill-prepared for the weather, for travel delays and for the lack of facilities. The result is a significant burden on local residents, who have to feed and house the visitors. And, of course, village residents, like other Alaskans, appreciate being treated by the same provider from visit to visit — especially providers who are familiar with local customs, language and cultural norms.

Our clients are committed to solving rural Alaska's dental health crisis for the long-term. They operate dental clinics at the regional hospitals and visiting dentist programs for the villages. These efforts, although valiant, are insufficient. The costs of traditional "dentist-based" dental health services are extremely high. And, even if our clients' budgets were unlimited (and they are not), there are simply not enough interested dentists available to meet the needs of rural Alaska. Alaska tribal health programs have experienced a persistent 25% vacancy rate among dentists and a 30% turnover rate.[14/] Recruitment is difficult.[15/] The traditional lures of higher salaries for professional positions in remote

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13/ Email from Dr. J. Borden, DDS, to Dr. J. Tucker, DDS, 5/4/05.

14/ Letter from Dr. Charles W. Grim, D.D.S., M.H.S.A., Assistant Surgeon General and Director of the Indian Health Service, to H. Sally Smith, Chair, Bristol Bay Health Corporation, 10/12/04, (copy attached).

15/

> While the number of dentists has been increasing [in the United States] for the past 20 years, it has not kept pace with overall population growth, resulting in a decreasing dentist-to-population ratio. This diminishing supply relative to the population is due primarily to a decline in the number of dental graduates and to an aging and retiring dentist population.

"Dental Education and the University of California: Final Report of the Health Sciences Committee – September 2004" (hereafter "Final Report"), pg. 3, footnotes deleted. Since 1960 (continued...)

locations and loan forgiveness for public practice are simply not adequate incentives.[16/]

Because the "dentist-based" practice model has been a costly failure, and in order to provide rural residents with continuity of care, the federal government and our clients have moved to another model of providing high quality dental health care for Alaska villages: CHAP dental health aides.

### 3.0 Community Health Aide Program

The Alaska dental health aides are a component of the Alaska Community Health Aide Program (the "CHAP"). The CHAP was developed by the Indian Health Service in the 1950's in response to the tuberculous epidemic, high infant mortality rate and

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15/ (...continued)
the number of dental schools in the United States has declined from 60 to 56, with seven having closed between 1986 and 1991. "Dental Education At-A-Glance 2004" (hereafter "Dental Education"), American Dental Education Association Institute for Public and Advocacy, pg. 2. There is also a shortage in dental school faculty where the greatest factors are retirement and faculty leaving to enter private practice. *Id.*

Maldistribution of dentists is even more serious. "Many rural areas have shortages of oral health professionals, and most minority and low-income urban areas are disproportionately underserved." "Final Report," at 4. In California 31 of 32 Medical Service Study Areas with no dentist at all are in rural areas. *Id.* But for the tribal health providers in Alaska, a similar situation would be present in Alaska's remote communities. The ADEA Dental Education At-A-Glance 2004" sums up the problem succinctly:

> Studies that focus merely on the aggregate number of dentists miss the evident issue that a sizable portion of the population has difficulty availing itself of needed or wanted oral health care, regardless of the current or projected number of dentists or projected levels of their productivity.

16/ "Nationwide Survey of Work Environment Perceptions and Dentists' Salaries in Community Health Centers," *Journal of the American Dental Association*, February 2005, 136:214. Key dentist retention factors include freedom to exercise professional judgment, altruistic motivation, sufficient admin time, and availability of specialty referral options. Money as a motivating factor was inversely related to retention. Ninety-three percent of all dentists practice are in private practice. "Final Report" at 2.

> For new dentists the average net income of new dentists graduating from U.S. dental schools between 1999-2001 it was (*sic)* $142,461; for graduates from 1996-1998 it was $153,174; and for graduates of 1992-1995 it was $174,565 (*Survey of New Dentist Financial Issues*, American Dental Association, 2002).

"Dental Education" at 2. The salaries that tribal health providers can offer cannot compete with the reasonable private practice expectations of new graduates.

high rate of injuries and deaths in rural Alaska. Today, the CHAP is the backbone of health care for rural Alaska residents. There are hundreds of rigorously trained, fully qualified and carefully supervised Community Health Aides in Alaska's villages. Community Health Aides and Community Health Practitioners (somewhat confusingly referred to as "CHA/Ps") provide over 300,000 patient care visits annually. CHA/Ps are the primary health care providers in Alaska villages.

For the most part, CHA/Ps are Alaska Natives who choose to live in their home villages. They work under the supervision of Alaska tribal health network physicians and dentists located at the regional hospitals. CHA/Ps are certified (and re-certified every two years) by the federal Community Health Aide Program Certification Board (CHAPCB).[17/] This is a critical distinction. Unlike other health care providers in Alaska, CHA/Ps are authorized and certified to practice by the federal government. They are not licensed by the State of Alaska and do not need a State license to practice.

The CHAP was established by the federal government under the Synder Act, 25 U.S.C. § 13, the Indian Health Care Improvement Act, as amended, 25 U.S.C. § 1616*l*, and through numerous directives and circulars of the United States Department of Health and Human Services, the Public Health Service, the Indian Health Service and the Alaska Area Native Health Service. The enabling statute provides:

> **(a) Maintenance of Program.** Under the authority of section 13 of this title, the Secretary shall maintain a **Community Health Aide Program in Alaska** under which the Service—
>
> **(1)** provides for the training of Alaska Natives as health aides or community health practitioners;
>
> **(2)** uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and
>
> **(3)** provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.
>
> **(b) Training; curriculum; certification board.** The Secretary, acting through the Community Health Aide Program of the Service, shall--

17/ *See generally*, Community Health Aide Program Certification Board — *Standards and Procedures* (Jan 2005) (copy attached).

> **(1)** using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;
>
> **(2)** in order to provide such training, develop a curriculum that–
>
> **(A)** combines education in the theory of health care with supervised practical experience in the provision of health care;
>
> **(B)** provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and
>
> **(C)** promotes the achievement of the health status objectives specified in section 1602(b) of this title;
>
> **(3)** establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;
>
> **(4)** develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;
>
> **(5)** develop and maintain a system that provides close supervision of community health aides and community health practitioners; and
>
> **(6)** develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services.[18/]

Provision of dental services has been part of the program since its inception. The demand to respond to acute care needs overwhelmed the ability of most CHA/Ps to emphasize dental services. Addressing the oral health crisis among Alaska Natives requires

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**18/** 25 U.S.C. § 1616*l* (emphasis added).

focused attention. After extensive work on the part of IHS and the dental chiefs in the Alaska Native Health System, the CHAPCB adopted standards for certification of specialized community health aides, known as dental health aides and dental health aide therapists (collectively, "CHAP dental health aides"). [19/]

### 4.0 CHAP Dental Health Aides

The dental health aide model for providing basic preventative and restorative dental health care in rural, underserved areas was initially developed in New Zealand during the 1920s. The New Zealand "School Dental Service" employs nearly 1,000 dental health therapists to provide basic dental health care to children throughout rural New Zealand. The program has been an extraordinary success. During the course of the school year, all children are examined and treated. "Because of this emphasis on treatment, essentially all the children in New Zealand are free of carious infection by the end of a school year."[20/] Similar programs based on this model, but with a broader patient base, have been utilized with great success in Canada and Australia.[21/]

The CHAP dental health aide component is designed to take full advantage of New Zealand's seventy-five years of experience with this practice model. Prospective dental health aides and therapists must first receive training that meets the extensive criteria of the federal Community Health Aide Certification Board.[22/] Most levels of dental health aides receive their training in Alaska. The first groups of Alaska dental health therapists are currently receiving training at New Zealand's Otago University, which has a long-established and excellent dental health program.[23/]

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19/ Copy enclosed.

20/ David A. Nash, D.M.D., M.S., Ed.D., "Developing a Pediatric Oral Heath Therapist to Help Address Oral Health Disparities Among Children," 68 *Journal of Dental Education*, No. 1, at 13 (2004). Contrast this health standard ("caries free") with the experience of Alaska Native and American Indian school age children, 60 — 67% of whom have untreated caries.

21/ *See e.g.*, 90 *Circumpolar Health* 668, Dental Therapists and the Delivery of Dental Care in Canada's Northwest Territories ("The dental therapist program has achieved some every positive results. The program has demonstrated that the native people can be trained to perform a wide variety of dental procedures, including simple extractions and restorative procedures, and that these graduates can enter the community and provide a high level of dental health care in their community. The use of dental therapists to provide dental care in the N.W.T. is proving to be an effective alternative to the problems of maldistribution of dental health care providers.").

22/ *See*, Community Health Aide Program Certification Board — *Standards and Procedures* (Jan 2005), Chapter 7 ("Certification of Dental health aide Training and Curricula").

23/ http://www.otago.ac.nz/ ; http://healthsci.otago.ac.nz/division/info/dthe.html

The Otago University training program is followed by preceptorships in Alaska under licensed dentists who work for Alaska tribal health programs.[24/] At every step of the training, preceptorship and certification process, the prospective dental health aides are required to have both academic and hands-on, practical training.[25/] The final step is certification by the Community Health Aide Certification Board at the level appropriate for the individual's training and abilities.

Following certification, the dental health aides return to their home communities to provide services. As with CHAP village health aides, who are supervised by physicians, CHAP dental health aides are closely supervised by dentists located in the regional Alaska tribal health network medical centers. The dental health aides must demonstrate and maintain core competencies,[26/] and are required to obtain continuing training and education in order to maintain and renew their certifications.[27/] CHAP dental health aides may have their certifications suspended or revoked for failure to maintain proper standards of care, failure to keep current, and for misconduct.[28/]

The CHAP dental health aide program has been enthusiastically received by federal authorities, tribal health providers and village residents alike. Assistant Surgeon General Charles W. Grim, D.D.S., head of the Indian Health Service and a dentist himself, noted that even the American Dental Association, which has been the strongest opponent of this program, has very limited objections. Even these limited objections, Dr. Grim believes,

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**24/** Community Health Aide Program Certification Board — *Standards and Procedures* (Jan. 2005), Chapter 2, Article 10 ("Initial Qualifications").

**25/** *See, e.g.*, Community Health Aide Program Certification Board — *Standards and Procedures* (Jan. 2005), Chapter 7, Article 20 ("Dental Health Aide Curricula").

**26/** *E.g.*, Community Health Aide Program Certification Board — *Standards and Procedures* (Jan. 2005), Chapter 2, Article 30, Sec. 2.30.610 ("Dental Health Aide Therapist and Competencies").

**27/** Community Health Aide Program Certification Board — *Standards and Procedures* (Jan. 2005), Chapter 3 ("Continuing Education").

**28/** Community Health Aide Program Certification Board — *Standards and Procedures* (Jan. 2005), Chapter 4 ("Discipline, Suspension or Revocation of a Community Health Aide, Community Health Practitioner or Dental Health Aide").

are not well-founded:

> The ADA objects to only one category of the dental health aide component of the Community Health Aide Program (CHAP). The organization wants to prevent dental health aide therapists, the highest level of dental health aides, from treating caries and performing pulpotomies and extractions. The ADA's concern is that these procedures should not be performed by anyone other than a licensed dentist because no other level of practitioner could be adequately trained.
>
> The dental health aide therapy program was modeled after extremely successful programs in New Zealand (operating since 1921) and Canada (operating since 1974). The World Health Organization documents 42 countries with some variant of a dental therapist, including Australia, Canada, China (Hong Kong), Great Britain, Malaysia, Singapore and Thailand. The first six Alaska Natives, who live in remote villages in Alaska, will complete their 2-year training at the Otago University in New Zealand in November 2004. Six additional students began their training in February 2004, and another class is scheduled to start this winter. I am convinced that this training will prepare dental therapists to perform these procedures and that the Alaska Tribal health leaders have developed thorough measures to endure the continuance of the high quality care they provide.[29/]

### 5.0 Mid-Level Dental Practice

The federal CHAP Certification Board's dental health aide model does not precisely correspond with the State of Alaska's Board of Dental Examiner's regulatory scheme. The federal CHAP Certification Board has determined that well-trained and supervised mid-level dental practitioners can provide high quality services and thereby expand access to dental services. Alaska, like most other states, has chosen to restrict delivery of dental services to dentists, with the exception of certain very limited services by dental hygienists.[30/]

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29/ Letter from Dr. Charles W. Grim, D.D.S., M.H.S.A., Assistant Surgeon General and Director of the Indian Health Service, to H. Sally Smith, Chair, Bristol Bay Health Corporation, 10/12/04.

30/ "Dental hygienists" are licensed by the Alaska Dental Board under AS 08.32.010 — .190. *See, e.g.*, AS 08.32.110(c) (limits on hygienist's scope of practice).

Reliance exclusively on dentists results in a *de facto* rationing of dental health care based on the availability of dentists. There are simply not enough dentists in Alaska to provide even a marginally acceptable level of dental health care in rural areas. Reliance on the "dentists only" model catastrophically limits dental health care in the predominantly Alaska Native areas of the State. The Federal government, acting through the Department of Health and Human Services and Indian Health Service, have chosen to address the dental health problem of Alaska Natives for which they have a responsibility to provide health care, in a different way: the dental health aide model of care.

In making this policy choice, the IHS relied both on its experience with the CHAP and on the experience throughout the country with other categories of mid-level practitioners. It was not many years ago that medical care could be delivered only by physicians – the "doctors only" medical model that was employed before the advent of physician assistants, mobile intensive care paramedics, advanced nurse practitioners and other mid-level medical are providers in Alaska.[31/] Those licensed mid-level practitioners have modernized the provision of medical care, and have greatly improved patient access to timely and affordable care, especially in Alaska's rural areas.

It appears from the request to your office that the State Dental Board has heard from the Alaska Dental Society and the American Dental Association. It is perhaps not surprising that these professional organizations oppose mid-level practitioners, although it is disappointing. The State Board frames its question to your office in entirely negative terms, without articulating an objective view of the situation:

> I am writing to alert you to the fact that there are people in rural Alaska practicing dentistry illegally. They are being allowed to practice dentistry without possessing the Alaskan license to do so. . . . The Board is concerned that we are putting our rural citizens at risk by allowing high school graduates who have attended a non-accredited dental program in a foreign country to practice dentistry in our state.[32/]

The State Board's letter is premised on conclusions that are both legally and factually unsupported. The CHAP dental health aides are neither "practicing dentistry illegally" nor required to "possess[ an] Alaska license." The dental health aides are fully qualified, federally-certified and federally-authorized to provide dental health services under authority of federal law. The dental health therapist model is a proven, effective method of

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31/ *E.g.*, AS 08.64.107 (physician assistants and paramedics).

32/ Dental Board President Robert E. Warren, D.D.S., to (former) Attorney General Gregg Renkes, Feb. 7, 2005.

improving dental health in isolated and underserved populations.[33/] The federal government's adoption of this sound approach holds the most promise of successfully combating the rural Alaska dental disease epidemic.

### 6.0 Federal Preemption

In considering the State Dental Board's opinion request, of course, your office does not need to reach or opine upon the clinical merits of the dental health aide component of the Community Health Aide Program. We provide background on that issue simply to dispel any misapprehensions arising from the unfortunate wording of the Dental Board's opinion request. As a legal matter, we believe you will agree that regulation of the CHAP's dental health aide component is simply beyond the Dental Board's jurisdiction, as the CHAP is a federal program.

The Supremacy Clause of the United States Constitution forbids state regulation of the federal government's programs. Shielding federal activities from state regulation is of such "fundamental importance" that "an authorization of state regulation is found only when and to the extent there is a clear congressional mandate," *i.e.*, Congressional action that is specific, "clear and unambiguous."[34/] Where federal and state laws are in conflict, or where the Congress has declared its intent to preempt state law, either expressly "or implicitly, by occupying the entire field of regulation on the subject in question," federal law prevails.[35/]

Providing health care services to American Indians and Native Alaskans has been an essential *federal* function for nearly two centuries.[36/] Alaska Supreme Court Justice Fabe has observed that the "[p]rovision of Indian health care services is comprehensively and

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33/ Letter from Dr. Charles W. Grim, D.D.S., M.H.S.A., Assistant Surgeon General and Director of the Indian Health Service, to H. Sally Smith, Chair, Bristol Bay Health Corporation, 10/12/04.

34/ *Hancock v. Train*, 426 U.S. 167, 179 (1976) (state could not require permit for operation of federal facility).

35/ *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, 75 P.3d at 1046, *citing and quoting, Webster v. Bechtel, Inc.*, 621 P.2d 890, 898 (Alaska 1980).

36/ *Fairbanks North Star Borough v. Denâ Nenâ Henash, supra.*, 88 P.3d at 134-135 ("The Self-Determination Act confirms the federal government's trust responsibility [towards American Indians and Alaska Natives]. The Act has the purposes of improving the provision of federal services by making them more responsive to tribal needs, and improving the functioning of the tribes through increased self-government. Thus, Self-Determination Act contracts are not merely conduits for federal funding that would be provided in any event. By reorganizing the services and their provision, the contracts permit tribes to "improve[] . . . the moral, mental, and physical welfare" of the individuals and the group.").

pervasively regulated" by the federal government.[37/] Federal law has entirely occupied the field of health care for American Indians and Native Alaskans.[38/]

The CHAP is a prime example. The provision of health care services by CHA/Ps – including dental health aides and therapists – to Native Alaskans and American Indians in Alaska's villages is "comprehensively and pervasively" regulated by the federal Community Health Aide Certification Board. The members of the Board are appointed by the federal Secretary of Health and Human Services. The Board has set strict, detailed, comprehensive standards for CHA/P and dental health aide training, practice, continuing education and performance monitoring.[39/] Our clients' dental health aides are closely regulated by this federal agency. Their activities directly further explicit Congressional goals for improving Alaska Native dental health care.[40/]

Thus, according to long-established Constitutional doctrine, by so comprehensively occupying this area, the federal government has preempted state regulation of the CHAP, including regulation of CHAP dental health aides by the State Board of Dental Examiners.[41/]

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37/ *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, 75 P.3d 1042, 1049 (Alaska 2003) (Fabe, C.J., joined by Carpeneti, J., dissenting). When deciding whether federal law prevails in tribal matters, the Alaska Court applies "a flexible preemption analysis sensitive to the particular facts and legislation involved. Each case 'requires a particularized examination of the relevant state, federal and tribal interests.'" *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, 75 P.3d 1042 (Alaska 2003), *citing and choosing to follow*, *Ramah Navajo School Bd., Inc. v. Bureau of Revenue of New Mexico*, 458 U.S. 832, 838 (1982) (holding ISDEAA preempts New Mexico gross receipts tax) ("federal statutes and regulations relating to tribes and tribal activities must be 'construed generously in order to comport with . . . traditional notions of sovereignty and with the federal policy of encouraging tribal independence.'").

38/ http://www.ihs.gov/NonMedicalPrograms/SelfGovernance/index.asp (Indian Health Service, Office of Trial Self-Governance); ISDEAA Title V, Pub. L. 106-260, Sec. 2 ("Tribal Self-Governance Amendments of 2000") ("transferring full control and funding to tribal governments, upon tribal request, over decision-making for Federal programs, services, functions, and activities (A) is an appropriate and effective means of implementing the Federal policy of government-to-government relations with Indian tribes; and (B) strengthens the Federal policy of Indian self-determination.").

39/ *See generally*, Community Health Aide Program Certification Board — *Standards and Procedures* (Jan. 2005).

40/ 25 U.S.C. § 1602(b)(20) – (26).

41/ *Nat'l Audubon Society v. Davis*, 307 F.2d at 851. For example, tribally operated health care facilities are entitled to payment by Medicare and Medicaid without being State licensed. The federal government takes the position that "tribally owned and operated [ISDEAA] 638 facilities are 'IHS facilities' [and] must meet all applicable standards for licensure but need not obtain a

(continued...)

### 7.0 Incompatibility of State Regulation

This conclusion is bolstered by the incompatibility doctrine. As the United States Supreme Court stated, when holding that the Indian Gaming Act preempted California from imposing gambling laws on tribal casinos, "[s]tate jurisdiction is preempted ... if it interferes with or is incompatible with federal and tribal interests reflected in federal law, unless the state interests are sufficient to justify assertion of state authority."[42/] This analysis rejects "a narrow focus on congressional intent to preempt state law as the sole touchstone" in matters that affect tribal interests, and equally rejects "the proposition that preemption requires 'an express congressional statement to that effect.'"[43/] The question is whether exercise of the state asserted authority with burden or interfere with the federal government's accomplishment of its goals.[44/]

The federal and tribal interests involved in providing dental health care services to Alaska Natives are indisputably substantial and significant. The right to adequate health care services is among the most fundamental and important rights of the Alaska tribes that have created and maintained the Alaska tribal health system.[45/] Congress explicitly stated that improving dental health care is an important goal of the CHAP.[46/]

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41/ (...continued)
State license." HCFA MOA, 12/19/1996, at 1, http://www.cms.hhs.gov/aian/moafinal.pdf; 42 CFR § 431.110.

42/ *California v. Cabazon Band of Mission Indians, et. al*, 480 U.S. 202, 216 (1987).

43/ *New Mexico*, 462 U.S. at 334, *citing, White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 144 (1980); *see also California v. Cabazon Band of Mission Indians*, 480 U.S. 202, 215-222 (1987).

44/ *See generally, Leslie Miller v. Arkansas*, 352 U.S. 187 (1956), *applied in United States v. Commonwealth of Virginia*, 972 F.Supp. 1008 (E.D. Va. 1997) (State's private investigator and security officer licensing laws do not apply to individuals performing background checks for the FBI; federal preemption applies to bar enforcement because "the state statute forms an obstacle to the accomplishment and execution of Congressional objectives"); *discussed in Gartrell Construction Inc. v. Aubry*, 940 F.2d 437 (9th Cir. 1991), *citing, Electric Const. Co. v. Flickinger*, 485 P.2d 547 (Arizona), *cert. denied*, 404 U.S. 952 (1971)

45/ As noted above, the Alaska Supreme Court recognizes that federal and tribal interests in self-governance of health care services are important and significant. *Fairbanks North Star Borough v. Denâ Nenâ Henash, supra.*, 88 P.3d at 134-135. The strong federal interest in the provision of health care services to Alaska Natives through the tribal health system is emphasized by ISDEAA's reassumption and retrocession provisions. 25 U.S.C. § 458aaa-5(f). *Also see*, Alaska Tribal Health Compact, Art. II, Sec. 11.

46/ 25 U.S.C. § 1602(b)(20) – (26).

In contrast, the State Dental Board's interests with respect to the CHAP are, comparatively, minimal. The federal Community Health Aide Certification Board "comprehensive[ly] and pervasive[ly]" regulates the CHAP dental health aide program. The tribal health providers must meet stringent Indian Health Service, Centers for Medicaid and Medicare Service standards, and Joint Commission on Accreditation of Health Care Organizations standards. While the Alaska Dental Board certainly has an interest in monitoring the unregulated practice of dentistry in Alaska, the federal government's comprehensive regulation of the CHAP obviates any legitimate interest for additional regulation by the State Board.

Our clients are gratified that the State Board recognizes that improving the dental health of rural Alaska residents should be an important policy goal for the State government. If applied to our clients, however, the "dentists only" model of service delivery would prohibit the CHAP's dental health aides from providing critically needed dental health care services in rural Alaska. This would be a great detriment to the Alaska Native beneficiaries of the CHAP, would directly contravene Congress's goals for the CHAP program, and would seriously "interfere with [and be] incompatible with federal and tribal interests reflected in federal law."[47/]

### 8.0 Federal Instrumentality Doctrine

We note also that in delivering health care and related services under Indian Self-Determination Act compacts with the United States, including CHAP dental health aide services, our clients effectively "stand in the [federal] government's shoes."[48/] As the federal government's "alter ego," they are immune from state regulation to the same extent as the

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47/ *California v. Cabazon Band of Mission Indians, et. al, supra.*, 480 U.S. at 216 (1987). We note that Congress' power to regulate matters relating to American Indians and Alaska Natives arises under the Indian Commerce Clause and has been interpreted broadly. The Supreme Court often refers to the Indian Commerce Clause as the primary constitutional provision supporting modern exercises of federal power over Indians. Despite the reference to 'commerce' with the Indian tribes, such commerce need not be interstate in character or impact for the Indian Commerce Clause to apply. See *McClanahan v. Arizona State Tax Comm'n.*, 411 U.S. 164, 172 n.7 (1973) (noting that it is generally recognized that the source of federal authority over Indian matters derives from the federal responsibility for regulating commerce with Indian tribes and for treaty making); *United States v. Antelope*, 430 U.S. 641, 646, n. 6 (1977) (noting that singling out of Indian tribes as subjects of legislation is expressly provided for in the Constitution); *Morton v. Mancari*, 417 U.S. 535 (1974) (stating Congress has plenary power, based on history of treaties and assumption of a guardian-ward status, to legislate on behalf of federally recognized Indian tribes; this power is drawn both explicitly and implicitly from the Constitution itself).

48/ *United States v. New Mexico*, 455 U.S. 720, 736 (1982).

United States itself.[49/] Or, put another way, the CHAP is "so intimately connected with the exercise of a power or the performance of a duty" by the federal government that state regulation would be "a direct interference with the functions of government itself."[50/] In fulfilling the United States' trust obligations, our clients act not only for, but *as*, the United States, and are thereby immune from state regulation.[51/]

### 9.0 State of Alaska's Medicaid Claims

We also note that the State's Department of Health and Social Services takes the position that our clients are operating federal programs when it submits claims for reimbursement to the federal government for CHA/P services. This is authorized by federal law:

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**49/** *Id.*; *see also U.S. v. Boyd*, 378 U.S. 39, 47-48 (1964), *U.S. v. City of Spokane*, 918 F.2d 84 (9th Cir. 1990) (Red Cross is a federal instrumentality immune from state taxation).

**50/** *United States v. Mexico*, 455 U.S. 720, 736 (1982) (quoting *James v. Dravo Contracting Co.*, 302 U.S. 134, 157 (1937)); *accord, Leslie Miller v. Arkansas*, 352 U.S. 187 (1956), *Gartrell Construction Inc. v. Aubry*, 940 F.2d 437 (9th Cir. 1991), *and United States v. Commonwealth of Virginia*, 972 F.Supp. 1008 (E.D. Va. 1997).

**51/** 25 U.S.C. § 450 *et seq.* ISDEAA vests contracting Alaska Native health care organizations with the funding and privileges of federal agencies, including:

(1) at least as much funding for their facilities and programs as if IHS were directly operating them (25 U.S.C. § 450j-1(a)(1); *see also* 25 U.S.C. § 458cc(*l*));

(2) tort defense and immunity under the Federal Tort Claims Act for claims arising from operation of their programs, as "a part of the Public Health Service in the Department of Health and Human Services" (25 U.S.C. § 450f(d) *and* related uncodified provisions of law);

(3) access to federal sources of supply, including pharmaceuticals from the federal supply source, as an "executive agency"(25 U.S.C. § 450j(k);

(4) full use of federal property in administering programs under the ISDEAA (25 U.S.C. § 450j(f);

(5) having federal employees detailed to work at their facilities and in their programs (5 U.S.C. §§ 3372(a)(1) and 3371(2)(c));

(6) having their employees retain federal rights and benefits (5 U.S.C. § 3372 and 25 U.S.C. § 450i(e));

(7) obtaining federal excess or confiscated property (25 U.S.C. § 450*l*(c)) at (b)(8)(E)); and

(8) use federal motor vehicles (25 U.S.C. § 450*l*(c)), at (b)(1)).

> [T]he Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility *whether operated by the Indian Health Service or by an Indian tribe or tribal organization.*[52/]

The 1996 Memorandum of Agreement ("MOA") between IHS and the Heath Care Financing Agency (now the Centers for Medicare and Medicaid Services, or "CMS") confirms that health care facilities operated by our clients are considered federal facilities eligible for "100% FMAP," *i.e.*, Medicaid charges for services provided at these facilities are paid in full by the federal government without a matching State contribution.[53/] The State of Alaska is paid "with 100% Federal medical assistance percentage (FMAP) for payments made by the State for services rendered through an IHS owned or leased facility or a tribal 638 facility,"[54/] including those provided by CHA/Ps and dental health aides at our clients' village clinics.

The 1996 MOA describes the basis for this treatment in detail, emphasizing that the provision of health services by tribes and tribal organizations are integral parts of the federal health care programs for American Indians and Alaska Natives:

> The United States Government has a historical and unique legal relationship with, and resulting responsibility to, American Indian and Alaska Native people. A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage maximum participation of American Indians and Alaska Natives in the planning and management of those services.
>
> The health care delivery system of American Indian and Alaska Native tribes with this unique government-to-government relationship consists of IHS-owned and operated health care facilities, IHS-owned facilities that are operated by American Indian and Alaska Native tribes or tribal organizations under [ISDEAA] Section 638 agreements (contracts, grants, or compacts), and facilities owned and operated by tribes or tribal

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52/ 42 USC § 1396d (emphasis added); *see also* 42 USC § 1396j *and* 25 USC § 1642.

53/ MOA, IHS and HCFA, 12/19/1996, at 1, http://www.cms.hhs.gov/aian/moafinal.pdf, *see also North Dakota v. CMS*, ___ F.3d ___, case no. 03-3954 (8th Cir., 2005).

54/ DHHS Memo, 12/23/1998, http://www.cms.hhs.gov/aian/1298memo.asp

organizations under such agreements.[55/]

The State of Alaska receives a substantial financial benefit by claiming the 100% FMAP from Medicaid for the CHAP services it purchases from our clients. It would be anomalous for the State to claim the CHAP dental health aides are providing federal services when billing Medicaid, but to argue they are not involved in a federal program for purposes of regulation by the State Dental Board.[56/]

**10.0 Conclusion**

We respectfully submit that, as a matter of federal law, the Community Health Aide Program's dental health aides and dental health therapists are not required to obtain State of Alaska licenses to provide dental health care services for our clients' patients. We trust that, upon analysis, you will agree that the State Board of Dental Examiners does not have jurisdiction over this critically important program.

Our clients sincerely appreciate the opportunity to comment on this matter, and would be pleased to provide any additional information you might need. Please do not hesitate to contact us if you need additional information, or if you would like comments in response to any additional communications from the Alaska Dental Society, the American Dental Association or the State Board of Dental Examiners.

Thank you very much.

Sincerely,

SONOSKY, CHAMBERS, SACHSE,
MILLER & MUNSON, LLP

/s/

By: Myra M. Munson
Richard D. Monkman

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55/ MOA, IHS and HCFA, 12/19/1996, at 1, http://www.cms.hhs.gov/aian/moafinal.pdf

56/ The doctrine of equitable estoppel applies against the State of Alaska in "certain exceptional cases." We believe the Courts may find this is one of those "exceptional cases," given the significant financial benefits obtained by the State through its Medicaid billings. *Cf. Alaska Trademark Shellfish, LLC., v. State*, 91 P.2d 953 (Alaska, 2004), *citing, State v. Schnell*, 8 P.3d 351, 356 (Alaska 2000) *and Wassink v. Hawkins*, 763 P.2d 971, 975 (Alaska 1988).

Attachments:

Community Health Aide Program Certification Board — *Standards and Procedures* (Jan. 2005)

Letter from Dr. Charles W. Grim, D.D.S., M.H.S.A., Assistant Surgeon General and Director of the Indian Health Service, to H. Sally Smith, Chair, Bristol Bay Health Corporation, Oct. 12, 2004

Copies by electronic mail, with attachment:

Hon. Ted Stevens, U.S. Senate
Hon. Lisa Murkowski, U.S. Senate
Hon. Don Young, U.S. Congress
Eric Broderick, D.D.S., Senior Advisor Tribal Health Policy, DHHS, Office of Intergovernmental Affairs, Office of Tribal Affairs
Charles W. Grim, D.D.S., M.H.S.A., Assistant Surgeon General, Director Indian Health Service
Hon. Joel Gilbertson, Commissioner, DHSS
Hon. Edgar Blatchford, Commissioner, DCCD
State of Alaska Board of Dental Examiners
Ms. Gayle Horetski, Assistant Attorney General, Department of Law, Juneau

Clients

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July 26, 2005

# STATEMENT BY PETER MILGROM, DDS IN SUPPORT OF THE ALASKA DENTAL HEALTH AIDE THERAPIST PROGRAM

Please submit this statement into the record of the hearing of July 14, 2005 regarding S1057 "The Indian Health Care Improvement Act Amendments of 2005".

**Qualifications:** I am Professor of Dental Public Health Sciences in the School of Dentistry at the University of Washington in Seattle. I also am Adjunct Professor of Health Services in the University of Washington School of Public Health. In addition, I am director of the Northwest/Alaska Center to Reduce Oral Health Disparities. This center, one of five in the United States, is supported by the National Institutes of Health. I serve as a consultant to the National Center on Minority Health and Health Disparities. I am a 1972 graduate of the University of California, San Francisco, School of Dentistry. Before coming to the University of Washington, I was a member of the staff of the Institute of Medicine of the National Academy of Sciences in Washington, D.C. I have served as a visiting professor at universities in the United Kingdom, South America, Europe, China, and Southeast Asia. I have been involved in the development of community-based programs for the prevention of early childhood caries and in improving access for children to private dental offices and nonprofit community and public health clinics in the United States and other countries. I conduct a dental practice limited to the care of the fearful and mentally ill. I was recognized in 1999 as the Distinguished Dental Behavioral Scientist by the International Association for Dental Research and received the Borrow Milk Award in 2000 from the same organization in recognition of my work in public health. The American Association for Dental Research recognized my work with the Giddon Award in both 1999 and 2000. I received the Martin Luther King, Jr. Community Service Award from the University of Washington in 2003 and was recognized in 2004 with a Commendation Award from the National Legal Aid and

Defenders Association for my public service on behalf of children. I have written five books and published more than 200 articles in professional journals. I am currently conducting research related to access to dental care for low-income children involving physicians as well as dentists. I am a member of the American Dental Association, the Washington State Dental Association, and the Seattle King County Dental Society. Within the latter organization, I have served as a member of the Executive Council. I have recently been appointed a consultant to the Washington State Dental Quality Assurance Commission.

In the course of my teaching and research I have personally worked with Dental Therapists and Nurses in New Zealand, Canada, Singapore, Malaysia and US-affiliated states and territories in the Pacific. I have served as a consultant to the training program in Singapore and taught in continuing education classes for Canadian therapists.

***What type of dental care should Native Alaskan and other American Indian children and adults receive?***

Native Alaskan and other American Indian children and adults should receive preventively-oriented dental care from the same clinic and from the same provider continuously throughout the life-span. I stress the need for continuity both in place and provider because research demonstrates that such care carries the highest probability of reducing the oral health disparities that plague native populations, particularly in rural areas. The current system, with its many unfilled dentist positions, fails to adequately serve this population. Moreover, the current output of all dentistry-training programs in the U.S. is inadequate to fill Community and Migrant Health Centers in the lower 48 states as well. Like in Alaska, more than 35 percent of positions are unfilled. Only about 30 percent of children served by Medicaid anywhere receive any dental care in a given year. Care is simply not available: participation rates by private practice dentists are very low. Because of these factors, few Native Alaskan and Native American children and adults receive preventive care and native communities will fail to meet the goals of Healthy People 2010. The Surgeon General and the Director of the National Institute of

Dental and Craniofacial Research and the Center for Minority Health and Health Disparities at NIH both have identified this health disparities problem and both NIH and IHS have supported work in my Center to help reduce these disparities.

### *Why are Dental Health Aide Therapists an appropriate response?*

As in medical care, DHA Therapists are generally drawn from the communities that they will serve. This strong link ensures culturally appropriate care and continuity. Therapists, as they are throughout the world, can be trained in two years in a specialized "need to know" curriculum. Physicians Assistants (PAs), Medex and military corpsmen are trained in similar manner. We have trained Physician Assistants at the University of Washington for more than 30 years and continue to do so. PAs perform routine medical care and surgery. We have proposed that future therapists be trained at the University of Washington School of Medicine in the same program where Physician Assistants are now being trained to operate under the standing orders of physicians. The training would incorporate the latest efficient computer-assisted surgical teaching technology used in many parts of the world and in several state and private schools of dentistry. By establishing such a training program in a well-respected university program, quality of care will not be an issue. The University of Kentucky College of Dentistry has also indicated its willingness to establish a training program, subject to the availability of funds.

Moreover, the Alaska Native Tribal Health Consortium, with the support of HRSA, has established forward thinking credentialing, supervision, and continuing education requirements that protect Native citizens. Indeed, the continuing education requirements for these personnel are more stringent than required for licensure of dentists in many states including Alaska. There is simply no evidence that quality must suffer because well-trained paraprofessionals are utilized in a health care system.

The US Surgeon General has stated that poor oral health can lead to exacerbation other health problems such diabetes, cardiovascular disease and poor birth outcomes. The integration of the Dental Health Aide Therapist program into the ongoing system of medical care is likely to have benefits that go beyond oral health alone. Such integration has long been the goal of the Indian Health Service. In contrast, the typical dental practice is largely isolated and unconnected to the rest of the health care system. This piece-meal isolation of an essential element of overall health care in the private practice system in dentistry, particularly for health care for populations heavily impacted by health disparities, cannot be a model for future care. According to the Surgeon General, this model has largely failed our minority ethnic and low-income adults and children.

**I AM IN SUPPORT OF THE ALASKA DHAT PROGRAM AND OPPOSED TO RESTRICTIONS PROPOSED THAT WILL RESTRICT THE SCOPE OF PRACTICE OR THE USE OF FEDERAL FUNDS FOR THIS PROGRAM.**

Sincerely yours,

Peter Milgrom, DDS
Center Director
Professor of Dental Public Health Sciences and Health Services
University of Washington, Seattle

**STATEMENT FOR THE RECORD**
**SUBMITTED BY DAVID A. NASH, D.M.D., M.S., Ed.D.**
**William R. Willard Professor of Dental Education**
**Professor of Pediatric Dentistry**
**University of Kentucky Medical Center**

I am writing with regard to Senate Bill 1057, The Indian Health Care Improvement Act, and wish to offer my unequivocal support for the practice of Dental Health Aide Therapists in Alaska.

I am David Nash, a professor of pediatric dentistry in the College of Dentistry at the University of Kentucky in Lexington, Kentucky. I am a board-certified pediatric dentist and have taught pediatric dentistry for 35 years at three of our nation's dental schools. I am a past president of the College of Diplomates in Pediatric Dentistry. From 1987-1997, I was dean of the College of Dentistry at the University of Kentucky, and now teach pediatric dentistry full time at UK in both the professional dental degree program and in our specialty training residency.

I have been involved in the idea of developing and deploying dental therapists in the United States since the current initiative began in late 2000/early 2001. As a component of a previously arranged sabbatical, I traveled to New Zealand in 2003 to study the School Dental Service there and their exclusive use of dental therapists. (97% of all children in New Zealand are treated by dental therapists in the School Dental Service.) My research was conducted at the University of Otago in Dunedin, which is New Zealand's national dental school. My host professor was Dr. Thomas Kardos, who was responsible for the dental therapy curriculum. The first group of students sent from Alaska to participate in the curriculum had arrived at the University a few months before me. During my time at the University I studied the School Dental Service as well as the curriculum for dental therapy.

Subsequent to my return I published an article in the Journal of Dental Education entitled "Developing and Deploying A Pediatric Oral Health Therapist to Help Address Oral Health Disparities in Children," in which I advocated that we develop and deploy dental therapists (which I call "pediatric oral health therapists") to address the significant disparity in oral health we have between the children of middle class America and our economically disadvantaged children. I am attaching the article for your reference. Because of the current interest in this topic, the editor of the Journal of Dental Education recently asked if I would write a "Letter to the Editor" to provide the nation's dental educators with a brief history and the current status of the dental therapy initiative in the United States. That letter was written with Dr. Ron Nagel, the Indian Health Service dentist who has been providing leadership, along with the Alaska Native Tribal Health Consortium, for the dental therapy initiative in Alaska. The letter provides a summary of how we have arrived at where we are today.

I have been a member of the American Dental Association for over 35 years. It is extremely disappointing to me to witness the ADA's attitude and behavior in this matter. However, it should not come as any surprise. The ADA has been opposed to three other attempts, since the late 1940s, to add a person such as a dental therapist to the dental team. Their efforts at this time are particularly reprehensible in that dental disease is epidemic in our lower socio-economic groups, with the AI/AN population being the worst. Dentists throughout the nation (and the American Dental Association) continue to ignore these children, both in policy and practice. As is made clear in the various papers referenced above, this is an issue of social justice; a moral issue that needs to be addressed by the society. It is also very unfortunate that the ADA leadership has chosen to use hyperbole in their rhetoric in an attempt to scare the public regarding dental care by dental therapists. The evidence of many years and multiple countries documents that these well-trained individuals provide safe, quality care. In fact, for their scope of practice, they are better prepared than a graduating dentist. The ADA's campaign is thoroughly disingenuous.

I noted that in the ADA's testimony to the Senate Committee they referenced and attached a proposal for a so-called "Community Oral Health Provider." (CHOP) This idea was a last minute effort on the ADA's part to propose something so that they could demonstrate some proactive concern for the problem. The proposal was developed this spring by a group of four individuals who were paid to do this "independent" work. A very respected public health colleague, Dr. Jay Friedman, critiqued their proposal in a devastating manner. CHOP just does not make sense, except as a proposal to undermine the dental therapist initiative and maintain the ADA hegemony over oral health in our country.

May I thank you for taking the time to read what has become somewhat of a discourse. I encourage Senator Murkowski to help the other Senators on the Committee understand what is at stake in this reauthorization, which is nothing less than the oral health of Alaska Native children. If this modest initiative is successful, it is conceivable the concept could grow and extend to American Indian children, and ultimately to disadvantaged children throughout the United States. If I can ever be of any assistance or support I trust that you will not hesitate to contact me.

Respectfully yours,

David A. Nash, D.M.D., M.S., Ed.D.

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*Critical Issues in Dental Education*

# Developing a Pediatric Oral Health Therapist to Help Address Oral Health Disparities Among Children

**David A. Nash, D.M.D., M.S., Ed.D.**

*Abstract: Oral Health in America: A Report of the Surgeon General* documented the profound and significant disparities that exist in the oral health of children in the United States. Recently, the country has been issued a *National Call to Action to Promote Oral Health*, under the leadership of the Office of the Surgeon General. Among the significant factors contributing to the disparities problem is the access to oral health care by disadvantaged populations. There are inadequate numbers of dentists able and willing to treat children, particularly poor and minority children. In the early part of the twentieth century, New Zealand faced a significant problem with oral disease among its children and introduced a School Dental Service staffed by allied dental professionals, known as "school dental nurses," who had received two years training in caring for the teeth of children. A number of other countries have since adopted this model. This article reviews attempts to develop a comparable approach in the United States. Furthermore, it justifies and advocates the development of pediatric oral health therapists in the United States as a means of addressing the disparities problem that exists in this nation. These pediatric oral health therapists would be trained in a two-year program to provide dental care services to children. The article concludes by asserting that such action is a practical and cost-effective way for dentistry to fulfill its professional obligation to care for the oral health of all children, thus ensuring justice in oral health for America's children.

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*Key words*: access, disparities, children's oral health, allied dental professionals, dental therapy, pediatric oral health therapist

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In 2002 the Robert Wood Johnson Foundation (RWJ) commissioned the National Conference of State Legislatures to conduct a study of policy barriers to accessing oral health care and to suggest opportunities for intervention by the foundation.[1] The report expressed the view that "those who work on oral health issues seem very much rooted in (and mired in) the present, and are not thinking about bold new solutions." Among the several recommendations to RWJ was one to fund "out-of-the-box" thinking.

Developing a pediatric oral health therapist is not a bold new solution, nor is it out-of-the-box thinking. While it may be out-of-the-box in the United States, it is clearly within-the-box of international thinking. This potential solution for helping address the access problem for low-income and minority children in the United States is actually an old solution that was boldly undertaken by the New Zealand Dental Association and the people of that nation, who in 1921 developed the now internationally famous New Zealand school dental nurse,[2-4] the progenitor of the pediatric oral health therapist advocated in this article.

The disparities that exist in oral health among children in the United States have been documented in *Oral Health in America: A Report of the Surgeon General*[5] and the recent *National Call to Action to Promote Oral Health*.[6] This article will review these disparities in the context of exploring one strategy to help address the problem, and it will suggest reasons for these disparities, focusing primarily on the problems of access to dental care for which the dental profession has not provided a solution. It will also review the use of allied dental professionals in other countries, with the New Zealand school dental nurse (now called a dental therapist) as an example; describe the curriculum in which these allied professionals are trained; delineate the competencies they attain; profile the environment in which they practice; and suggest means by which these international

programs can inform the development of pediatric oral health therapists to help address dental care disparities in the United States. Finally, the existence of oral health disparities in the world's most affluent nation will be addressed as a moral problem, an issue of justice, and a problem American dentistry must resolve if it is to validate its continuation as a profession, in the classic sense of that word and concept. President John Kennedy once said that "Children may be the victims of fate—they must never be the victims of neglect."

## Epidemiology of Oral Disease and Access to Care

A recent article in the journal *Pediatrics* identified dental care as the most prevalent unmet health need in U.S. children.[7] Numerous studies, many of which were cited in the *Surgeon General's Report*, document the profound and significant disparities in oral health among America's children. Children lose 52 million hours of school time each year due to dental problems,[8] and poor children experience nearly twelve times as many restricted activity days from dental disease as do children from higher income families.[9] Eighty percent of dental disease among children is found in 20-25 percent of children (approximately 18 million), and these are primarily children from African-American, Hispanic, American Indian/Alaskan Native, and low-income families.[10] The prevalence and severity of dental disease are linked to socioeconomic status across all age groups.

Access can be understood as the ability to personally utilize professional health services to achieve optimal health results. Clearly, the problem of access to oral health care for children is multidimensional; involving complex social, cultural, educational, and financial issues. Access to oral health care also is influenced by the system that the profession of dentistry operates today to deliver its services to the public.

Relevant facts regarding children's access to oral health care include the following:

- Children with no dental insurance are three times more likely to have an unmet dental need than their counterparts with either public or private insurance.[5]
- Children from families with incomes below 200 percent of the federal poverty level (FPL) are three times more likely to have unmet dental care needs than children from families at or above 200 percent of the FPL.[7] One in four children are born into families with incomes below the FPL,[6] which in 2003 was $18,400 for a family of four.[11]
- Nearly 25 percent of America's children are entitled to comprehensive dental coverage by Medicaid, yet fewer than one in five of these received a single preventive visit in a recent year-long study period.[12] Poor children have one-half the number of dental visits of higher income children.[9]
- One in four American children have not seen a dentist prior to beginning kindergarten.[6]
- While almost 90 percent of poor children have a usual source of medical care and 74 percent of poor children nineteen to thirty-five months of age receive all their vaccinations, only 22 percent of all children under age six years receive any dental care.[13]

## Barriers to Access

While multiple barriers to access have been identified,[1,5,14,15] two will be examined here in the context of advocating for the development of a pediatric oral health therapist. These two are dentists and leadership/advocacy.

### Dentists

Dentists are among the more significant barriers to access for disadvantaged populations: their numbers, distribution, and ethnicity; their education; and their attitudes.

First, the number and distribution of dentists in the United States contribute to the inadequate access to care for children in greatest need. The dentist/population is declining from its peak of 59.5/100,000 in 1990 and will drop from the current 58/100,000 to 52.7/100,000 in the year 2020—a decline of 10 percent.[16,17] Compounding the access issue is the location of dental practices. The overwhelming majority of dentists practice in suburbia, with few practicing in the rural and inner-city areas where children with the greatest need live. In fact, the number of federally designated shortage areas has more than doubled from 792 in 1993 to 1,895 in 2002.[14]

Approximately 12 percent of the population is African-American, but only 2.2 percent of dentists are. Individuals of Hispanic ethnicity make up another 10.7 percent of the population, yet only 2.8 percent of dentists are Hispanic.[18] Less than 5 per-

cent of entering student dentists are African-American, and less than 5 percent are Hispanic.[19] Yet the demographics of oral disease indicate that these two minority groups comprise a significant proportion of the disparity problem.

A second barrier is that student dentists do not receive adequate instruction and experience in treating children. In a recent study entitled "U.S. Predoctoral Education in Pediatric Dentistry: Its Impact on Access to Dental Care," Seale and Casamassimo concluded that "U.S. pediatric dentistry predoctoral programs have faculty and patient pool limitations that affect competency achievement and adversely affect training and practice."[20]

The number of pediatric dentists also contributes to access barriers for children. There has been a significant increase in the number of pediatric dentists over the past thirty years, but there are still only 4,357 trained specialists in children's dentistry practicing in the United States today.[21] Compare this with the 57,000 pediatricians who care for the general health of the nation's children.[22]

In a President's Report entitled "We Need Help," Dr. Paul Casamassimo, then-president of the American Academy of Pediatric Dentistry, stated it bluntly and well: "even with a Herculean increase in training positions [for pediatric dentists], improved workforce distribution, and better reimbursement and management of public programs, pediatric dentistry [the specialty] will never be able to solve this national problem [of disparities] alone. *We need help*."[23]

The third factor that contributes to access barriers is the attitude of dentists. Dentists generally do not want to treat publicly insured children, be they children covered by Medicaid or the State Children's Insurance Program (S-CHIP). It is difficult to discuss the issue of access to care, particularly when focusing on the disparities that exist in oral health among America's children, without referencing the Medicaid system. Medicaid provides an entitlement to comprehensive dental services for children who live at 150 percent of the federal poverty level ($27,600 for a family of four in 2003) or below; such care is a mandate.[24] The S-CHIP program, [25] authorized by Congress in 1997, extends dental services to children living at 200 percent of poverty ($36,800 for a family of four in 2003) or below. Yet Medicaid and S-CHIP fail to meet the oral health needs of America's children.

Dentists offer multiple reasons for failing to treat children with publicly financed insurance, including low reimbursement schedules, demanding paper work and billing requirements, and the frequent failure of parents of these children to keep scheduled appointments. A 1996 study indicated only 10 percent of America's dentists participate in the nation's program to help ensure access to oral health care for poor American children.[12] The report to RWJ by the National Conference of State Legislatures (NCSL) states that even though reimbursement rates may be dismal, many state legislators believe that dentists "have a community service obligation . . . [to participate in these programs], that they are not meeting."[1]

However, reimbursement does not appear to be the major issue. The General Accounting Office released a report in 2000 stating that "raising reimbursement rates—a step 40 states have taken recently—appears to result in a marginal increase in use, but not consistently."[15] For example, the state of Maine increased its fees for dental services by 40 percent in 1998, but utilization increased by only 2 percent. The state of Indiana increased its Medicaid reimbursement rates to those approximating private insurance, and dentist participation increased by 6 percent—but total participation by dentists was only 26 percent. If raising reimbursement rates is a component of the solution to the Medicaid/S-CHIP dilemma, such is not likely to happen any time soon, as states are struggling to deal with significantly shrinking state revenues.

The problem is more complex than just reimbursement. Most dentists are already as busy as they care to be, as they manage the increasing number of baby-boomers and others who require implants, esthetic dentistry, and other complex services in high demand. The NCSL study indicated that dentists do not believe they need to see more patients to deal with the access issue, particularly when this action would mean seeing publicly insured patients. There is a significant cultural issue at work. Many dentists just do not want publicly insured patients in the reception areas and offices.

Dentists, in general, are also leery of any program affecting their practices that has any sort of government relationship; it is the *private practice* of dentistry. American dentistry has relentlessly eschewed government programs it believes might negatively impact private practice even though such programming could improve access to care for disadvantaged populations. In a recent issue of the *Journal of the Massachusetts Dental Society*, coeditors Drs. Norman and David Becker, in an editorial entitled "Raise Your Voice," commented that "the

problem of children's untreated dental disease is beyond the scope of an organized charitable function . . . the solution must be found in government programs."[26]

As a result of the failure of dentistry to fulfill its professional obligation to care for the health of the public, society is becoming increasing impatient with dentists. This is borne out by informative, but disturbing, comments made to the researchers in the NCSL study. One consistent finding was that there is a steady undercurrent of negative feelings about dentists among many of the people interviewed. People in every state included in the study made some potentially offensive and controversial comments about typical personality types of dentist: they are difficult to work with, extremely independent, resistant to change, and don't partner well with other professionals.[1]

If dentistry fails to engage and creatively develop solutions to the problem of oral health care for the poor and disadvantaged (especially children), we run the serious risk of losing the status a society grants to a profession and jeopardizing the monopoly we have received to practice dentistry.

## Lack of Effective Leadership/ Advocacy

The NCSL report to RWJ further states that "a consistent theme . . . is the lack of effective advocacy for oral health issues in general and access to dental care for low-income people in particular."[1] Those individuals who form public policy, both at the state and federal level, have a low level of awareness, knowledge, and/or interest concerning issues of oral health. There are few champions of the issue in the halls of Congress or our state capitols. And there are not strong coalitions of support among public advocacy bodies.

The report went on to emphasize that the main and most powerful advocacy group for oral health issues in most states is the state dental association. While calling such associations extremely powerful, possibly second in influence only to state medical associations, the report expressed the view that dental associations are "poor advocates for access to dental services, particularly for Medicaid and S-CHIP beneficiaries, as they are perceived as self-serving in seeking increased reimbursement rates." It also suggested they are perceived as providing "false leadership or 'lip service' to access issues for low-income people."[1]

There is a dearth of leaders in dentistry advocating elimination of barriers to oral health, improving access, and erasing the disparities that exist. One would expect the American Dental Association (ADA) to provide such leadership and advocacy; however, the comment in the NCSL report about "lip service" is probably accurate. Although the ADA supports the concept in principle, it generally opposes any programs that would significantly alter the status quo. It advocates voluntary charity care by its members, but rejects expansion of organized public health programs that would be more effective. The *ADA News*[27] recently praised the generosity of dentists in addressing the disparity problem through their donation of time to the "Give Kids a Smile" promotion during National Children's Dental Health Month and stated, without documentation, that dentists provide $1.7 billion of charity care annually. The public relations campaign extended to having a legislator (Rep. Cantor, R-Virginia) introduce a resolution in Congress commending dentists for their efforts in addressing the issue of access for poor children and congratulating the American Dental Association on its efforts. Certainly there is merit in feeling good about oneself and one's profession; however, it is difficult to document substantive advocacy for genuine access from the ADA.

In March 2003 a President's Commission of the American Dental Education Association (ADEA) released a report entitled "Improving the Oral Health Status of All Americans: Roles and Responsibilities of Academic Dental Institutions."[14] The report provides comprehensive background information and justification for change, and while none of the five major categories of recommendations are inappropriate, no specific strategies are advocated that provide creative leadership for change. Rather, the report seems to encourage more intensive continuance of what is been being done—that is, working at the margins, rather than initiating significant change.

The report does propose, as one of its thirty-four recommendations, educating dental and allied dental students to assume new roles in the prevention, detection, early recognition, and management of a broad range of complex oral and general diseases and conditions in collaboration with their colleagues from other health professions. Including student dentists in the recommendation certainly dilutes any specific emphasis on developing new types of allied professionals or expanding roles for current ones.

## New Zealand's School Dental Nurses

In 1921 a group of thirty young women entered a two-year training program at Wellington, New Zealand, to study to become "school dental nurses" and in so doing transformed the oral health of the children of a country, laying the basis for what was to become an international movement.[2] New Zealand's School Dental Service continues to this day and has developed an enviable record of caring for the oral health of all children in New Zealand. There have been changes in the School Dental Service through the years, as well as in the training program for school nurses. However, the basic training and service strategies of over eighty years ago remain intact, having stood the test of time. The program's mantra through the years has been: "we train first-rate technicians, not second-rate dentists."[28]

By the 1970s the School Dental Service had grown to approximately 1,350 school dental nurses deployed in schools throughout New Zealand.[29] At that time there were training programs in Wellington, Auckland, and Christchurch. Each elementary school in New Zealand had its own dental clinic and, in most instances, its own dental nurse, though in some rural areas one dental nurse served more than one school. School dental nurses were employees of the federal health care system and were certified to perform oral examinations; develop treatment plans; provide preventive services, including prophylaxis; administer local anesthesia; prepare and restore primary and young permanent teeth; and extract primary teeth, all under the general supervision of a Ministry of Health dentist. Today, the health care system has been devolved to district health boards, and the school dental therapists (the name change occurred in 1988 by a vote of the dental nurses) "operate under the direction and supervision of the principal dental officer [of the district board], or other [licensed] dentist acting on behalf of the principal dental officer."[30]

The advent of high-speed instrumentation, water fluoridation, and modern transportation created changes in the New Zealand School Dental Service. Caries prevalence declined, dental nurses were able to provide care more efficiently, and they could travel to multiple schools more easily. The need for educating school dental nurses was reduced, not only due to these factors, but also because the attrition rate for dental nurses declined as more and more women chose to continue their careers as dental nurses even after marrying and having children. In 1998 there were 569 school dental therapists in New Zealand.[31] They care for 497,000 school children in over 2,000 schools.[32] (The population of New Zealand is 4 million.) Due to the decrease in the number of new therapists required, the training programs at Auckland and Christchurch were phased out in the 1980s, leaving only the one at Wellington. It too was closed in 1999, and the program moved to the national dental school at the University of Otago, in Dunedin. In 2001 Auckland University of Technology established a program as well. The two training programs each admit approximately twenty students each year into the two-year curriculum.[33]

New Zealand's record of oral health for children is notable. All children from age two and one-half years of age (six months for children at high risk) through age thirteen are eligible to participate in the School Dental Service and receive free comprehensive preventive and restorative care at their local school clinic by the school dental therapist. Children requiring root canal therapy, management of dental trauma, or extraction of permanent teeth are referred to private practitioners, who serve under contract with the government. Enrollment is not compulsory, yet 97 percent of all school-aged children and 56 percent of preschoolers participate.[30] The School Dental Service remains a New Zealand "icon."[34] As one colleague expressed it, "The School Dental Service has become an integral component of the New Zealand culture. To Kiwis it is like motherhood, apple pie, and the flag."[35] And it is highly valued, not only by the public, but by dentists as well.[32]

Children who are medically compromised, handicapped, or present significant management problems are enrolled in a Special Dental Benefits program and are served by private practitioners, frequently specialists. There are nine licensed pediatric dentists in New Zealand, with eight of these working in the public sector and only one in private practice.[36] These special needs children account for some of the 3 percent of children not enrolled in the School Dental Service. Adolescents from fourteen to seventeen are seen in private dental offices under a General Dental Benefits program whose funding is managed by the government on a capitation basis. Children who do not participate in the School Dental Service are generally seen in private practices, but without government financial support for such

care. After age seventeen, government support for oral health care is limited to emergency care for pain and/or infection.

Dental caries continues to be a significant problem for New Zealand children. It disproportionately affects the Maori (aboriginal New Zealanders), Pacific Islanders, and individuals from lower socioeconomic groups.[30,37] Only 56 percent of the population drinks fluoridated water.[37] While the number of decayed, missing, and filled primary and permanent teeth (deft and DMFT) of the children of New Zealand and the United States is roughly comparable, of particular note are the differences in the components of these epidemiological indices. A 2003 report[38] notes that 53 percent of five year olds are caries-free, with a mean eft of 1.8. At age twelve to thirteen, 42 percent of children are caries-free with a mean MFT of 1.6. What is surprising and fascinating about these data is that the decayed (d/D) components are not included in these figures. When asked about this anomaly, the University of Otago School of Dentistry's epidemiologist indicated that these data represent the children enrolled in the School Dental Service and are collected at the end of each school year.[35] During the school year the decayed teeth have either been restored or extracted. Because of this emphasis on treatment, essentially all of the school children in New Zealand are free of carious infection at the end of a school year. How does one explain the success of such a program? In a 1972 article in the *Journal of the American Dental Association*, Friedman suggested that "perhaps it is the unusual circumstance of the application of common sense."[28]

Sir John Walsh, dean of New Zealand's national dental school at the University of Otago from 1946 to 1971, in addressing the Centennial Conference on Oral Health at Harvard in 1968, suggested the employment of a "Care Index," with such an index being calculated by developing a ratio of the filled teeth component (the f/F) of the deft or the DMFT to the overall deft or DMFT.[39,40] In 1968, the Care Index in New Zealand was 72 percent—meaning 72 percent of all teeth of children affected by caries had been restored. In the United States, that figure was 23 percent. Dean Walsh made the claim that the Care Index provides a convenient measure of the effectiveness of a country in treating dental caries. Today the Care Index for New Zealand children approximates 100 percent.[39] In the United States, the Care Index drops significantly when adjusted for income status. For primary teeth it is 72.3 percent for children at 300 percent of the FPL, but only 48.7 percent for children at 100 percent of the FPL.[41] For permanent teeth it is 93.2 percent for children at 300 percent of the FPL and only 72.3 percent for children at the 100 percent of the FPL.[41] Such disparities help underscore the access to care issue for poor children.

## Training Dental Therapists in New Zealand and Elsewhere

A prerequisite for admission to one of the two dental therapy educational programs in New Zealand is graduation from high school, with the completion of a course in biology. Each of the two years in the curriculum is thirty-two weeks in duration. The total curriculum clock hours are approximately 2,400. During the first year, topics of study include the basic biomedical sciences (general anatomy, histology, biochemistry, immunology, and oral biology), as well as clinical dental sciences (dental caries, periodontal disease, preventive dentistry, patient management, radiography, local anesthesia, restorative dentistry, dental materials, and dental assisting). In the second year, course content includes pulpal pathology, trauma, extraction of primary teeth, clinical oral pathology, developmental anomalies, health promotion/disease prevention, New Zealand society, the health care delivery system, and recordkeeping, as well as administrative and legal issues associated with dental therapy practice in New Zealand. Approximately 760 hours of the 2,400-hour curriculum are spent in the clinic treating children. Graduates entering the School Dental Service must serve for one year with another school dental therapist who provides assistance, support, and supervision, much in the manner of a residency program. (The preceding general information was obtained through personal communication with Helen Tane, director of the University of Otago's program in dental therapy.)

During my recent visit to New Zealand, members of the dental profession whom I interviewed, both within and outside the School of Dentistry, were highly complimentary of the skills of the dental therapists, as well as the work of the School Dental Service. As a result of legislative changes in 2002, dental therapists are now also able to practice in private offices in New Zealand under the direct supervision of a dentist.[42]

The New Zealand school dental nurse/therapist has served as a prototype for adding such a member to the dental team in many additional countries throughout the world, although the specific approach, including practice environments and restrictions, varies from country to country. A 1978 comprehensive assessment of dental nurses worldwide suggested that a major factor predisposing to the introduction of dental nurses was an access problem related to a shortage of dental manpower.[43] The World Health Organization documents forty-two countries with some variant of a dental therapist; these include Australia, China (Hong Kong), Singapore, Thailand, Malaysia, Great Britain, and Canada.[44] The Canadian experience is relevant to this discussion as it apparently is the only country in the Western hemisphere to have a training program for dental therapists.

The National School of Dental Therapy for Canada is a component of the First Nations University of Canada in Prince Albert, Saskatchewan. The school, which began in 1972 at Fort Smith in the Northwest Territories, was modeled after New Zealand's, with modifications appropriate for the anticipated service area.[45,46] The mission was to train dental nurses in a two-year program to provide care for the remote First Nation (aboriginal Indians) and Inuit (Eskimo) villagers of the Canadian North, where dental care was virtually inaccessible. In 1984 the school was moved to Prince Albert due to an inadequate supply of patients in the Fort Smith area. The school continues to prepare dental therapists, with an emphasis on training aboriginal people to care for aboriginal people, specifically on First Nation reserves and in the North.

In the early 1970s, the province of Saskatchewan implemented a school-based dental plan for all children; and in 1972 a dental nurse training program was opened in Regina, Saskatchewan, at the Wascana Institute of Applied Arts and Sciences, now the Saskatchewan Institute of Applied Science and Technology (SIAST).[47] In the mid-1980s, the province faced budgetary constraints, as well as pressure from dentists to focus on funding dental hygiene rather than dental therapy. As a consequence, the dental therapy training program at Regina was closed in 1987.

Dental therapists are able to work for Health Canada (Canada's ministry of health) on federal First Nation reserves throughout Canada, with the exception of the provinces of Ontario and Quebec. There are eighty-eight dental therapists employed today by Health Canada.[48] Similar to New Zealand, recent legislation (2001) enables therapists to also work in private dental offices in the province of Saskatchewan, under the indirect supervision of a dentist.[49] Currently there are 208 licensed dental therapists in Saskatchewan.[50]

The educational program at the National School of Dental Therapy is fully funded by Health Canada and maintains an affiliation agreement with the School of Dentistry at the University of Saskatchewan. The school accepts twenty students each year into a two-year curriculum. The program is focused on training to care for children, although instruction is also provided in treating dental emergencies in adults, including extraction of permanent teeth.

Each year of the two-year curriculum is forty weeks in length. The basic didactic curriculum in the biomedical sciences and clinical dental sciences is taught in the first year, with the second year devoted primarily to clinical care. Thus the students receive approximately 1,600 clock hours of didactic instruction in the first year and an equivalent amount of clinical instruction the second year, for a total of 3,200 clock hours. (The preceding general information was obtained through personal communication with Dr. Glenn Schnell, director of the National School of Dental Therapy.)

Double-blind studies of the work of the Canadian dental therapists in comparison to federal dentists have been conducted.[46,51] The results indicated that the restorations placed by dental therapists were equal to those placed by dentists. Trueblood documented the cost-benefit effectiveness of Health Canada's developing and deploying dental therapists in a doctoral dissertation in 1992.[52]

## The United States Experience

In the United States, studies of expanded functions for dental auxiliaries began in the 1960s. During that decade six notable programs studied the delegation of *reversible* expanded functions to dental assistants: the Great Lakes Naval Training Center,[53] the Division of Indian Health,[54] the University of Alabama,[55] the University of Minnesota,[56] USPHS Dental Manpower Development Center in Louisville,[57] and a program in Philadelphia.[58] All demonstrated that reversible procedures could be effectively taught to dental assistants in a reasonable period of time.[59]

During the 1970s, the emphasis changed, and studies were conducted involving the delegation of both reversible and *irreversible* procedures to dental hygienists. Notable among these studies were those at the Forsyth Dental Center,[60] the University of Kentucky,[61] and the University of Iowa.[62] Before considering these, however, it is important to note that there have been two attempts to develop a New Zealand dental nurse in the United States. Both were met with strong opposition from the practicing profession.

In 1949 the Massachusetts legislature passed a bill authorizing the receipt of funding from the United States Children's Bureau by Forsyth Dental Infirmary for Children to institute a special five-year program of dental research in this area.[63,64] The research would prepare "feminine personnel," in a two-year training program, to prepare and restore cavities in children's teeth under the supervision of a dentist in a dispensary or clinic approved by the Massachusetts Commissioner of Health. The training program was to be conducted under the supervision of the Department of Health and the Board of Dental Examiners. Thus, the passage of this legislation provided for the establishment of an experimental dental care program for children similar to the school dental nurse of New Zealand.

The reaction of organized dentistry was swift and negative. The ADA House of Delegates passed resolutions "deploring" the program; expressing the view that any such program concerning the development of "sub-level" personnel, whether for experimental purposes or otherwise, be planned and developed only with the knowledge, consent, and cooperation of organized dentistry; and stating that a teaching program designed to equip and train personnel to treat children's teeth cannot be given in a less rigorous course or in a shorter time than that approved for the education of dentists.[64] Faced with increasing pressure from organized dentistry in Massachusetts, as well as nationally, the Massachusetts governor signed a bill in July 1950 rescinding the enabling legislation.[65]

In February 1972, Dr. John Ingle, dean of the University of Southern California School of Dentistry (USC), proposed the use of school dental nurses, as employed in New Zealand, to address the problem of dental caries among America's school children.[66] In the spring of that year he authorized the submission, on behalf of USC, of a proposal for a training grant of $3.9 million from the U.S. Public Health Service to train dental nurses, with Dr. Jay W. Friedman, who had studied New Zealand's School Dental Service, as the project director. At the same time, the then-governor of California, Ronald Reagan, established a committee to study the functions of all dental auxiliaries, in order to make recommendations to the California legislature and the State Board of Dental Examiners.[67] As a result of these two significant developments, the then-two California Dental Associations established a committee to study the New Zealand dental care system, analyze the relationship of the school dental nurse to private practice, assess the work of the school dental nurse, and compare the New Zealand and California systems.[67] The committee of four individuals visited New Zealand in late 1972. Their report, published in 1973, stated that "there is little doubt that dental treatment needs related to caries for most of the New Zealand children age 2½ to 15 have been met."[67,68] However, the report concluded that the public of California would "probably not" accept the New Zealand type of school dental service, as it would be perceived as a "second class system." Drs. Ingle and Friedman wrote sharp rebukes to the committee's report, pointing out the inconsistencies of the objective findings of the investigation in relation to the subjective conclusions of the report, which they judged to be drawn to placate the practicing profession in California.[69,70] Dunning also criticized the report's conclusions in a letter to the *Journal of the American Dental Association* editor,[71] and Goldhaber, in a *Journal of Dental Education* article, called the committee's conclusion "absurd."[72] According to Dr. Ingle, the American Dental Association mounted a nationwide protest against him and the dental nurse project, which probably contributed to the Public Health Service's failure to fund the grant. He subsequently resigned his position as dean at USC to join the staff of the Institute of Medicine.[73]

In 1970 the Forsyth Dental Center initiated what was subsequently designated, and described in a book of the same title, "The Forsyth Experiment."[60] The House of Delegates of the Massachusetts Dental Association had recently passed a resolution favoring research on expanded function dental auxiliaries. Forsyth communicated, to both the Massachusetts Board of Dental Examiners and to the Massachusetts Dental Society, its plans to initiate a research project to train dental hygienists in restorative procedures for children, which were typically reserved for dentists alone. The experiment was designed to teach and evaluate clinical performance for administering local anesthesia and preparing and placing Class I, II, and V amalgam restorations and

Class III and V composites. No problems were encountered between 1970 and 1973. However, in October 1973 the Board of Dental Examiners notified Forsyth that a hearing would be held to review the project's feasibility. Subsequently, the state board voted unanimously that the drilling of teeth by hygienists was a direct violation of the Dental Practice Act of Massachusetts and submitted such a decision to the attorney general's office for a ruling and action. In March 1974, the attorney general ruled that "drilling teeth is deemed in the act to be undertaking the practice of dentistry, and the legislature had not exempted research from this provision." Forsyth was forced to close its "experiment" in June 1974, but not before it was able to objectively document that hygienists could be taught to provide restorative dental services effectively, efficiently, and at a positive cost-benefit. Whereas the projected curriculum time to achieve the competencies desired was forty-seven thirty-hour weeks, the project was able to achieve its desired educational outcomes in twenty-five thirty-hour weeks.

Another expanded functions project was implemented between 1972 and 1974 at the University of Kentucky, supported by the Robert Wood Johnson Foundation.[61] This project also involved the training of dental hygienists in restorative dentistry. Thirty-six students, who were completing a four-year baccalaureate program in dental hygiene, participated in a compressed curriculum that provided for 200 hours of didactic instruction in children's dentistry, as well as 150 hours of clinical practice. The program was specifically addressed to providing primary care for the child patient, including administration of local anesthesia, restoration of teeth with amalgams and stainless steel crowns, and pulpal therapy. Toward the conclusion of the curriculum, these hygienists trained in dentistry for children participated in a double-blind study comparing their restorative skills with fourth-year student dentists. No significant differences were found between the quality of their work and that of the student dentists.

At the College of Dentistry at the University of Iowa, a five-year project was conducted between 1971 and 1976, supported by the W.K. Kellogg Foundation, that trained dental hygienists to perform expanded functions in restorative dentistry and periodontal therapy for both children and adults. The results were the same as the studies at Forsyth and Kentucky: hygienists could be effectively trained, in a relatively brief time period, to perform, at a comparable quality level, procedures that traditionally are reserved solely for dentists.[62]

## Justifying a Pediatric Oral Health Therapist

Despite documentation of the ability of individuals other than dentists to successfully provide quality care to children, both in the United States and internationally, American dentistry has been immovable in its resistance to this type of allied professional. The crisis faced today, as represented by the disparities in oral health among our more disadvantaged populations, demands challenging the traditional practice paradigm and advocating the addition of a new member of the dental team—a pediatric oral health therapist.

Throughout this article, references have been made to circumstances that justify the development of pediatric oral health therapists to help address the disparities in oral health among children in the United States. To summarize:

- There are profound disparities in oral health between the children of the rich and the poor in America.
- There is a general lack of access to care for the nation's disadvantaged children.
- There is a general lack of training of general dentists in children's dentistry in the current predoctoral dental curricula.
- There are insufficient numbers of dentists in urban inner-city and rural areas, where children are most in need of care.
- There are inadequate numbers of minority dentists to work with minority populations.
- There is a declining dentist to population ratio.
- There are far too few pediatric dentists to have an impact on access for disadvantaged populations.
- There is a general lack of interest on the part of dentists in treating children, given the current demand for other dental therapies.
- There is even less interest by dentists in treating low-income children, particularly if their care is being financed by Medicaid or S-CHIP programs.
- There is a need to provide care in a cost-effective manner, particularly for patients whose care is being publicly funded.
- There is ample evidence, from within the United States and internationally, that high school gradu-

ates can be trained in a two-year academic program to render, under general supervision by a dentist, safe, effective, high-quality preventive and restorative care for children.

All of these circumstances point to the reasonableness and value of developing and deploying pediatric oral health therapists.

## Developing Pediatric Oral Health Therapists

A curriculum for developing pediatric oral health therapists exists and has been documented to be effective in numerous countries throughout the world. It is the traditional curriculum of the school dental nurse/therapist. It is known that high school graduates can safely, effectively, and efficiently provide oral health care for children after two academic years of training. The curriculum for a pediatric oral health therapist could be considered comparable to the two academic year (associate degree) curriculum for preparing dental hygienists: 230 of the 260 dental hygiene training programs in the United States are two-year programs. The primary difference would be the focus of the training—with that of the hygienist being on periodontal disease, particularly in the adult, and the therapist on dental caries, specifically for the child. The curricula would share areas of commonality, such as the basic biomedical sciences, oral biology, preventive dentistry, infection control, the diagnostic sciences, and radiography. The perceptual motor skills required to restore the teeth of children are no more complex than those to perform scaling and root planing. Research has demonstrated these skills can be taught in a two-year program to individuals with a high school degree.

It may be possible to shorten the training period if the students matriculating in a pediatric oral health therapist program were already certified dental hygienists; however, there is reason to encourage hygienists to continue to be the expanded-function allied dental professional for managing adult periodontal health and disease. Hygienists are too valuable in their current role, particularly in the context of their relative shortage and the aging of the population, with concomitant needs for periodontal therapy. Rather, it appears more reasonable to create a new allied dental professional who focuses on the unique oral health needs of children, specifically as these relate to the problem of dental caries.

Where and under what circumstances might a pediatric oral health therapist practice? To effectively address the access problem, it appears practitioners must go to where children are located. As in New Zealand, the most logical place to capture this audience is in the school system. As Dunning stated over thirty years ago, "any large-scale incremental care plan for children, if it is to succeed, must be brought to them in their schools."[29] A number of our colleges of dentistry are having some success with mobile dental van programs. Such approaches enable student dentists to learn children's dentistry in an era when it is increasingly difficult to draw children in need of dental care to institutional facilities. It is reasonable for pediatric oral therapists to practice (under the general supervision of a dentist) in mobile vans providing care on a financial needs-tested basis, for example, to all Medicaid- and S-CHIP-eligible children in a school, moving through the year from one school to another. Such a program, begun in an incremental manner with the youngest children (with the least carious experience and the greatest potential for implementation of preventive care), would seem to be a cost-effective way of managing the oral health needs for our poorest and neediest children.

In New Zealand, a dental therapist with an assistant is responsible for 1,450 children.[32] The Commonwealth of Kentucky has essentially the same population as New Zealand. Kentucky has 384,832 children ages five to eleven (K-6). Of these, approximately 43 percent (or 172,418 children) live at a level of 200 percent of poverty or below and are eligible for Medicaid/S-CHIP benefits.[74] Using the New Zealand model, to care for this many children would (hypothetically) require 212 dental therapists. While no direct economic comparisons can be made due to the significantly different circumstances, it is interesting to note that New Zealand spends approximately $34 million (US) caring for *all* enrolled children ages six months through seventeen years[75] and that Kentucky's dental expenditures for children covered by Medicaid/S-CHIP *alone* in 2002-03 were approximately $40 million.[76]

A second potential environment for pediatric oral health therapists could be in the private sector, as exists now in Saskatchewan. In such, therapists could work under the supervision of a dentist and serve as a dentist-extender for children's primary care, in much the same manner that a dental hygienist serves in such a role for adult periodontal care. It does not make economic sense for a dentist to rou-

tinely perform scaling, root planing, and polishing of teeth, when such can be delegated to a hygienist. Research has documented the economic benefit that dentists gain by employing hygienists.[77] In like manner, it is not reasonable for dentists to perform primary care procedures for children when a pediatric oral health therapist can do so. Adding such an individual to the dental team not only makes sense; it seems unreasonable, in economic terms, not to proceed as rapidly as possible. However, the profession continues to cling to the belief that cutting tooth structure is paradigmatically different than scaling teeth and such is a boundary never to be crossed by allied professionals. It is a cultural tradition, not a justifiable belief. In Saskatchewan, dental therapists are employed in private offices, frequently caring for all the children in a practice. Saskatchewan dentists testify to the significant economic return on their investment in employing dental therapists, apart from the opportunity it provides to care for more patients and a broader range of patients than one would be able to treat without such personnel. That is improved access. It would be in dentistry's economic self-interest to develop pediatric oral health therapists able to practice in dental offices.

## Values and a Profession

The *ADA Principles of Ethics and Code of Professional Conduct* has been revised over the past twenty years to include the classic troika of principles of professional ethics: respect for autonomy, beneficence, and justice. Regarding justice, the *Principles* state: "In its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all."[78]

One of the most important and influential books of political philosophy written in the twentieth century was *A Theory of Justice,* by the late Professor John Rawls of Harvard University,[79] in which he carefully explicates the nature of justice. His definition is based on the now famous hypothetical in which he asks one to stand behind a "veil of ignorance" and envision a world into which one will be born, but not knowing into what circumstance he or she will be born, that is, to a rich or poor family, intelligent or dull, male or female. He argues that, given such a condition, people will design a world with some degree of risk aversion, in which the following conditions would exist: 1) each person will have an equal right to the most extensive system of liberties comparable with a system of equal liberties for all; 2) persons with similar skills and abilities will have equal access to offices and positions of society; and 3) (the critical one for our consideration of access and disparities) social and economic institutions will be so arranged as to *maximally benefit the worst off.* Such a design he affirms would be "just."

Given a Rawlsian view of justice, the oral health care delivery system in the United States, if it is to be just, must be structured to maximally benefit the worst off in society. In reality, as has been demonstrated, it is quite the opposite. Poor and minority children, the most vulnerable individuals in society, are the "worst off" and have the poorest access to oral health care and the poorest oral health. Justice would demand they be maximally benefited, in order that they ultimately have "equal opportunity" to do well. Yet our system is so structured as to maximally benefit those who are already "well off."

The time has come for the profession of dentistry to seriously and courageously provide access to oral health care for all of America's children. Access should be provided in such a manner that major barriers are destroyed, and parents, no matter their economic status, ethnicity, or cultural circumstance, can be assured their children will be treated justly by society, in that they have an equal opportunity, with other children, for good oral health. A method that can be effective in helping achieve this goal is the development of pediatric oral health therapists—allied professionals uniquely trained to care for the oral health of children.

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# Response to Drs. Bramson and Guay's Comments on the Proposed Pediatric Oral Health Therapist

**David A. Nash, DMD, MS, EdD**

I am pleasantly surprised to have had the Executive Director of the American Dental Association (ADA), Dr. Bramson, and the Association's Associate Director for Policy, Dr. Guay, respond to the article on adding a pediatric oral health therapist to the dental team; surprised in that the ADA, as an organization, does not customarily respond to articles in the dental literature, and pleasantly so in that it suggests (to me) that possibly the leadership of the ADA is concerned that the proposal could gain traction in the United States—as it has in over 40 countries in the world.

Drs. Bramson and Guay suggest I am advocating the "development of a lower level practitioner as a dentist-substitute." No; I am recommending the addition of a pediatric oral health therapist as a member of the dental team—a dentist-extender, just as the dental hygienist is a valued dentist-extender. No one would refer to a dental hygienist as a "lower level practitioner" or as a "dentist substitute." Dental hygienists are acknowledged partners with dentists in caring for patients. Indeed, most dentists would prefer a hygienist for the scaling and polishing of their own teeth.

In Great Britain, where dental therapy is recognized and practiced, "dental nurses, dental hygienists and dental therapists form an essential part of the dental team (1)." And in the broader field of medicine we have an excellent model of health care extenders. Physicians could not care for the ever-expanding population of patients without nurse practitioners, physicians' assistants, and nurse anesthetists as members of their team. To imply, as Bramson and Guay do, that an oral health therapist would be a "lower-level" or incompetent health care extender is simply incorrect. As has been demonstrated internationally, therapists provide safe, quality treatment at a standard of care comparable to that of a dentist.

My ADA colleagues contend that it is not *just* to treat children (by the) "relegation of the dental care for children to an auxiliary with less education, skills, experience and training." In fact, a two-year training program for a pediatric oral health therapist would provide many more hours of clinical experience than that of the typical graduating student dentist, resulting in an individual with far more training, skills, and experience treating children. A recent study found that 33% of dental school graduates had not had any actual clinical experience in performing pulpotomies and preparing and placing stainless steel crowns (2). Official ADA policy also questions the adequacy of the dental curriculum in preparing dentists to treat children. A 2000 House of Delegates resolution called for "a review of the predoctoral education standard 2.25 regarding pediatric dentistry to assure adequate and sufficient clinical skills of graduates" (3). The background statement supporting the resolution suggested that inadequate educational preparation for treating children could be a barrier to access.

Drs. Bramson and Guay state that the "ADA has long favored the appropriate use of dental auxiliaries to enhance the efficiency and increase the productivity of dentists." An ADA task force issued a very thoughtful and comprehensive 1995 report entitled, "The Dental Team in 2020: Future Roles and Responsibilities of Allied Dental Personnel" (4). The report advocated a significant expansion of the types and roles for dental auxiliaries. However, the ADA leadership chose not to advance the report to the House of Delegates as it was deemed too politically controversial. There is little evidence for the ADA encouraging the expansion of roles for dental auxiliaries.

As Bramson and Guay stated, the New Zealand School Dental Nurse program (the progenitor of today's therapist) was launched in 1921 because of the poor oral health of the individuals being called into military service during World War I. Ironically, *The New York Times* recently reported that one of the significant impediments in the U.S. deploying troops to Iraq was poor oral health: "roughly a quarter of reservists in seven early-deploying Army units had dental problems that could require emergency attention within the next year." And, "some reservists and Guard members chose to have their teeth pulled so that they could be deployed"(5). Striking parallels.

The "adequacy of the dental workforce" is a major point of contention. Projections are always challenging as assumptions of future conditions (environmental and otherwise) are subject to error. In my paper, I reported a decline in the actual number of dentists in the future based on *The Surgeon General's Report: Oral Health in America* (6). The report went on to say that "the dentist-to-population ratio is declining, creating concern as to the capability of the dental

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workforce to meet the emerging demands of society and provide required services efficiently." Drs. Bramson and Guay report a 2003 ADA study that projects a real increase in the number of dentists, from approximately 170,000 in 2002 to approximately 185,000 in 2020. However, Dr. Jackson Brown, Associate Executive Director for the Health Policy Resource Center of the ADA, co-authored an article in the *Journal of the American Dental Association* in December 2000, indicating that beginning in 2008 there would be more dentists retiring than graduating, and that this trend would continue until 2020 (7). The American Dental Education Association estimates the aggregate number of dentists will begin declining in 2014 (8). These projections contradict those of Drs. Bramson and Guay. More recently, Solomon reported projections that are in keeping with the Surgeon General's Report and the ADEA estimates, indicating a significant decline in the actual number of dentists in the future (9). However, *all* agree that the dentist/population will decline, with the ADA calling the drop from 55/100,000 to their projected 52/100,000 "slight" in the present article, and "moderate" in an internal ADA document (10). Solomon's 2020 projection of 45/100,000 must be considered alarming. Regardless of which projection you accept, all indicate there will be relatively *fewer dentists* to treat *more patients* in the future. However, the issue is that we have significant access problems with the *current* workforce, not considering a reduced workforce in the future.

As Bramson and Guay point out, the issue of dentists failing to treat publicly insured patients is a multifaceted problem. They believe the primary impediment is under-funded reimbursement, which makes it financially infeasible for dentists to care for these patients. Actually, the addition of a pediatric oral health therapist to the dental team would help address this objection, just as including a dental hygienist on the dental team has been documented to be cost-effective for dentists, and economically advantageous for dentists and patients alike. The employment of a pediatric oral health therapist by a dentist (or other health care entity) would result in a delegation of restorative procedures for children to a dentist-extender, thus reducing actual costs and increasing the potential for dentists (and/or other entities) to provide care in a more financially efficient manner. Because therapists would earn less than dentists, services could be provided at a lower fee, and dentists could focus on therapy uniquely requiring their knowledge and skills, and for which they are better remunerated.

Bramson and Guay understate, largely by omission, the extent of the problem of oral health among American children. The results of the Surgeon General's Report have been disseminated so widely that it would seem unnecessary to review them (6):

- Dental caries is the single most common chronic childhood disease.
- Over 50% of 5-9 year old children have at least one cavity or filling and that figure increases to 78% among 17 year olds.
- There are striking disparities in dental disease based on family income. Poor children, one in four American children, suffer twice as much decay as their more affluent peers, and their disease is more likely to be untreated.
- Early professional care is necessary to prevent and maintain oral health, yet 25 % of poor children have not seen a dentist before kindergarten.
- The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted activity days due to dental problems than do children from higher income families.
- Oral health is critically important to well-being. Pain and suffering due to untreated dental disease can lead to problems with eating, speaking, and learning.

The core of the issue between the leadership of the ADA, ADA policy, and myself (and many others as well) is our philosophical assumptions regarding health care delivery. This is brought out in the rejoinder of Drs. Bramson and Guay. They rightly draw a distinction between the effective demand for dental care and the need for care. In doing so, they espouse a "self-producing system that operates without direct subsidization by government." They acknowledge that the trade-off in such a market-driven system is the maldistribution of resources in relationship to need. I contend that this is at the heart of our access and disparities problem today!

The eminent free market theorist, Adam Smith, in *The Wealth of Nations*, drew a distinction between *social* goods and *consumer* goods (11). He argued that for a market economy to function, it must be based on a foundation of what he called *social* goods. Among the identified foundational social goods are security, health, and education. Such social goods were, for Smith, outside the marketplace and not subject to the forces of supply and demand. Rather, they were seen as basic human needs and imperatives to be met by society in order for a marketplace to even exist. It is difficult to imagine our market-based economy surviving without citizens having a strong sense of personal safety and security, the physical health with which to work, and a basic education in the cognitive skills necessary to function in the marketplace. I join with Adam Smith in believing that health, including a "decent basic minimum" of oral health, is a social good, not a consumer good. As such it must be addressed outside the marketplace of consumer goods. Basic oral health care for children is not analogous to purchasing an automobile or buying a television. To understand basic dental care as a consumer good to be purchased in the marketplace is to accept the access problem children of poor families face today. A dental delivery system for children based on demand rather than need is not a system that meets the demands of social justice.

On the grounds of social justice, as advanced in my paper, it is unjust for children to have to suffer the ravages of oral disease—regardless of their race, ethnicity, socio-economic-cultural circumstance or any such environmental condition. Children are who they are, what they are, and where they are as a result of a natural lottery. They had no choice of the circumstance into which they were born. That is the reason the distinguished philosophers I quoted in the paper argue forcefully that social justice for children requires they receive priority consideration by society and be maximally benefited. The first grade child of a dentist has no greater right or claim to oral health than a classmate who is from a family living in poverty.

The profession of dentistry has a moral obligation—as a profession—to ensure that all children are provided with basic preventive and therapeutic oral health care. Society has granted dentistry the status of being a profession, with a monopoly to practice, in order to ensure the oral health of the public. Society could (and should) consider rescinding such protected status, absent the profession vigorously and courageously addressing the problem of access to oral health care, and disparities in the oral health among our children.

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# Confronting Oral Health Disparities Among American Indian/Alaska Native Children: The Pediatric Oral Health Therapist

David A. Nash, DMD, MS, EdD, and Ron J. Nagel, DDS, MPH

American Indian and Alaska Native (AIAN) children are disproportionately affected by oral disease compared with the general population of American children. Additionally, AIAN children have limited access to professional oral health care. The Indian Health Service (IHS) and AIAN tribal leaders face a significant problem in ensuring care for the oral health of these children.

We discuss the development and deployment of a new allied oral health professional, a *pediatric oral health therapist*. This kind of practitioner can effectively extend the ability of dentists to provide for children not receiving care and help to confront the significant oral health disparities existing in AIAN children.

Resolving oral health disparities and ensuring access to oral health care for American Indians and Alaska Natives is a moral issue—one of social justice. (*Am J Public Health*. 2005; 95:1325–1329. doi:10.2105/AJPH.2005.061796.)

*"... of all the forms of inequality, injustice in health care is the most shocking and inhumane."*

—Martin Luther King, Jr.

Dental caries is the most common form of chronic disease in childhood: by midchildhood more than 50% of children are affected, and by late adolescence 80% of children have experienced dental caries. The prevalence and severity of dental disease are linked to socioeconomic status across all age groups.[1,2] Dental caries disproportionately affects minority groups, particularly the American Indian/Alaska Native (AIAN) population.[3]

We outline the problem of dental disease and access to care for AIAN children; propose an alternative delivery system involving a new class of allied oral health professional, the *pediatric oral health therapist*; describe previous, failed attempts to pursue this alternative system in the United States; and report on the current efforts in Alaska to introduce the pediatric oral health therapist into the tribal health care system. We argue that solving the problem of dental disease and access to care for American Indians and Alaska Natives is a moral issue—one of social justice.

## DEFINING THE PROBLEM

The AIAN population has the highest tooth decay rate of any population cohort in the United States: 5 times the US average for children 2–4 years of age. Seventy-nine percent of AIAN children, aged 2–5 years, have tooth decay, with 60% of these children having severe early childhood caries (baby bottle tooth decay). Eighty-seven percent of these children, aged 6–14 years, have a history of decay—twice the rate of dental caries experienced by the general population. Ninety-one percent of AIAN young people, aged 15–19 years, have caries. In general, 68% of AIAN children have untreated dental caries. One-third of school children report missing school because of dental pain, and 25% report avoiding laughing or smiling because of the way their teeth look.[3] This prevalence of caries infection exists in spite of the implementation of significant dental decay prevention programs by the IHS and tribes, including fluoridation of water systems suitable for fluoridation, the use of topical fluorides and dental sealants, and educational programs on oral health for children and parents.

Lack of access to professional dental care is a significant contributor to the disparities in oral health that exist in the AIAN population. Two major factors contribute to inadequate access to care: the relative geographic isolation of tribal populations, particularly in Alaska; and the inability to attract dentists to practice in IHS or tribal health facilities in rural areas.

Alaska offers a specific example of a geography-related barrier to providing access to care. There are 120 000 Alaska Natives in the state, with approximately 85 000 of these individuals living in the 200 villages that make up rural Alaska. A majority of these villages are not connected to the rest of the state by roads, thus requiring travel by air or water. Although village clinics provide essential medical care, in many instances villagers must travel hundreds of miles by bush-plane or boat to obtain dental care.

Despite intense recruitment efforts and significant financial incentives, the IHS and the tribes continue to experience great difficulty in attracting dentists. Approximately one-fourth of the dentist positions at 269 IHS and tribal health facilities were vacant in 2000.[4] Historically, Alaska's tribal programs have had a 25% vacancy rate for dentists and a 30% average annual turnover rate. (J. Tucker, DDS, oral communication). There is 1 dentist for every 2800 individuals in the IHS and tribal health clinics, compared with 1 dentist for every 1500 individuals in the general population.[3] The lack of dentists of AIAN ethnicity is a contributing factor to the access problem. There are only 85

AIAN dentists in the United States (1 for every 35 000 AIAN individuals); 70 of these are employed by the IHS or a tribe.[5]

## EXPANDING THE ORAL HEALTH CARE TEAM

The potential to reach more AIAN children in need of oral health care can be significantly improved by expanding the number of individuals capable of providing care. Although physician's assistants and nurse practitioners are commonly employed as "physician extenders" (providers licensed to practice under the direction of a supervising practitioner), the only comparable "dentist extender" is the dental hygienist, who deals primarily with issues of periodontal health for adults and generally is able to work only under direct supervision of a dentist. In 1995, an American Dental Association (ADA) task force recommended a significant expansion of the dental team in order to meet the emerging crisis in the workforce.[6] Recently, the editor of the *Journal of the American Dental Association* called for an expansion of allied dental personnel and their duties as the preferable alternative to increasing the number of dentists being educated in our dental schools.[7] Several leaders in dental practice and education have echoed his call.[8,9]

The New Zealand school dental nurse, now called a dental therapist, has served as a prototype for adding such a member to the dental team in many countries throughout the world. School dental nurses have provided comprehensive primary care for children in the schools of New Zealand since 1921. The World Health Organization documents 42 countries with some variant of a dental therapist.[10] The typical justification for developing and deploying dental therapists in these countries has been an inadequacy of the dental workforce, adversely affecting access to oral health care.[11]

## NEW ZEALAND'S MODEL

The training curriculum for New Zealand dental therapists consists of 2 academic years, both of which are 32 weeks in duration, with a total of 2400 curriculum clock hours. Approximately 760 hours of the curriculum are spent in the clinical setting treating children. Upon graduation, individuals enter the School Dental Service and must serve for 1 year with another school dental therapist.

School dental nurses/therapists in New Zealand have transformed the oral health of the children of the country and laid the basis for what was to become an international movement.[12] New Zealand's School Dental Service has developed an outstanding record in caring for the oral health of all children in New Zealand. Dental therapists provide a full range of care for children in school-based clinics, including preventive therapy, restoration of teeth with fillings and stainless steel crowns, pulp therapy, and extraction of primary teeth. In 1998, there were 569 dental therapists in the School Dental Service caring for 497 000 school children in over 2000 schools.[13] All children, aged 6 months through 13 years, are eligible to participate in the School Dental Service and receive comprehensive preventive and restorative care, without fee, at their local school clinic from the school dental therapist. Although enrollment is not compulsory, 97% of all school-age children participate in the School Dental Service.[14]

Although the indices of decayed, missing or extracted, and filled (primary and permanent) teeth (deft/DMFT) of the children of New Zealand and the United States is roughly comparable, there are differences in the components of these epidemiological measures. A 2003 report[15] indicate that 53% of New Zealand's children of 5 years of age are caries free, and the cohort has a mean rate of extracted/filled primary teeth (ef) of 1.8. At ages 12–13 years, 42% of children are free of caries, with a mean missing/filled permanent teeth (MFT) of 1.6. These data are interesting in that the decayed (d/D) components are not included, because these data are collected at the end of each school year and represent children enrolled in the School Dental Service whose decayed teeth, at that time, have either been restored or extracted, or have exfoliated. This means that essentially all of the school children in New Zealand are free of untreated caries at the end of an academic year.

In 1968, at the Centennial Conference on Oral Health held at the Harvard School of Dental Medicine, Dr John Walsh of the University of Otago (New Zealand) School of Dentistry suggested the use of a *care index*, which can be calculated by developing a ratio of the filled-teeth component (f/F) of the deft or the DMFT to the overall deft or DMFT, thus yielding a percentage of the teeth requiring treatment for which restoration had been provided.[16,17] In 1968, the care index in New Zealand was 72%, meaning that 72% of all teeth of children affected by caries had been restored. In the United States, the figure was 23%. Walsh made the claim that the care index provides a convenient measure of the effectiveness of a country in treating dental caries. Today, the care index for New Zealand children is essentially 100%.[18] In the United States, although significantly improved from 1968, it is 63.3% for primary teeth and 74.0% for permanent teeth through age 14.[19] Of note is the fact that the care index drops significantly for US children when adjusted for family income. For primary teeth, it is 72.3% for children at 300% of the federal poverty level (FPL) but only 48.7% for children at 100% of the FPL. For permanent teeth, it is 93.2% for children at 300% of the FPL and only 72.3% for children at 100% of the FPL.[19] The care index for AIAN children, aged 2–5 years, is 34.9%.[3]

## HEALTH CANADA'S UTILIZATION OF THERAPISTS

Health Canada (the Canadian Ministry of Health) adopted the New Zealand model of dental nurses/therapists and has trained and utilized dental therapists to provide access to dental care for "First Nation" Canadians since 1972.[20] The National School of Dental Therapy for Canada exists as a component of the First Nations University of Canada, in Prince Albert, Saskatchewan. The school's mission is to train dental therapists, in a 2-year program, to provide care for the remote villagers of the Canadian North (Schnell GM, DDS, unpublished data). The curriculum is modeled after New Zealand's program. Dental therapists are able to work for Health Canada on federal First Nation reserves

throughout Canada, with the exception of the provinces of Ontario and Quebec. There are approximately 90 dental therapists so employed today.[21]

With the advent of the use of therapists in Canada on First Nation reserves, the ratio of extractions to restorations dropped significantly, from over 50 extractions per 100 restorations in 1974 to fewer than 10 extractions per 100 restorations in 1986.[22] New Zealand experienced a similar circumstance with the introduction of school dental nurses/therapists, with a decline of 75 extractions per 100 restorations when the program first began in the mid-1920s to 7.5 per 100 in 1945 and 3.6 per 100 in 1964.[23]

Double-blind studies of the work of the Canadian dental therapists, in comparison to federally employed Canadian dentists, have been conducted (Schnell GM, DDS, unpublished data).[24] The results indicated the quality of restorations placed by dental therapists was equal to those placed by dentists.

## THE UNITED STATES EXPERIENCE

In 1949, Massachusetts passed legislation authorizing the Forsyth Dental Infirmary for Children (Boston) to accept funding from the US Children's Bureau to initiate a research project to train individuals, in a 2-year program, to prepare and restore cavities in children's teeth.[25,26] The passage of this legislation provided for the establishment of an experimental dental care program for children similar to the school dental nurse program of New Zealand. The American Dental Association (ADA) swiftly passed resolutions "deploring" the program, expressing the view that any such program concerning the development of "sub-level" personnel, whether for experimental purposes or otherwise, should be planned and developed only with the knowledge, consent, and cooperation of organized dentistry. The position of the ADA was that a teaching program designed to equip and train personnel to treat children's teeth cannot be given in a less rigorous course, or in a shorter time, than that approved for the education of dentists.[26] Faced with increasing pressure from organized dentistry, the Massachusetts governor signed a bill in July 1950, rescinding the enabling legislation.[27]

In 1970, the House of Delegates of the Massachusetts Dental Association passed a resolution favoring research on expanded-function dental auxiliaries. As a result, the Forsyth Dental Center launched a research project to train dental hygienists in anesthesia and restorative therapy for children. However, in 1973, the Board of Dental Examiners voted unanimously that the drilling of teeth by hygienists was a direct violation of the dental practice act of Massachusetts and forced the Forsyth Dental Center to end its experiment, but not before investigators were able to document that hygienists could be taught to efficiently provide quality restorative dental care for children in a cost-benefit–effective manner.[28]

In 1972, the University of Southern California School of Dentistry proposed employing school dental nurses, like those in New Zealand, to help solve the problem of dental caries in school children.[29] This proposition prompted the California Dental Association to establish a committee to study the New Zealand dental care system.[30,31] Their report stated that "there is little doubt that dental treatment needs related to caries for most of the New Zealand children aged 2 to 15 years have been met." However, the report concluded that the California public would "probably not" accept the New Zealand type of school dental service, as it would be perceived as a "second-class system." A number of individuals wrote sharp rebukes to the committee's report, pointing out the inconsistencies of the objective findings of the investigation in relation to the subjective conclusions of the report, which they judged to be drawn to placate the practicing profession in California.[32,33–35]

Between 1972 and 1974, at the University of Kentucky, another expanded-functions project, supported by the Robert Wood Johnson Foundation, took place (Spohn EE, DDS, unpublished report). The project also involved the training of dental hygienists in restorative dentistry for children. Thirty-six students, who were completing a 4-year baccalaureate program in dental hygiene, participated in a compressed curriculum that provided 200 hours of didactic instruction in children's dentistry, as well as 150 hours of clinical practice. The program was specifically designed to provide primary care for children, including administration of local anesthesia, restoration of teeth with amalgams and stainless steel crowns, and pulp therapy. A double-blind study found no significant differences between the quality of the hygienists' work and that of the graduating student dentists (Spohn et al., unpublished report).

At the College of Dentistry at the University of Iowa, a 5-year project, conducted from 1971 to 1976, and supported by the W.K. Kellogg Foundation, trained dental hygienists to perform expanded functions in restorative dentistry and periodontal therapy for both children and adults.[36] The results were the same as those of the studies at the Forsyth Dental Center and the University of Kentucky. Hygienists could be effectively trained, in a relatively brief time period, to perform, at a comparable level of quality, procedures traditionally reserved for dentists.

A curriculum to develop dental therapists, more recently designated "pediatric oral health therapists,"[37] exists and has been documented to be effective in multiple countries throughout the world. It is the traditional curriculum of the New Zealand school dental nurse/therapist. The curriculum for a pediatric oral health therapist would be comparable to the 2-year (associate's degree) curriculum for preparing dental hygienists. The primary difference would be the focus of the training: the hygienist's focus would be periodontal disease, particularly in the adult; the therapist's focus would be dental caries, specifically in the child. Evidence suggests the performance skills required to restore children's teeth are no more complex than those skills typically taught to dental hygienists in a 2-year curriculum (Spohn EE, DDS, unpublished report).[28,36]

## DEPLOYING THERAPISTS IN ALASKA

In 2001, the Forsyth Institute approached the Robert Wood Johnson Foundation for funding to develop a training program for

pediatric oral health therapists.[38] Funding was not forthcoming. Absent the availability of a program for training therapists in the United States, the Alaska Native Tribal Health Consortium proceeded, in 2003, to send 6 Alaskan students to the University of Otago in New Zealand to train as therapists; 6 additional Alaskan students enrolled in the training program in January of 2004.

The first group of therapists returned to Alaska from New Zealand in December of 2004 to provide oral health care in the context of the Community Health Aide (CHA) program, a program authorized by federal statute, in which tribes provide primary health care throughout Alaska. The program has been in existence for 36 years. There are over 500 CHAs in Alaska, working in 180 villages, providing culturally sensitive health care to fellow villagers. A component of the CHA Program is the dental health aide (DHA). There are 3 levels of functioning for DHAs: DHA I and DHA II, and the third and highest level, the DHA therapist, a responsibility to be assumed by the pediatric oral health therapists who have recently returned to Alaska from New Zealand. CHAs, including DHAs, must meet specified training requirements, undergo a protracted preceptorship, and have their skills reevaluated every 2 years. Continuing education is required for continued certification. CHAs and DHAs are recruited from villages that they will return to serve. This practice ensures culturally competent care, as well as sustainable jobs in areas that need them most.

The ADA was informed of the Alaskan students studying dental therapy in New Zealand and the intent for them to return to tribal programs to practice. At the October 2003 annual session, the ADA House of Delegates passed a resolution calling for a task force to "explore options for delivering high quality oral health care to Alaska Natives."[39] The Alaska Native Oral Health Access Task Force submitted its report to the ADA Board of Trustees in August 2004. On the basis of the task force's recommendations, the board, at the ADA's October 2004 Annual Session, advanced to the House of Delegates a resolution with 14 elements to address access to oral health care for Alaska natives. Two of the elements dealt specifically with the advanced-level DHA therapist (pediatric oral health therapist): (1) "the ADA work with the ADS (Alaska Dental Society) and tribal leaders to seek federal funding with the goal of placing a dental health aide (i.e., a Dental Health Aide I or II) trained to provide oral health education, preventive services and palliative services (*except irreversible procedures such as tooth extractions, cavity and stainless steel crown preparations and pulpotomies* [emphasis added]) in every Alaska Native village that requests an aide"; and (2) "The ADA is opposed to non-dentists making diagnoses or performing irreversible procedures." The resolution passed the House of Delegates overwhelmingly on a voice vote.[40]

Subsequently, the ADA initiated an effort to amend the Indian Health Care Improvement Act, which was in the process of being reauthorized by the Congress in the closing days of the 108th Congress. This act authorizes development and operation of the CHA Program, which includes dental health aides. House Bill HR 2440 was amended at markup to read "ensure that no dental health aide is certified under the program to perform treatment of dental caries, pulpotomies, or extractions of teeth."[41] However, the ADA's amendment was not successful, as reauthorization of the Indian Health Care Improvement Act was not accomplished by the 108th Congress; reauthorizing legislation will have to be re-introduced in the 109th Congress. It is clear that organized dentistry's opposition to developing a new member of the dental team to provide primary oral health care for underserved children has not changed since the first attempt to train dental nurses at the Forsyth Dental Infirmary in 1949.

## SOCIAL JUSTICE

Kopleman and Palumbo have published a thoughtful and compelling article in the *American Journal of Law and Medicine* entitled: "The US Health Delivery System: Inefficient and Unfair to Children."[42] The article explores the 4 major ethical theories of social or distributive justice: utilitarianism, egalitarianism, libertarianism, and contractarianism. They conclude that no matter which theoretical stance is taken, children should receive priority consideration in receiving health care. Yet, AIAN children (as well as poor and minority children throughout America) do not receive equal, much less priority, consideration.

In his *A Theory of Justice*, one of the most important and influential books of political philosophy written in the 20th century, the late John Rawls of Harvard University carefully explicated a model of justice in which social and economic arrangements would be such as to maximally benefit the least advantaged.[43] Given a Rawlsian view of social justice, our nation's oral health care system, if it is to be just, must be committed to maximally benefiting the least advantaged. AIAN children and other children of socioeconomic and racial/ethnic minority groups have a higher prevalence of oral disease and disproportionately experience oral health access problems compared to non-minority children and those in higher socioeconomic groups. Norman Daniels, Professor of Bioethics and Population Health at the Harvard School of Public Health, agreed with Rawls and argued that a just society should provide basic health care to all but that health care should be redistributed more favorably to children.[44] He justified his conclusion based on the effect health care has on equality of opportunity for children, with equality of opportunity being a fundamental requirement of justice.

The time has come for American public health leaders to openly and forthrightly support the implementation of the pediatric oral health therapist's program in Alaska. It is also incumbent on the American public health community to courageously challenge the existing barriers to developing and deploying pediatric oral health therapists as members of the dental team in the remainder of the United States. Doing so will help ensure that our disadvantaged and underserved children are treated justly by society by having access to basic, primary oral health care and by having an opportunity for good oral health equal to that of other children. ■

## About the Authors

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*This article was accepted March 15, 2005.*


## Contributors

D. A. Nash conducted the research on the history and international utilization of dental therapists. R. Nagel served as the resource person for the Alaska project. Both participated in writing the article.


## Acknowledgments

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## Letter to the Editor

# A Brief History and Current Status of a Dental Therapy Initiative in the United States

Dear Dr. Alvares:

As per your invitation we are providing a brief review of the history of the current attempt to add a dental therapist to the dental team in the United States, as well as indicate the status of the effort.

In November of 2000, Oral Health America sponsored a conference in Boca Raton, Florida on the Surgeon's General's Report, *Oral Health in America*. At that meeting David Nash invited Dominick DePaola, president of Forsyth Institute and Wendy Mouradian, professor of pediatrics and pediatric dentistry at the University of Washington, to discuss the potential that introducing a New Zealand style "school dental nurse/therapist" could have on addressing oral health disparities among America's children. As a result of that discussion, a larger meeting of interested parties was held in February of 2001 at the Forsyth Institute in Boston. The intention of the Forsyth meeting was to consider how such a new member of the dental team could function in the delivery system, and to seek funding for a training program and experimental initiative. A result of the Boston meeting was the decision to focus on working with American Indians/Alaska Natives, as this population experiences an inordinate disparity in oral health. Additionally, the Tribes are sovereign and the ability to develop and deploy "pediatric oral health therapists" could be facilitated in such an environment.

Concurrent with these discussions, the Alaska Native Tribal Health Consortium (ANTHC) was beginning the development of dental health aides, under the provisions of the Congressionally-authorized Alaska Community Health Aide Program (CHAP). Initially, the program called for development of a Primary Dental Health Aide (PDHA) and an Expanded Function Dental Health Aide (EFDHA). The PDHA would function primarily as a community dental educator but also provide preventive services under the general supervision of a dentist. The EFDHA would work under the direct supervision of a dentist and serve as an expanded function dental assistant. A contract to provide training for these two levels of dental health aide was awarded to the University of Kentucky in 2002. The first series of training programs for the PDHA and EFDHA will be completed in September of 2005. A third level of dental health aide was also conceptualized, the Dental Health Aide Therapist (DHAT), that is, a "pediatric oral health therapist."

Ron Nagel was responsible for working with the Alaska Native Tribal Health Consortium (ANTHC) to develop the dental health aide program. He was also involved in the conversations emanating from the Forsyth meeting. Discussions proceeded within the ANTHC regarding the training of DHATs, and sources of funding for such. The School of Dentistry at the University of Otago in New Zealand agreed to accept six Alaska Native students per year into their dental therapy training program. Funding to support training and travel was obtained from the Rasmuson Foundation. In February, 2003, six Alaska Native students traveled to New Zealand to participate in a two academic year curriculum to be trained as dental therapists. In May of that year, Nash arrived at the University of Otago for a previously arranged sabbatical to study the work of the "school dental nurse/dental therapist" in New Zealand, and its potential applicability to the disparities problem in the U.S. Six additional students from Alaska were sent to study in New Zealand in February of 2004, and six more in February of 2005. Four of the initial six students completed the program in December of 2004, and are currently serving brief preceptorships in preparation for practicing dental therapy in remote Alaskan Tribal villages. The therapists will provide primary oral health care for children under the general supervision of a dentist. The other two initial enrollees are in the process of completing training requirements.

The American Dental Association was informed of the Alaska students studying dental therapy in New Zealand and the intention for them to return to Tribal programs to practice. At the October, 2003, annual session, the ADA House of Delegates passed a resolution calling for a task force to "explore options for delivering high quality oral health care to Alaska Natives." The Alaska Native Oral Health Access Task Force submitted its report to the ADA Board of Trustees in August of 2004. Based on the Task Force's recommendations, the Board advanced to the House of Delegates, at the ADA's October 2004 Annual Session, a resolution with 14 elements to address access to oral health care for Alaska Natives, with two dealing specifically with the advanced level Dental Health Aide Therapist: (1) "the ADA work with the ADS [Alaska Dental Society] and tribal leaders to seek federal funding with the goal of placing a dental health aide (i.e., a Dental Health Aide I or II) trained to provide oral health education, preventive services and palliative services (*except irreversible procedures such as tooth extractions, cavity and stainless steel crown preparations and pulpotomies*) in every Alaska Native village that requests an aide" (emphasis added); and (2) "The ADA is opposed to non-dentists making diagnoses or performing irreversible procedures." The resolution passed the House of Delegates overwhelmingly on a voice vote.

Subsequently, (November/December, 2004) the ADA attempted to amend the Indian Health Care Improvement Act which was in the process of being reauthorized by the Congress in the closing days of the 108th Congress. This Act authorizes development and operation of the Community Health Aide Program, which includes Dental Health Aides. House Bill HR 2440 was amended at legislation mark-up to read "ensure that no dental health aide is certified under the program to perform treatment of dental caries, pulpotomies, or extractions of teeth." However, the ADA's amendment was not successful because reauthorization of the Indian Health Care Improvement Act was not

accomplished by the 108th Congress. Reauthorizing legislation will have to be re-introduced in the current 109th Congress.

The ADA has constituted a Task Force on Workforce Models. At their April 2005 meeting, several individuals/organizations were asked to testify regarding perspectives on the dental workforce of the future. Nash was asked to testify on the concept of adding a "pediatric oral health therapist" to the dental workforce. The Task Force is to present its report and recommendations to the ADA House of Delegates in October of 2005.

The ADA also retained four consultants who were paid to independently examine the access problem of Native Americans in Alaska. They were Dr. Howard Bailit and Dr. Tryfon Beazoglou of the University of Connecticut, Dr. Amid Ismail of the University of Michigan, and Dr. Thomas Kovaleski, Dental Director of the South Central Foundation in Alaska; one of the twelve Tribal associations. They submitted a report to the ADA, dated April, 2005, entitled, "Integrated Dental Health Program for Alaska Native Populations." Among their recommendations was that the dental therapists' model be replaced with a lesser-trained individual, a Community Oral Health Provider (COHP). These individuals would have organizational and management duties in the proposed integrated system, and would also have clinical responsibilities including Atraumatic Restorative Treatment (ART), treatment of mild periodontal disease by prophylaxis and scaling, and management of acute pain and infection under the direction of dentists. Unlike dental therapists, they would not be able to provide definitive therapy such as permanent restorations, pulpal therapy, or simple extractions. At the time of submission of this letter to the editor, this proposal had been advanced to the ANTHC leadership, discussed by the dental directors of the ANTHC, but had not been formally responded to by the chief executive officer of the ANTHC.

The Alaska State Board of Dentistry, at the instigation of the Alaska Dental Society, has challenged the legality of dental therapists practicing in the Tribal health care system. Its challenge is currently under review by the State's attorney general. Again, no response from the attorney general had been issued at the time of this letter.

It should be noted that the ADA Task Force that visited Alaska in April, 2004, indicated to the Tribal leadership that the ADA would develop a volunteer program in which dentists from other states would voluntarily spend time in Tribal villages caring for Native Alaskans without access to care. The program, named "Operation Backlog," was prominently publicized by the ADA; however, no provisions have as yet been made by the ADA for dealing with the logistics associated with temporary licensure and deployment of volunteer dentists. Thus, over one year later, no volunteers have been sent to Alaska under the ADA program.

At the most recent ADA Board of Trustees meeting, June 12-14, 2005, the Board unanimously passed a resolution supporting the idea of litigation, should it become necessary, against dental therapists practicing in the Tribal health care system in Alaska. The Board also authorized "an advertising campaign up to a $150,000 level to educate

Alaskan natives and others about the risks of allowing non-dentists to perform irreversible procedures."

Two articles describing the concept of a "pediatric oral health therapist," as well as the significant history of attempts to implement a school dental nurse/therapist model in the United States have been published by Nash: *Developing a Pediatric Oral Health Therapist to Help Address Oral Health Disparities Among Children*, J Dent Educ 2004; 68:8-20, and *Developing and Deploying a New Member of the Dental Team: A Pediatric Oral Health Therapist*, J Pub Health Dent 2005; 65:48-55. A third article by Nash and Nagel, *Addressing Oral Health Disparities of American Indian/Alaska Native Children: Developing and Deploying a New Member of the Dental Team--A Pediatric Oral Health Therapist*," will appear in the August 2005 issue of the American Journal of Public Health.

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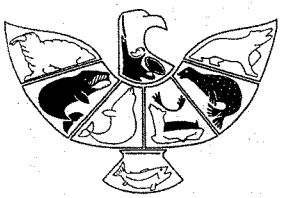


# Alaska Native Health Board

101 Constitution NW, Ste 8B02 Phone: (202) 742-4430
Washington, DC 20001 Fax: (202) 742-4285


July 14, 2005

**To: Chairman McCain and Chairman Enzi**
**Senate Committee on Indian Affairs**
**Senate Committee on Health, Education, Labor and Pensions**
**109th United States Congress**
**Washington, DC 20510**

This is the written testimony for Dr. Mary Williard.
Submitted by the Alaska Native Health Board.

The Yukon-Kuskokwim Health Corporation manages a comprehensive health care system on behalf of 58 federally recognized Tribes for 50 rural communities in southwest Alaska. This area is roughly the size of Oregon. The system includes community clinics, sub regional clinics, a regional hospital, dental and optical services, mental health services, substance abuse counseling and treatment, health promotion and disease prevention programs, and environmental health services.

Alaskan children suffer from tooth decay at 2-1/2 times the national rate, and the number of Alaska Natives has doubled since 1970. There is an epidemic of dental caries in Alaska Native villages. This epidemic is not hidden; it is seen in every smile that reveals missing or decayed teeth in the mouths of Alaska Natives of all ages.

The Alaska Native Health Board endorsed the Dental Health Aide Program to address the epidemic of dental disease in Alaska Native Villages in 1999. The program then began the process of developing program standards, requirements, and certification guidelines. The board that carried out this process included experienced Public Health Dentists, local community members, Community Health Aide Practitioners and Directors, attorneys and other experts as necessary. Five Dental Health Aides Therapists have been trained and are now in their preceptorship training with dentists in regional hospitals, others are curtently in training in New Zealand.

In 1991, a dental manpower study was conducted in Alaska. This study showed that if the IHS/Tribal health system doubled the number of dentists, it would take 10 years to eliminate the unmet need for dental services. The problem has continued to increase since this study, however, there have been no funding increases, nor has the dental community provided a viable solution.

There have been suggestions that having dentists volunteer would provide a viable solution to the dental problems of rural Alaska. The itinerant approach where dentists visit periodically has not been effective in reducing the rate of dental disease. One of the issues that arise with the volunteer program is that there is no continuity of care for the people of the villages. Volunteer dentists would not be able to develop a long-term relationship with the population that they serve. The dental therapists will ideally be Alaska Natives from the rural community and have strong ties to the people. They will provide a more consistent basis of care. Being Native Alaskans, they will be more culturally sensitive to the issues of the indigenous population. Alaskan Natives will be empowered to take care of their own people.

For the 85,000 Alaska Natives who live in the 200 villages without road access, the only time dental services are available is when a dentist flies in to conduct a dental clinic. Alaska Tribal Health Programs experience a 25% vacancy rate among dentists and a 30% average annual turnover rate. Tribal health programs have increased their dental budgets above the IHS allocation of funds so that they could increase salaries, and have built numerous well-equipped dental facilities. But dentists still don't choose to live in remote, isolated communities or to travel by small planes to even more remote villages to conduct clinics in buildings that may not even have running water.

Dental therapists have a two-year training program; general dentists have a four-year program. The dental therapy program has a more clinical focus. The therapists gain competencies within a more limited scope of practice. The dental health aide therapist's competence assessments are equal to the requirements of an accredited dental school. The therapists graduate with more clinical hours in their area of training than the average dental student.

There is bi-annual recertification for the dental therapists where they are required to demonstrate their clinical competencies. A 3-month or longer preceptorship under a dentist is required before dental health aide therapists are allowed to practice independently. The DHAT is then able to work under a consultation/referral status with the dentist who supervised their preceptorship. This preceptorship is more stringent than what is required by other dental professions. All Alaskan tribal health programs, including the dental health aide program, are scrutinized independently by national hospital accreditation organizations. Dental professionals in private practice are not held to the same standard.

- The Dental Health Aide Program is a local solution to a local crisis. This program will be as successful as the Community Health Aide Provider Program, which has been in place for 30 years, because of local residents receiving appropriate training, employment, and providing high quality care to their community.
- Dental health aides will have as many hours of educational clinical experience in their limited scope of practice as most dentists receive during their educational program.
- Dental health aides will be supported by telemedicine access to the dentist who will be able to actually view the same tooth and x-rays that the DHAT is examining.
- Dental health aides are subject to biannual recertification and continuing education requirements.

- Mid-level providers such as nurse midwives, physician assistants, and paramedics have been successful in delivering other types of health care in the United States for years with good economic and public health benefits.

- Due to the distance and isolation of these Alaskan communities, dental care is only offered on a very basic level. With dental health aides addressing these basic needs, the dentist would have more time to perform root canals, dentures, crowns, bridges, and orthodontics.

- Dental therapists will be able to raise dental awareness. Once the overall general dental aptitude is increased, the need for re-treatment would be reduced.

- Canada and other countries, such as New Zealand and Australia are successfully using the dental therapy model to increase access to restorative and preventive oral care. In the Province of Saskatchewan - Canada, there are about 170 dental therapists currently practicing. They can legally provide all procedures within their scope of practice including, but not limited to: fillings, extractions and pulp therapy. In over 30 years of regulation, evidence clearly shows that there have been no disciplinary actions taken against a dental therapist for either professional misconduct or professional incompetence, or any claims against their independent malpractice insurance

I have been the Chair of the Academic Review Committee for the Dental Health Aide Program for the last 3 years, during which time I have been involved in the development of certification standards, educational course curriculums, and levels of practice. These processes were performed with care and attention to the scientific literature, which has addressed the questions of quality and safety in the dental therapists practice; clearly the science supports our claim that therapists provide safe and high quality dental care. To date, the American Dental Association has not provided any scientific evidence to support their position that Dental Therapists would provide substandard quality of care, yet they persist in spreading these unsubstantiated and fear-based claims.

My Personal experience includes mentoring two Alaska Native people who completed the two-year Dental Therapy Diploma course in New Zealand. They returned to Bethel, Alaska, in January 2005, to start their preceptorship. I have scrutinized every aspect of their work and have found them to be competent in their scope of practice, and in knowing their limits. My own children have been treated by the therapists. I have had my teeth cleaned by them. Moreover, our patients are happy to see the therapists. Following are some quotes by patients who have been treated by our therapists.

"I had my teeth cleaned by Lillian, {a dental therapist at YKHC} and I'd say it was better than any other cleaning I had received by a hygienist. She was good." – Angie Whitman, a dental assistant with 15 years experience.

"You know, historically, out here (in the YK Delta) we have lead the state with health aides, VPO's (Village Police Officers) and now tribal courts. And there are always naysayers. But I think self determination and getting more services directly out to the people is the name of the game and you guys are right on the ball with the Dental Health Aide Therapists." – Susan Taylor, life-long Alaska resident.

The name of the game is also disease prevention, which has been pushed aside during much of this discussion, but the major push of the Dental Health Aide program is to improve the dental presence in the rural communities, the Therapist could be the leader of this effort, as well as offering much needed routine and basic care.

Please listen to the people who live and work in these communities, and refuse to take away our federally recognized right to manage our own healthcare. Support the S. 1057 of the Indian Health Care Improvement Act that does not limit the scope of practice of the Dental Health Aides.

FC



Bristol Bay Area
Health Corporation
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P.O. Box 130
Dillingham, AK 99576
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*Bristol Bay Area Health Corporation is a tribal organization representing 34 villages in Southwest Alaska:*

- Aleknagik
- Chignik Bay
- Chignik Lagoon
- Chignik Lake
- Clark's Point
- Dillingham
- Egegik
- Ekuk
- Ekwok
- Goodnews Bay
- Igiugig
- Iliamna
- Ivanof Bay
- Kanatak
- King Salmon
- Knugank
- Kokhanok
- Koliganek
- Levelock
- Manokotak
- Naknek
- New Stuyahok
- Newhalen
- Nondalton
- Pedro Bay
- Perryville
- Pilot Point
- Platinum
- Port Heiden
- Portage Creek
- South Naknek
- Toglak
- Twin Hills
- Ugashik

*To promote health with competence, a caring attitude & cultural sensitivity*

July 26, 2005

RECEIVED
JUL 28 2005

Chairman McCain and Chairman Enzi
Senate Committee on Indian Affairs
Senate Committee on Health, Education, Labor and Pensions
109th United States Congress
Washington D.C. 20510

RE: Written testimony supporting the S.B. 1057 language

Dear Chairman McCain and Chairman Enzi,

**INTRODUCTION**

Bristol Bay Area Health Corporation (BBAHC) is a tribal organization serving 34 tribes in Southwestern Alaska. BBAHC's service area is approximately 47,000 square miles (approximately the size of Ohio) with no road system connecting to urban areas. Our organization compacts with Indian Health Service (IHS) through the Alaska Tribal Health Compact (ATHC) to provide health services including medical, dental, hospital, optometry, audiology, behavioral health, environmental health and health education service. We maintain membership in Alaska Native Health Board (ANHB) and National Indian Health Board (NIHB) and have Board of Directors representation in the Alaska Native Tribal Health Consortium (ANTHC).

The State of Alaska is 586,000 square miles and makes up approximately 1/5 of the landmass of the entire United States. There are 229 tribes in Alaska, making up almost ½ of the tribes in America.

ANHB is comprised of 23 member organizations. These organizations either have Title I contract or Title V compact with the IHS to carrying out health care delivery in their area. Alaska is the only area in the nation where 99% of health programs are managed by Native organizations.

The Alaska Native Health care is delivered through a referral system.

As you may already know, are the Community Health Aide Practioner's (CHA/Ps) are the backbone of the system. There are approximately 500 CHA/P local employees working in 178 communities. They serve as the first responders, along with Village Public Safety Officers, to any situation.

When a patient needs a higher level of care, they are transported to one of six regional hospitals (as available in the area). The six hospitals are located in: Barrow, Kotzebue, Nome, Bethel, Dillingham and Sitka.

The flagship statewide hospital – the Alaska Native Medical Center (ANMC) – serves as the final referral facility. This is the only level II trauma center in the State of Alaska. If specialty services are not available at ANMC, patients will then be transferred to a private facility.

It is important to note that Native health organizations not only serve a Native population. They are – in many areas – the only health service providers available.

The Alaska Tribal Health System represents diverse organizations and Alaskan people. Because we have 229 federally recognized tribes that live across 586,000 miles of roadless land, it was crucial for us to develop this innovative and essential statewide health system.

**DENTAL CRISIS**

- Alaskan children suffer from tooth decay at 2-1/2 times the national rate. 1/3 of school children miss school because of dental pain and 25% report avoiding laughing or smiling because of the way their teeth look.

- The number of Alaska Natives has doubled since 1970 and there is an epidemic of dental caries in Alaska Native villages.

**TRAINING**

The ANHB endorsed the Dental Health Aide Program to begin planning, certification, and drafting standards. Experienced Public Health Dentists, local community members, CHA/P Directors and Aides, attorneys and other experts convened to carry out ANHB's directive to create a Dental Health Aide Program. We now are at the stage that individuals have been trained and are now in their preceptorship training in regional hospitals with dentists.
Dental therapists have a two-year training program and dentists train for four years. The dental therapy program has a more clinical focus to learn the competencies within their more limited scope of practice. The dental health aide therapist's competence assessments are equal to the requirements of an accredited dental school.

There is bi-annual recertification for the dental therapists where they are required to demonstrate their clinical competencies. A 3-month or longer preceptorship under a dentist is required before dental health aides are allowed to practice independently. The DHAT is then able to work under a consultation/referral with the dentist who supervised their preceptorship. This preceptorship is more stringent than what is required by other dental professions. All Alaskan tribal health programs, including the dental health aide program, are scrutinized

independently by national hospital accreditation organizations. Dental professionals in private practice are not held to the same standards.

**RECRUITMENT/RETENTION**

In 1991, a dental manpower study was conducted in Alaska. If the IHS/Tribal health system doubled the number of dentists, it would take 10 years to eliminate the unmet need for dental services.

For the 85,000 Alaska Natives who live in the 200 villages without road access, the only time dental services are available is when a dentist flies in to conduct a dental clinic. Alaska Tribal Health Programs experience a 25% vacancy rate among dentists and a 30% average annual turnover rate. Tribal health programs have increased their dental budgets above the IHS allocation of funds so that they could increase salaries. But dentists don't choose to live in remote, isolated communities or travel nearly every week by small planes to even more remote villages to conduct clinics in buildings without running water.

**VOLUNTEER PROGRAM**

There have been suggestions that having dentists volunteer would provide a viable solution to the dental problems of rural Alaska. The proposed volunteer program suggested by the American Dental Association (ADA) would not be effective in reducing the rate of dental disease. One of the issues with the volunteer program is that there is no continuity of care for the people of the villages. Volunteer dentists would not be able to develop a long-term relationship with the population that they serve. The dental therapists are Alaska Natives from the rural community and have strong ties to the community. They will provide a more consistent basis of care. Alaskan Natives will be empowered to take care of their own people.

Another issue that has been brought to our attention is that the (ADA) has approached Congress requesting an appropriation through the IHS to fund this 'volunteer' program. As you may already know, the IHS continues to be 40% under funded. We feel the ADA is misleading the public and congressional representatives when claiming they have a solution to address our dental disparities.

**PUBLIC HEALTH SUPPORT**

Other organizations with a profound interest in public health - but not profit motive - have all come out in support of the Dental Health Aide Therapist program. These include the IHS, under director Dr. Charles Grim, himself a dentist. The Alaska Department of Health and Social Services, who's Commissioner, Joel Gilbertson, said (DHAT) "holds great promise for addressing

the profound dental problems of rural Alaskans, and we applaud Congress for giving the program a chance to demonstrate its potential for success."

In addition, the American Association of Public Health Dentistry and the Oral Health Section of the American Public Health Association both support the Dental Health Aide Therapy program in Alaska. The support of these national public health dentistry associations illustrates the fact that only private dentists oppose the Dental Health Aide Therapy program. Private dentists have a financial motivation; public health dentists are motivated to elevate the dental health for the betterment of the general public.

SUMMARY

- **The Dental Health Aide Program is a local solution to a local crisis.** This program will be as successful as the Community Health Aide Providers Program is because of local residents receiving training, employment, and providing high quality care to their community.
- Dental health aides will have had as many hours of educational clinical experience in the limited number of procedures as most dentists receive during their educational program.
- Dental health aides is **supported by telemedicine** access to the dentist who will be able to actually view the same tooth and x-rays that the DHAT is examining.
- Dental health aides are **subject to biannual recertification** and continuing education requirements.
- Mid-level providers have been successful in delivering other types of health care.
- Due to the distance and isolation of these communities, dental care is only offered on a very basic level. With dental health aides to address these basic needs, then the dentist would have more time to perform root canals, dentures, crowns, bridges, and orthodontics.
- Dental therapists will be able to raise dental awareness. Once the overall general dental aptitude is increased then the need for re-treatment would be reduced.
- **Is there any evidence that the Dental Health Aide Therapy program is effective?** DHAs are new to the United States, but New Zealand has a 75-year history of success in using dental health paraprofessionals. The World Health Organization shows that dental health aide/therapists now work in 42 countries, including Australia, Hong Kong, Great Britain, and

Canada. After Canada started its program, the ratio of teeth pulled to teeth fixed dropped from over 50% to less than 10%. A thorough study of the Canadian effort compared the work of dental therapists and dentists and found that the quality of restorations by therapists equals that of dentists.

- While DHAs are new to the U.S., a role model exists in medicine – the Community Health Aides. The Community Health Aide Program has been used as a model by President Bush to address the HIV/AIDS crisis in South Africa and to build a health system in Afghanistan. It is proven that CHAPs have had a major impact on increased access to general medical care.

Sincerely,

**BRISTOL BAY AREA HEALTH CORPORATION**

Robert J. Clark

Robert J. Clark
President/Chief Executive Officer

c: Congressman Don Young
Senator Ted Stevens
Senator Lisa Murkowski
Governor Frank Murkowski
Senator Byron Dorgan – Vice Chairman of the Senate Committee on Indian Affairs
Senator Edward Kennedy – Ranking Member of the Senate Health, Education, Labor and Pension Committee

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## American Dental Hygienists' Association

***SAME LETTER SENT TO SENATE COMMITTEE ON INDIAN AFFAIRS AND SENATE COMMITTEE ON HEALTH***

July 12, 2005

Honorable John McCain
Chairman
Senate Committee on Indian Affairs
836 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman McCain:

The American Dental Hygienists' Association enthusiastically supports S. 1057, the Indian Health Care Improvement Act Amendments of 2005 (IHCIA), as introduced on May 17, 2005. ADHA is hopeful that this important legislation, which will improve the health and well-being of American Indians and Alaska Natives, will be enacted this year.

ADHA urges rejection of efforts to add controversial language that would disallow the provision of "irreversible" oral health services by dental health aide therapists working in Alaska under the Community Heath Aide Program. Importantly, the Department of Health and Human Services (including the dentist director of the Indian Health Service) and the Oral Health Section of the American Public Health Association support the provision of irreversible procedures by dental health aide therapists. Moreover, any effort to restrict the provision of services by dental health aide therapists would roll back existing legal authority of the Indian Health Service and tribes.

Specifically, the restrictive language (which was included in legislation approved by the House Resources Committee last year) would disallow the provision of certain dental procedures (treatment of caries (tooth decay), pulpotomies (root canals on baby teeth) and extractions) by certified dental health aide therapists, who are not only educated to perform these procedures but are certified by the Indian Health Service to perform these procedures. Inclusion of this

restrictive language would cripple the IHS's ability to respond to the crisis in access to dental health care among Alaska Natives and American Indians. Because this issue has drawn so much attention, ADHA wants to provide further information so that legislators may make an informed decision.

The Community Health Aide Program (CHAP), under which dental health aide therapists would provide services, was developed in the 1950s in response to a number of health concerns, including the tuberculosis epidemic, high infant mortality, and the high rate of injuries in rural Alaska. In 1968, CHAP received formal congressional recognition and federal funding. It was subsequently authorized, exclusively for Alaska, in the IHCIA in 1976. CHAP has proven to be a cost effective, efficient and essential component in improving the health of the Alaska Native people by decreasing morbidity and mortality. The 500 Community Health Aides in this successful program provide more than 300,000 patient visits each year. In the pending Senate IHCIA reauthorization bill (and in last year's House bill), CHAP is authorized outside Alaska, subject to new appropriations. (S.1057, Section 121(c)(1).)

Community health aides have always had authority to provide some dental care. Due to other pressures on the program, however, it has never been sufficient to fully meet the need for dental services. Neither has the number of dentists in the Indian health system. In Alaska, as throughout the Indian health system, funding is insufficient to fully meet the dental health needs of Alaska Natives and American Indians. But money is not the whole problem. There are simply too few dentists, and even fewer willing to move to remote and rural locations. Alaska tribal health programs are currently experiencing a persistent 25 percent vacancy among dentists with an annual 30 percent turnover. Recruitment of more dentists simply is not a viable option.

There are various categories of dental health aides under CHAP. Dental health aide therapists are the highest level of dental health aides. The dental health aide therapy program was modeled after extremely successful programs in New Zealand (operating since 1921) and Canada (since 1974). The World Health Organization documents 42 countries with some variant of a dental therapist, including Australia, Canada, Great Britain, Hong Kong, Malaysia, Singapore, and Thailand. On Canada's First Nation reserves, the ratio of extractions to restorations dropped dramatically, from over 50 extractions per 100 restorations to less than 10 extractions per 100 restorations.[1] New Zealand experienced a similar improvement with the introduction of school dental nurses/therapists: a decline from 75 extractions per 100 restorations when the program first began in the mid-1920s to 7.5 per 100 in 1945 and only 3.6 per 100 in 1964.[2]

To be certified by the IHS as a dental health aide therapist, the individual must:

- be an employee of the IHS or a tribal health program that is operating programs of the IHS under the Indian Self-Determination and Education Assistance Act;

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[1] McDermott, PT, Mayhall, JT, Leake, JL, "Dental therapists and the delivery of dental care in Canada's Northwest Territories," *Circumpolar Health*, 1990:668-671.
[2] Walsh, JP, "The dental nurse," *J. Amer. Coll. of Dentists*, 1965: 32:62-69.

- complete a two year training program;
- undergo a protracted preceptorship of no less than 400 hours and three months under the direct supervision of a licensed dentist, including successful performance of each procedure for which the therapist will be certified;
- satisfy all additional requirements of the Standards and Procedures adopted by the IHS for certification;
- satisfy continuing education requirements;
- undergo periodic reviews by the supervising dentist including chart reviews and patient examinations; and
- be recertified every two years.

Only when a dental health aide therapist satisfies all of these conditions is the therapist permitted to carry out those procedures approved by the supervising dentists. In all the years the Canadian dental therapy program has been operating there has never been a serious injury to a patient receiving an irreversible dental procedure from a dental therapist.

The first six Alaska Natives, who came from remote villages in Alaska, have completed their two year training at the Otago University of Dentistry, New Zealand. Six additional students began in February 2004. The training curriculum for New Zealand dental therapists consists of two academic years, each of 32 weeks duration; total curriculum clock hours is 2,400. The actual time spent clinically treating children is 760 hours.

Alaska tribal health leaders strongly support this program because it will offer the continuity of culturally appropriate care that Alaska Native and American Indian people deserve. In 1991, a dental manpower study was conducted in Alaska. The conclusion: if the IHS/tribal health system doubled the number of dentists, it would take 10 years to eliminate the unmet need for dental services. Even if the resources were available, there is an insufficient number of dentists to recruit. The dentist/population ratio is declining from its peak of 59.5/100,000 in 1990 to the current 58/100,000 to a projected 52.7/100,000 in 2020. The current practice model simply cannot fill the gap.

Decades of inadequate access to dental care, along with other factors that contribute to the generally worse health condition of Alaska Natives and American Indians compared to the general population, have led to a true epidemic of dental caries among Alaska Natives. The incidence rates are 2-1/2 times those of the general public. It is not uncommon for village children to require extraction of all of their baby teeth due to pervasive caries (tooth decay). It is not uncommon for the nutritional status of Alaska Native elders to be compromised by an inability to consume healthy foods due to dental pain or missing teeth.

Workforce experts have recognized that today's dental health care delivery system is not working for much of Americans, including Alaska natives and American Indians. Workforce experts site the existence of:

> "abundant evidence that a sizable segment of the population does not have access" to private [dental] care, while the dental safety net is "poorly defined and underdeveloped." Dentists' participation in Medicaid is not robust; community health centers and public health facilities have scant dental capabilities; and Medicare offers no dental coverage. "Radical steps" will be needed to correct "a growing disconnect between the dominant pattern of practice...and the oral health needs of the nation,"...including new practice settings for dental care, integration of oral and primary health care, and expanded scope of practice for hygienists and other allied professions.[3]

The current dental delivery system is simply not working for Alaska Natives, American Indians and for many other Americans. The dental health aide therapist is a necessary and appropriate response to this crisis. Another necessary, appropriate and more far-reaching response is the adoption at ADHA's June 2004 Annual Session of policy supporting the creation of an advanced dental hygiene practitioner, defined as "a dental hygienist who has graduated from an accredited dental hygiene program and has completed an advanced education curriculum approved by the American Dental Hygienists' Association, which prepares the dental hygienist to provide diagnostic, preventive, restorative and therapeutic services directly to the public." ADHA is committed to improving access to oral health services and believes that the advanced dental hygiene practitioner will increase access to care in presently underserved areas. ADHA has sought the inclusion of other dental and non-dental groups (including the American Dental Association, the American Dental Education Association, the Children's Dental Health Project, and Special Care Dentistry) on an ADHP Advisory Committee.

Today, too few American Indians, Alaska Natives and other Americans enjoy good oral health and evidence clearly demonstrates that good oral health is essential to overall health and general well-being. We simply must address the "silent epidemic" of oral diseases which are afflicting millions of Americans despite the existence of safe and effective means of maintaining oral health.

ADHA strongly supports S. 1057, the Indian Health Care Improvement Act Amendments, as introduced on May 17, 2005. We urge rejection of the language added to Section 121(c) last year by the House Resources Committee, which would disallow the provision of irreversible procedures by dental health aide therapists. This language would, without legal or health policy justification, impede access to care for Native Americans and Alaska Natives. New in this year's Senate IHCIA reauthorization bill is a four-year moratorium on the provision of irreversible procedures by dental health aide therapists outside of Alaska. During this hiatus, a

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[3] Mertz, E. and O'Neil, E., "The Growing Challenge of Providing Oral Health Care Services To All Americans," *Health Affairs*, Volume 21, Number 5 September/October 2002, p.65.

review of the dental health aide program would be conducted. Given that a comprehensive dental health aide evaluation plan is already in place, this hiatus and additional review is not warranted. Resources would better be directed toward the provision of services. Nonetheless, ADHA supports S. 1057 and looks forward to its passage. We are committed to shaping a future in which all Americans can access the dental health care they need.

Please do not hesitate to contact me or our Washington Counsel, Karen Sealander of McDermott Will & Emery LLP (202.756.8024), with questions or for further information.

Sincerely,

Katie L. Dawson

Katie L. Dawson, RDH, BS
President

cc: Marge Green, RDH, MS, ADHA President-Elect
Helena Gallant Tripp, RDH, ADHA Immediate Past President
Ann Battrell, RDH, MSDH(c), ADHA Executive Director
Tim Lynch, ADHA Director of Governmental Affairs
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July 15, 2005

The Honorable John McCain
Chair
Committee on Indian Affairs
United States Senate
836 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Enzi
Chair
Committee on Health Education, Labor and Pensions
United States Senate
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman McCain and Chairman Enzi:

I am writing to express the support of the American Bar Association (ABA) for the reauthorization of the Indian Health Care Improvement Act (IHCIA). Recognizing the United States' continuing obligation to provide adequate health care to American Indians and Alaska Natives, the ABA adopted policy in February 2004 urging Congress to reauthorize the Act.

Notwithstanding the progress that has been made since the founding of the Indian Health Service, American Indians and Alaska Natives continue to experience dramatic health disparities and high mortality rates compared to the rest of the American population. For instance, the mortality rate from diabetes for American Indians and Alaska Natives is 420 percent higher than that for the general population; from accidents, 280 percent; from suicide, 190 percent; and from alcoholism, 770 percent higher.

Congressional action is critical because IHCIA has not been reauthorized since 1992. In 2000, the Act's authorizing provisions for federal funding and specific IHS programs expired. Congress extended the Act's funding authority through 2001, but since then has relied upon the Snyder Act to justify federal funding for Indian health care programs. Reauthorization of IHCIA would authorize funding for programs more targeted to the needs of the Native American community and more specifically

geared to bringing Indian health care into parity with that provided to the majority of other Americans.

Enactment this Congress of reauthorizing legislation, such as S.1057, is an important first step to improving the quality of health care for Native Americans and Alaska Natives. We urge that the Senate Committee on Indian Affairs and the Senate Health, Education, Labor and Pensions Committee support timely and expeditious reauthorization of IHCIA.

Thank you for considering the views of the ABA on this important matter.

Sincerely,

Robert D. Evans

Robert D. Evans

cc: The Honorable Byron Dorgan
The Honorable Ted Kennedy
The Honorable Richard Pombo
The Honorable Nick Rahall

19 TRIBES

INTER TRIBAL COUNCIL of ARIZONA

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MEMBER TRIBES
AK-CHIN INDIAN COMMUNITY
COCOPAH TRIBE
COLORADO RIVER INDIAN TRIBES
FORT MCDOWELL YAVAPAI NATION
FORT MOJAVE TRIBE
GILA RIVER INDIAN COMMUNITY
HAVASUPAI TRIBE
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HUALAPAI TRIBE
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PASCUA YAQUI TRIBE
QUECHAN TRIBE
SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY
SAN CARLOS APACHE TRIBE
TOHONO O'ODHAM NATION
TONTO APACHE TRIBE
WHITE MOUNTAIN APACHE TRIBE
YAVAPAI APACHE NATION
YAVAPAI PRESCOTT INDIAN TRIBE

July 28, 2005

The Honorable John McCain, Chair
Senate Committee on Indian Affairs
United States Senate
Senate Hart Building #836
Washington D.C. 20510

The Honorable Byron Dorgan, Vice-Chair
Senate Committee on Indian Affairs
United States Senate
Senate Hart Building #836
Washington D.C. 20510

Dear Senator McCain and Senator Dorgan,

The Inter Tribal Council of Arizona (ITCA) fully supports the reauthorization of the Indian Health Care Improvement Act (IHCIA) and your efforts to assure that passage of the legislation occurs in the 109th Congress. You and Senator Byron Dorgan introduced S.1057 on May 17, 2005 and a hearing on the bill was held on July 14, 2005. The bill contains several advancements; such as improving home health care, establishing a long-term care program and enhancing children's health and behavioral health services. However, our member tribes wanted to inform you of a provision in the bill that is a concern. The issue pertains to the continuation of the Alaska Community Health Aide Program (CHAP) Dental Health Aide Therapist (DHAT) program and the authority of the Indian Health Service to establish a national Community Health Aide Program.

A principal request is that effort be made to guard against any regression from current law in the reauthorization of the Act. In this light, ITCA fully supports the continuation of the Alaska DHAT program and the authority of the Indian Health Service to establish a National Community Health Aide Program. The proposed language, however, that would restrict the scope of practice of Dental Health Therapists in a national program, to perform preventive, restorative and simple dental surgical procedures. These restrictions are a regression of current law in that the scope of practice would be limited for a period of four years and potentially longer pending the outcome of the proposed study and future action by the U.S. Congress. It is requested that the restrictive scope of practice language be deleted from S.1057.

A restriction of the scope of DHAT's is perplexing in light of the great need to remedy the severe shortage in oral health services among the nation's American Indian population. ITCA has been informed by the American Dental Association (ADA) that preliminary efforts to develop a volunteer dental program for tribal communities have begun. It is hoped, however, that the advocacy and organizational

force of the ADA would be focused on finding long-term remedies to address the shortage of dentists especially in rural areas, with a focus on American Indian communities across the nation. It is discouraging, in spite of the positive benefits of the dental health therapy program, that ADA has sought restrictions on the scope of the DHAT program from providing some limited, but essential irreversible procedures. The CHAP DHAT program in Alaska has been in developmental and planning stage for many years, including the establishment of standards and a comprehensive training program. ITCA views this program as a promising expansion of the Indian Health Service dental program that will greatly benefit areas where dental services are in acute deficiency.

The Inter Tribal Council of Arizona urges you to support measures to incorporate CHAP DHAT program in the Indian Health care system and not restrict the certification practice of CHAP DHAT's in Alaska nor among the Indian health programs in all other states.

A position paper, outlining in further detail, views of the member tribes of the Inter Tribal Council of Arizona regarding other provisions in S.1057, is attached. Due to the extensive range of titles contained in the Act please be advised that ITCA will continue to correspond with you regarding reauthorization of the Indian Health Care Improvement Act. Thank you for your efforts to address our concerns.

Sincerely,

Vivian Juan-Saunders

Vivian Juan-Saunders, President,
Inter Tribal Council of Arizona
Chairwoman, Tohono O'Odham
Nation

Attachment

**INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION**
POSITION PAPER

Inter Tribal Council of Arizona

**ISSUE STATEMENT:** Senator John McCain and Senator Byron Dorgan introduced S. 1057, a bill to amend the Indian Health Care Improvement Act on Tuesday, May 17, 2005. The bill contains several innovations, such as providing for community and home health care, long-term care and enhancements to children's health and mental health services. The bill also contains provisions that will need additional work during the legislative process. These include the following areas of concern stated by the Administration.

1) Limited certification of the CHAP Dental Health Aide Program in Alaska and restrictions on the scope of the National Community Health Aide Program (CHAP) along with the requirement that IHS shall conduct a review in four years of the CHAP Dental Health Aide Program in Alaska to determine whether the program is appropriate and necessary to carry out in any other Indian community. (Section 121)

2) Application of the Federal Tort Claims Act to urban Indian clinics to provide that in any civil action or proceeding against any Urban Indian Organization or any employee of such Urban Indian Organization the full protection and coverage of the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.) shall be afforded. Future coverage under that Act shall be contingent on cooperation of the Urban Indian Organization with the Attorney General in prosecuting past claims. (Section 515)

3) Establishment of the Indian Health Service as an agency within the Public Health Service of the U.S. Department of Health and Human Services to be administered by an Assistant Secretary of Indian Health who shall be appointed by the President with the advise and consent of the Senate. The Assistant Secretary shall directly report to the Secretary of the Department. (Section 601)

4) Establishment of a National Bipartisan Commission on Indian Health Care that would replace recommended bill language that had established a Commission to study the provision of Indian health care as a Federal entitlement program. (Section 814)

As of this writing, reauthorization legislation had not been introduced in the House of Representatives, but is expected according to National Indian Health Board information. The staff reported extensive conversation with the House Resources Committee regarding the above listed provisions.

**RECOMMENDATIONS:** Tribes governments in Arizona have long supported the reauthorization of the Indian Health Care Improvement Act and continue to communicate their concerns to the U.S. Congress. A major point of concern is that effort be made to guard against any regression from current law. In addition, once passed and signed into law, tribes advocate for the necessary appropriations to fully implement all Titles contained in the Act.

Tribal nations in Arizona also convey in their support for the new reauthorization legislation the following:

- The Community Health Aide Program (CHAP), Dental Health Aide Therapy Program was established in Alaska in 1992. ITCA supports language to expand the program to the lower 48 states without limiting dental health therapist practice so that the intended goal of making available dental care in rural and isolated locations may be accomplished. .

- ITCA recommends that dental health therapists be able to provide preventive, diagnostic and restorative (fillings and stainless steel crowns) care, nerve therapy on baby teeth, simple extractions and emergency services. In Arizona, the access to dental care issue for tribal members is very serious and the dental health aide program is seen as part of the solution to increase these needed services. The IHS reports utilization rates for dental access were only 21.7% in the Phoenix Area IHS and 17.5% in the Tucson Area IHS. Clearly, there are not enough dental providers and a large backlog of treatment needs exists.

- ITCA supports Contract Health Service (CHS) provisions to prohibit private providers holding individual Indian patients liable for CHS bills. Other sections in Title II supported by the tribes include provisions for emergency medical services, elder health, safe water, and environmental health hazards.

- ITCA supports the Home Health Care Services provision and that Indian Health Care Improvement Act Funds may be used for these services and traditional health care practices. Further the bill authorizes the IHS to enter into contracts or compacts with Tribes or tribal organizations for the delivery of long-term care services in facility-based settings. It also provides that funding may be provided for 1) hospice care, 2) assisted living, 3) long term health care, 4) home and community based services and 5) related public health functions.

- ITCA is in agreement that Indian health construction and renovation needs should be assessed and reported annually. The bill language provides that the priority system for funding new construction projects be revised and states that projects currently on the Health Care Facilities Construction priority list are "grandfathered" into the revised priority system.

- Medicaid and the State Children's Health Insurance Program (SCHIP) collections are essential sources of revenue for Indian health programs and now provide approximately one-fourth of all funding that comes into the system. The tribal recommended language facilitates access to third party resources and helps eliminate barriers to participation.

- Tribes in Arizona concur with the recommended changes to Title V: Health Services for Urban Indians and the extension of the Federal Tort Claims Act (FTCA) coverage to urban Indian programs.

- Tribes in Arizona have long endorsed the elevation of the position of IHS Director to Assistant Secretary status.

- Tribes in Arizona support the provisions contained in Title VII – Behavioral Health Programs in that one title now combines all programs dealing with substance abuse, mental health, and social services programs, and provides for the integration of these programs.

**Conclusion:** Tribes have been seeking reauthorization of the Indian Health Care Improvement Act (IHCIA) since 1999. The Act is a vitally important policy that serves as the foundation for the delivery of health care by the Indian Health Service, Indian tribes, and urban Indian programs to millions of American Indians and Alaska Natives. The Indian Health Care Improvement Act (IHCIA), P.L. 94-437, was first enacted in 1976 to address long-standing disparities in Indian health care. IHCIA is an extensive Act that describes the federal responsibility with regard to Indian health and along with the Snyder Act of 1924 and the Indian Self Determination Act of 1975 provide overall guidance and authority for most of the programs of the Indian health care system.

ITCA 07.27.05

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Prevent Diabetes
for Life!

Senator John McCain
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July 20, 2005

Senator McCain,

I write to you at a very crucial moment in the healthcare history of the U.S. As legislation progresses to reauthorize the Indian Healthcare Improvement Act, I strongly urge your support of inclusion of naturopathic medicine in the definition of health profession for the Indian Health Service. Without this change, Native Americans will not have access to medicine that is highly effective and culturally compatible, and licensed naturopathic physicians will continue to be excluded from participating in the IHS physician's loan repayment program.

I am the Medical Director for the San Carlos Apache Tribe's Diabetes Prevention Program Weight Management Clinic in San Carlos, AZ. The IHS Director for the southwest region located in Phoenix and the Director of Health and Human Services for the San Carlos Apache Tribe interviewed me for this position along with a clinical endocrinologist medical doctor. After a lengthily interview process by the government, I was hired for the Medical Director position by the San Carlos Apache Tribe. In my capacity as Medical Director, I have written the Policies and Procedures manual for this brand new clinic and expect to make a significant impact on the obesity epidemic and in preventing Type II diabetes in Native Americans using naturopathic medicine in conjunction with standard allopathic care.

A graduate of Southwest College of Naturopathic Medicine in Tempe, AZ, I actively sought out this opportunity to work in an under-served area where I knew my skills could be utilized to their fullest capacity. As you know, student medical loans are a tremendous burden to bear for any physician. The San Carlos Apache Tribal Council, along with the Health and Welfare Committee, wrote in support for this new clinic and my participation in the IHS physician's loan repayment to the Program Director. My application was denied due to the fact naturopathic medicine is not included in the definition of health profession. In order to hire and retain qualified, licensed Naturopathic physicians in rural and underserved populations naturopathic physicians must be granted the same consideration and access to the IHS physician's loan repayment program as our allopathic MD colleagues now enjoy.

Naturopathic medicine has a rich history in the U.S. and has been proven to be safe, effective and cost efficient over the last 150 years. Including naturopathic physicians in S. 1057 will not only improve healthcare dramatically in underserved and rural populations but will also lower the astronomical rise in healthcare costs for the entire IHS program. I respectfully urge you to please include naturopathic physicians in S.1057 and any House legislation that is introduced so that we can practice to the full extent of our training and meet the ever increasing health care demands of the underserved Native American populations in the U.S.

Respectfully,

Andrew J. Kaufmann, ND

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Letter to the Editor,
American Journal of Public Health

The article by Sekiguchi et al.[1] has provoked controversy around the acceptability of Dental Health Aide Therapists (DHATs) who are trained to provide diagnostic and dental treatment services in Alaskan Tribal health programs.

To deal with extensive unmet dental needs, DHATs have been trained under a Federal program to deliver year-round care in their remote villages under the general supervision of a dentist, where it is difficult to recruit dentists.[2] However, Sekiguchi et al disagree with this initiative stating that dentists are the only personnel qualified to provide these services and that DHATs cannot be effective substitutes. They provide no evidence for their opinion.

In contrast, Nash has proposed that use of DHATs is an acceptable and valid means to address current unmet treatment needs, especially among young children, and not just in Alaskan villages.[3, 4] Double-blind studies comparing Canadian dental therapists with federal dentists, demonstrated equivalent quality of dental restorations. Currently, there are some 42 countries with some variant of a dental therapist including New Zealand, Australia, China (Hong Kong), Singapore, Thailand, Malaysia, Great Britain, and Canada.[2]

There has been a lack of dentists willing to work in these communities for years. Most dentists prefer to work in more economically viable communities. One of the constructive responses by the American Dental Association has been to ask Congress fund a loan forgiveness program for dentists willing to work in the Indian Health Service where there are positions currently vacant.[5]

The Alaska Board of Dental Examiners has informed the State Attorney General that in the Board's opinion, currently trained DHATs are practicing dentistry illegally. However, the Board has no jurisdiction because the therapists are working in tribal programs outside the purview of state law.[6] Ultimately, the tribes will decide which way to go.[7]

The leadership of the Oral Health Section of the American Public Health Association believes that the rural Alaska Natives will be best served by the DHATs and endorses the program as a practical and innovative response to address the extensive oral health needs of these communities.

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**April 2005**

# Integrated Dental Health Program

# for Alaska Native Populations

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## *Executive Summary*

During recent discussions of proposed changes in the dental care system for Alaska Natives, the American Dental Association (ADA) asked a group of dental care experts to independently study and make recommendations on the current and proposed systems. The primary problem is that the 125,000 members of the Alaska Native community, and especially those living in villages that are not accessible by roads, have a high prevalence of untreated dental diseases.

Faced with an acute problem, the Alaska Native Tribal Health Consortium (ANTHC) developed a new delivery plan for rural villages; locally recruited dental health aides and therapists will live in the rural villages and provide community and personal level preventive and treatment services. The Panel supports this general plan and suggests that with modifications it could be more effective.

The Panel offers these recommendations:

- With a relatively modest investment in facilities and allied dental health personnel, the current delivery system can be greatly improved, providing significantly more services to the entire population. Sustainable improvement requires the prevention of disease and efficient delivery of therapeutic services.
- Community-based oral health providers (COHPs) are needed to improve the oral health of remote village residents. Led by a centrally-based dentist(s), COHPs should be responsible for the organization of the overall provision of community and personal level oral health services to clusters of villages. Their management role should include organizing community level health promotion and disease prevention programs, directing the activities of the dental health aides, and increasing the efficiency of visiting dentist teams to villages. Their clinical role should include providing oral health screenings, primary and secondary preventive services, gross tooth decay removal and stabilization (ART), secondary prevention of mild periodontal diseases, and under dentist supervision pain and infection control.
- The ANTHC, ADA, American Dental Education Association should work collaboratively to develop a national model for training these new oral health care providers in Alaska. More generally, a major effort is needed to recruit, educate, and retain a local dental workforce that is committed to working in Alaska and is culturally competent to serve the needs of this population.

A financial analysis of different options proposed for improving the efficiency of the delivery system indicates that a relatively modest addition to currently planned expenditures will result in major gains in the number of patients receiving care annually. As the system becomes more efficient, the cost per patient treated or service provided are expected to decrease.

**I. Introduction**

During the past several months, the ADA, the US Indian Health Service, the Alaska Native Tribal Health Consortium, and others have been involved in discussing the proposed changes in the oral health care system for Alaska Natives. To obtain a wider view of the issue, the ADA asked four nationally recognized dental care experts to examine and make recommendations on the current and proposed oral health care systems. This report represents the group's independent views; it has not been approved or modified by the ADA. The members of the ad Hoc Panel and their contact information are seen in Attachment A.

The two primary data sources used in this report come from the Indian Health Service - the oral health of the Alaska Native populations[1] and from the Southcentral Foundation of the Alaska Native Medical Center – dental delivery system organization, staffing, utilization, and expenditures. Attachment B presents detailed information on the Southcentral Foundation system. Information provided by different informants on other Alaska Tribal dental systems varied widely. Thus, the analyses presented in this report will probably have to be adjusted as more data become available on individual Tribal programs.

**II. Problem Definition**

Epidemiological studies indicate that the 125,000 members of the Alaska Native community have a significantly higher prevalence of untreated decay,

periodontal diseases and their sequelae - pain, infection, and missing teeth - than other US populations. In the early half of the 20th century, Alaska Natives had one of the lowest dental caries experiences in North America. The incidence and severity of dental caries significantly increased as traditional lifestyles and dietary habits changed (e.g., canned drinks).

It appears that the current dental care system has not been able to effectively prevent and treat oral diseases in this population. The problems are especially acute for the approximately 50 percent of the population that lives in remote villages not accessible by roads.

There are multiple, separately organized and managed, delivery systems that provide personal dental services to the population. Overall, the system appears adequately funded and has sufficient numbers of licensed dentist positions to provide care, but operates with varying levels of effectiveness. Some important limitations in the current system include: 1) many dentists are assigned by the Indian Health Service or are contractors and do not have a long-term commitment to living and practicing in Alaska; 2) there are too few allied dental health personnel and operatories per dentist; 3) few providers are village-based staff who can provide culturally competent and continuous community and personal level services; 4) there are insufficient local training programs to prepare dental residents, hygienists, dental assistants, etc. who have a long-term commitment to serving Alaska Native populations; and 5) the productivity and efficiency of the current system is variable and can be improved substantially.

[1] The 1999 Oral Health Survey of American Indian and Alaska Native Dental Patients: Findings, Regional Differences and National Comparisons, Indian Health Service, 2000.

**III. Alaska Native Tribal Health Consortium (ANTHC) Plan**

Faced with an acute oral health problem, the ANTHC developed a new strategy to provide preventive and therapeutic services to the significant segment of the population residing in remote villages that are only accessed by plane or boat. The plan calls for the establishment of locally recruited dental health aides to live in the villages and provide community and personal level preventive oral health services. This strategy has excellent potential to reduce the incidence and prevalence of disease and to provide the community with continuous, culturally competent care.

Another plan feature is training locally recruited dental therapists to permanently reside in the villages and provide screening, pain and infection management services, personal preventive care, and some restorative services to patients under the indirect supervision of dentists. The new system is supported with grant funds from multiple Medical Foundations and is in the process of being implemented. The effectiveness of the new system will not be known for several years.

In this proposal, COHPs replace therapists on the dental team. These new dental personnel have considerable potential, if they are integrated into an effective delivery system for villages. Specific recommendations for this new auxiliary are included in the next section of this report.

**IV. Recommendations**

The ad Hoc Panel offers several recommendations for consideration by the ANTHC leadership. In order of priority, they include:

**1. Improve the Effectiveness and Efficiency of the Delivery System**

Although the ANTHC plan has the potential to improve access to care and oral health in villages, it does not address the larger problem of the overall effectiveness of the dental delivery system for the entire Alaska Native population. In this regard, the dental care delivery system run by the different Tribal corporations can be greatly improved with a relatively modest investment in new facilities and allied dental health personnel. The basic problem faced by the ANTHC system is common to many safety net dental delivery systems. The productivity of dentists is low, because of inadequate investment in dental operatories, allied health personnel and financial incentive plans for personnel. A related issue may be the need to put more resources into the management of the delivery system. This includes experienced managers, training programs, information systems etc. Further, many operational efficiencies may be realized if the different Tribal corporations worked cooperatively in the management of the overall system. To this end, the ANTHC should consider the formation an over-sight organization to coordinate the management of the different Tribal dental care systems. In the initial phases of this effort consultants from the dental profession and industry should be used as needed. As seen in the financial analysis section, without additional dentist positions, it should be possible to provide care to 65 percent or more of the population, annually.

**2. Integrate Dental Health Aides and Community Oral Health Providers into Village Delivery System**

As previously noted, the proposed system for villages developed by the ANTHC has many advantages. The ad Hoc Panel believes that the system could be made substantially more effective with some modification and expansion of the role of COHP and with a greater focus on the integration of the dental health aides and COHPs into the village delivery system.

In terms of organizational position, the COHPs should be assigned to a cluster of villages to serve around 2,000 residents. COHPs should have a dental assistant to provide personal services efficiently and at least two dental health aides for the delivery of community and personnel level prevention programs. Two or more specific dentists should be assigned responsibility for the clinical management of each COHP village dental team and should visit the villages periodically to provide dental services. The dentists should be in frequent communications with their COHP and should have an on-call schedule to deal with emergencies. The dentists and the COHP team should be responsible for assuring that most village residents are screened, receive appropriate educational and primary and secondary preventive and treatment services annually.

In terms of clinical responsibilities, COHPs and dental health aides should screen at least 85 percent of residents twice per year, provide primary and secondary preventive treatments for caries and periodontal diseases, remove gross tooth decay where appropriate and insert temporary filling materials or sealants using the Atraumatic Restorative Treatment (ART) techniques (with or without minor removal of caries-destroyed dental tissues using hand instruments

or a small round bur in a slow speed handpiece), treat mild periodontal diseases by prophylaxes and scalings, and manage acute pain and infection under the direction of dentists. The proposed use of COHPs to restore teeth with permanent filling materials is not an appropriate use of their time and skills. Because of the severity of disease and complexity of treatment commonly seen in this population, COHPs will have insufficient skills to permanently restore a large percentage of carious teeth. They will have a greater impact on the oral health of Alaska Natives by preventing and controlling caries and periodontal diseases with the described clinical duties. This approach will also be more cost-effective, based on studies published by the World Health Organization on the use of advanced dental auxiliaries in rural areas.[2] A letter from the Pan American Health Organization supporting the use of ART and offering to collaborate in training of COHPs in this technique is seen in Attachment C. Finally, COHPs can be trained in Alaska to provide these services in approximately 12 months.

In terms of management responsibilities, COHPs should direct the activities of the dental team assigned to local communities (i.e., dental health aides and assistants), integrate dental programs with the overall plan for local medical and public health services, and organize the activities of the periodic dentist visits to villages. A more detailed description of the clinical and management roles of COHPs is presented in Attachment D.

[2] ART is successful as a long-term temporary restoration (1-2 years) for Class I and Class II restorations (Frencken JE, Holmgren CJ. ART: A minimal intervention approach to manage dental caries. Dent Update 2004;31:295-8).

In addition, an effective management structure needs to be in place to integrate these new allied dental health personnel into the overall village delivery system. Thus, the current system of dentist visits to villages needs to be modified to make better use of these resources. The changes recommended in the overall dental care system for villages, including the integration of dental health aides and COHPs, are presented in Appendix E.

**3. Establish Training Programs**

Clearly, the long-term success of the delivery system for the 125,000 Alaska Native population depends on recruiting, educating, and retaining a local workforce that is committed to working in Alaska and is culturally competent to serve the needs of this population. Although beyond the scope of this report, a major effort needs to be made to:

- Recruit Alaska Natives into the dentistry, hygiene, COHP, assisting and dental health aides.
- Establish residency training programs in Alaska Tribal hospitals for general dentistry and the recognized specialties of dentistry.
- Develop managerial training programs to prepare the personnel needed to manage the dental delivery system.

**V. Financial and Outcome Analyses**

The ad Hoc Panel presents two options for increasing the overall capacity of the dental care system to serve the needs of the Alaska Native population. There are many variations on these two options, and they are presented to provide a framework for further discussion of these issues.

Further, as already noted, estimates of the number dentists, operatories, and allied health staff in the other Alaska Tribal programs varied widely. As such, the Panel recognizes that the numbers used in the analyses may not accurately reflect the current situation. As such, additional analyses may be necessary.

Options

1. Have the other Alaska Tribal programs operate at the same level of efficiency as the Southcentral Foundation. This organization has recently made a major and successful effort to improve the efficiency and productivity of its dental delivery system. The details are provided in Attachment B.
2. Have the other Alaska Tribal programs operate at the same level of as the Southcentral Foundation (Option 1) and establish COHPs and dental health aides in villages.

Current System Configuration

Table 1 compares the delivery configuration for the Southcentral Foundation region with the other Tribal programs (combined).

**Table 1**
**Current Dental Delivery System Configuration**

| Foundation | Population | Dentists | Operatories | Assistants | Hygienists | Other Staff |
|---|---|---|---|---|---|---|
| Southcentral | 45,000 | 26 | 52 | 64 | 8 | 27 |
| Other | 80,000 | 36* | 47 | 50 | 10 | 56 |
| Total | 125,000 | 62 | 99 | 114 | 18 | 83 |

*15 positions are open and being recruited.

Compared to the other Alaska Tribal programs, the Southcentral Foundation has more dentists per eligible and more operatories, assistants, and hygienists per dentist. Under this configuration, the Southcentral Foundation treats 47.2 percent (actual) of the eligible population annually and the other Alaska Tribal programs about 33.0 percent (estimation based on 36 dentists). Compared to the national private sector dental delivery system, the current system (Southcentral Foundation and Other) for Alaska Natives has far fewer operatories and allied health staff per dentist.

Approximately 60,000 of the 125,000 eligibles live in 200 villages that cannot be accessed by road. For this population, dentists and their staff need to fly to the villages periodically to provide services. These villages will be the base of operations for the dental health aides and COHPs. It is estimated that the villages range in size from 60 to 1,400 residents and that 200 villages need to be served. The analysis assumes that one COHP team that includes at least one COHP, one dental assistant and two dental health aides will have responsibility for managing several contiguous villages, totaling an average of 2,000 people. Some unknown percentage of people living in remote villages obtain dental care when visiting central area clinics. For this analysis we assume that 25 percent of village residents will receive care in these clinics. This reduces the target population that needs therapeutic services from 60,000 to 45,000.

Increase System Capacity

**Option I - Configure other Alaska Tribal Programs Similar to Southcentral Foundation**

This will require building 25 more dental operatories and employing 40 more dental assistants and one more hygienist. The other Alaska Tribal programs appear to have adequate numbers of administrative staff.

**Option II – Add Dental Health Aides and COHPs to Option I**

Twenty three dental COHPs teams, eight in the Southcentral Foundation and 15 in other Alaska Tribal programs will be employed and assigned with dental aides and a dental assistant to serve the 200 villages. It is assumed that the COHP teams will operate (actually see patients) 200 days a year and treat at least 20 patients per day. This includes services provided by the two dental health aides and the COHP working with a dental assistant. Thus, each dental team can be expected to provide 4,000 visits per year and to serve about 1,700 patients, based on 2.32 visits per person. Thus, some 85 percent of the target population will receive screening, prevention, and therapeutic services by the COHP teams.

Impact on Utilization

Table 2 presents the expected impact of the two options on utilization rates.

**Table 2**
**Impact of Options on Utilization rates**

| Utilization | Current System | Option I | Option II |
|---|---|---|---|
| **Southcentral Foundation** | | | |
| Visits | 49,398 | 49,398 | 81,398 |
| Patients | 21,250 | 21,250 | 34,850 |
| % Utilization | 47.22 | 47.22 | 77.4 |
| **Other** | | | |
| Visits | 62,000 | 68,397 | 128,397 |
| Patients | 26,600 | 29,423 | 54,923 |
| % Utilization | 33.0 | 36.8 | 68.7 |

Compared to the current system, Options I and II lead to major gains in visits and patients treated. If the other Tribal programs filled their 15 open dentist positions, they would approximate the Southcentral Foundation utilization rates. The Southcentral Foundation dental program has made a first step in addressing the core problem of dentist productivity and has made a large investment in more operatories and allied dental health personnel that has led to major gains in utilization. Both the Southcentral Foundation and other Tribal programs could increase their efficiency substantially more with the addition of more operatories and allied dental health personnel per dentist.

Impact on Expenditures

This analysis of expenditures for the two options is based on current labor costs and does not take into account the impact of prevention programs on

reducing oral disease levels and the demand for care. This analysis also does not account for the costs of training more allied dental health personnel and administrators. The focus is on labor costs, since they account for a large percentage of clinic operating expenses. All labor costs include salary, 30 percent fringe benefits, and a 20 percent productivity bonus payment that 50 percent of clinical providers are expected to achieve.

**Table 3**
**Additional Labor Costs for Two Options to Improve Alaska Tribal Dental Delivery System**

| Personnel | Current | Option I | Option II |
|---|---|---|---|
| Dentists | $26,688,000 | $26,688,000 | $26,688,000 |
| Dental Assistants | 3,402,560 | 5,103,840 | 6,197,076 |
| Dental Hygienists | 1,630,800 | 1,721,400 | 1,721,400 |
| COHPs | - | - | 2,083,800 |
| Dental Health Aides | | | 1,736,500 |
| Totals | 31,721,360 | 33,513,240 | 38,426,776 |

## VI. Implementation

The ad Hoc Panel recommends that the ADA and other dental organization provide the ANTHC technical support in the design and implementation of a more effective oral health care system. The ADA and other dental organizations should also work with the ANTHC to gain political support in Alaska and nationally for building the training and delivery system infrastructure needed to implement this plan.

The major advantages of this proposal are:

- It addresses both the immediate and long-term needs of the Alaska Native population.

- The delivery system remains in the exclusive control of the Native Corporations and the ANTHC.
- The proposed system employs Alaska Natives in remote villages, since they are best able to understand the needs of the population and provide culturally competent, continuous care.
- It greatly improves access to care for village residents.
- It increases the effectiveness and efficiency of the overall system for all Alaska Natives.
- It is sustainable over time.
- It provides a standard of care that should be available to all Americans.

**Attachment A**
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The American Dental Association provided travel support for the panel for one meeting and a small stipend, $6,000 total, for the Panel.

**Attachment B**
**Southcentral Foundation Dental Delivery System**

The Southcentral Foundation, a non-profit Native corporation, took over the management of the dental program in 1997 and mandated a new approach to meeting the needs of the Anchorage Service Unit. The first part of the solution was to become more efficient in delivering dental care. The historical typical model was one chair, one dentist, and one assistant. A dental management consultant group Accelerated Practice Concepts, Inc. was hired to evaluate the efficiency of the dental care system. Their assessment was that more efficient models needed to be developed, and additional capacity was needed to meet the needs of the population in the Anchorage area. The new more efficient models were first applied to school aged children. For example, the "school exam" model utilized three chairs, three dental assistants, one dentist, and one hygienist. The children received bitewings, a panorex radiograph, oral hygiene instruction and disclosing by the dental assistant. The hygienist provided supra and sub-gingival scaling and pre-charts with the assistant. The dentist completed the exam and helped this team provide definitive care (e.g. simple fillings, extractions, or sealants) on all three of the children appointed during that hour. The Southcentral Foundation supported enhancement of an in-house dental assistant training program. This program utilizes credentialed dental educators teaching Native students. During 2004, 36 assistants were trained to meet the needs of the program. The Southcentral Foundation agreed to build a "state of the art" paperless and digital 27 chair dental facility on the campus of the Alaska Native Medical Center, and the facility was completed July 2003. Utilizing adult models developed by Accelerated Practice Concepts and a small increase in staff, the Fireweed Dental clinic raised its productivity substantially (Table B1).

**Table B1**
**Productivity of the Southcentral Foundation Dental Program**

| | FY 00/01 | FY 01/02 | FY 02/03 | FY03/04 |
|---|---|---|---|---|
| Oct | $1,055,911 | $1,092,271 | $1,324,842 | $1,779,034 |
| Nov | $904,029 | $906,015 | $1,284,458 | $2,238,720 |
| Dec | $795,965 | $967,711 | $1,257,157 | $2,200,947 |
| Jan | $962,561 | $1,033,009 | $1,255,611 | $2,611,374 |
| Feb | $923,067 | $1,019,445 | $1,195,912 | $2,548,926 |
| March | $1,000,909 | $1,166,336 | $1,224,683 | $2,887,142 |
| April | $1,008,464 | $1,203,598 | $1,298,466 | $2,957,660 |
| May | $1,087,680 | $1,274,903 | $1,092,131 | $2,515,743 |
| June | $880,120 | $1,076,595 | $947,756 | $2,594,972 |
| July | $826,956 | $1,182,749 | $1,179,183 | $2,817,816 |
| Aug | $1,102,474 | $1,230,075 | $1,049,614 | $2,823,880 |
| Sept | $884,319 | $1,122,983 | $1,166,877 | $3,039,033 |

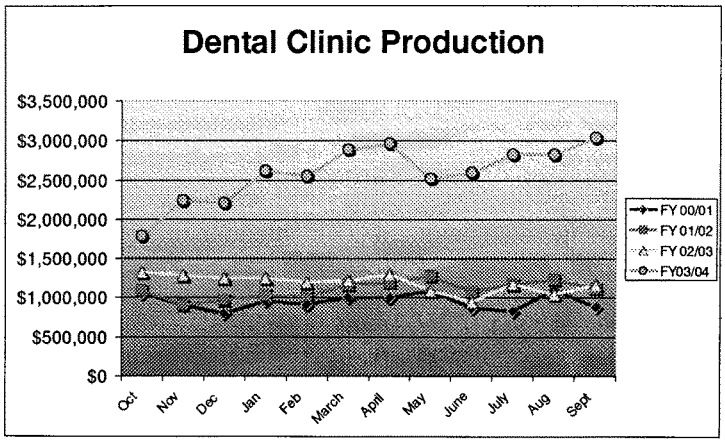
| | | | | |
|---|---|---|---|---|
| **Total:** | **$11,432,455** | **$13,275,690** | **$14,276,690** | **$31,015,247** |

The impact of increased efficiency and capacity (50 chairs) has been noticed by those seeking care. Children can usually make an appointment for routine care within three weeks. The adult backlog of care is still notable with most adult patients waiting six weeks for routine care. The emergency care is very efficient with 30 to 40 patients per day treated utilizing four chairs. The electronic record with digital radiographs also provides increased efficiency and communication between the two dental clinics. The productivity of the village delivery system is also enhanced by delivering care with two or three chairs and dental assistants.

The Southcentral Foundation also purchased and equipped a dental operating room at ANMC, reducing the waiting time for pediatric full mouth reconstruction. There are now less than 200 patients on the wait list, and it is decreasing. The Foundation also entered into an agreement to with Lutheran Medical Center in Brooklyn, New York to institute a residency program to train more pediatric dentists. This program will begin July 2005 with two residents and another two will be selected in 2006. The hope is to place more pediatric dentists in Alaska communities and to further reduce the backlog.

The costs to bring in dental efficiency experts (APC), train dental assistants, implement paperless/digital technology, and fly more equipment and staff to the villages are substantial. The Southcentral Foundation's ability to build a 27 chair clinic and a full-time dental operating room speak to its commitment to meeting customer needs. These improvements have resulted in better access and high staff morale and retention. The following graph (Figure B2) shows the dramatic increase in productivity when the efficiency models were implemented along with the additional capacity of the Fireweed clinic's 27 chairs. No additional staffing has been added since 2002.

**Figure B2**
**Productivity Increases in Fireweed Clinic**


Dental Clinic Production
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Oct
Nov
Dec
Jan
Feb
March
April
May
June
July
Aug
Sept
FY 00/01
FY 01/02
FY 02/03
FY03/04

Pan American Health Organization
Regional Office of the World Health Organization

Technology and Health Services Delivery
Health Services Organization

IN REPLY REFER TO: THS/OS (ORH) 28.1 (028-05)

17 March 2005

Dr. Amid Ismail
University of Michigan
Cariology, Res Sci & Endo
2361 Dent
Ann Arbor, MI 48109-1078

Dear Dr. Ismail:

I write to you concerning the position of the Pan American Health Organization for the ART dental technique and or activities in the Region on that matter. We have been very excited to hear about the possibilities of the ADA utilizing this technique among others in the development of a new dental professional as part of your recommendations to address the challenges of the profession for the future.

PAHO as the regional office of the World Health Organization, began to endorse and promote the ART technique shortly after the endorsement the WHO in 1998. Indeed we presented a proposal for funding to the Inter American Development Bank and since April 2000 have been conducting one of the largest oral health studies in order to determine the comparative cost effectiveness of ART and amalgam for use in the public oral health programs in various settings in Latin America. The Proyecto PRAT which will be ending this year.

It is true to say therefore that over the past 5 to 7 years PAHO has been vigorously promoting ART for use in the public oral health services of the Region. We have also been pushing hard for the inclusion of this technique as part of the curriculum of dental schools in the Region. A partial list of the development of ART under the leadership of PAHO is as follows.

The direct training by PAHO of over 150 dentists and auxiliaries in over 12 training courses in the last 4 years. These courses have taken place in Ecuador, El Salvador, Mexico, Nicaragua, Panama, Trinidad and Uruguay.

The adoption by a number of countries of the wide scale use of ART in their public oral health services. Uruguay was the most recent having developed a plan with PAHO's assistance in January of 2005 to begin implementation in March of 2005. Mexico earlier has developed a plan to implement over 20 million ART restorations over a 3 year period.

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**Attachment D**
**Role of the Community Oral Health Provider**

The COHP is a member of a team that includes dentists, hygienists, dental health aides, and dental assistants. The COHP works and lives in a village and is assigned responsibility for a cluster of villages with a total population of about 2,000. The COHP works with one or more dental assistants using both portable and fixed dental equipment.

The primary objectives of COHPs are health promotion and disease prevention and management. They identify resources and develop networks with other social and health providers in the villages; design and implement group, as well as individually tailored oral health prevention programs that are integrated with other general health promotion activities in the villages; identify opportunities for fluoridating the water; educate and train other healthcare providers on how to screen for and advise residents to promote oral health.

As dental providers, COHPs provide screening and preventive services, temporary treatment of caries (ART), and treatment of mild periodontal diseases. Under the direction and approval of dentists assigned to lead the village dental team, COHPs manage pain and infection in emergency situations when dentists are not available.

With the epidemic of severe dental caries in Alaska, COHP training should focus on community-based health promotion, prevention, triage, emergency care, and temporization (ART). They should: 1) have training in community health and be a major advocate for oral health; 2) be assigned and evaluated based on progress in promoting oral health and reducing the burden of disease; 3) serve around 2,000 residents in contiguous clusters of villages; and 4) work with and under the general supervision of two or more specific dentists. The supervising dentists should define in writing the specific duties for each COHP, based on his/her clinical skills and the needs of the population.

In summary, COHPs, directed by dentists and assisted by dental health aides and dental assistants, should provide these services:

<u>Children (school-based)</u>
- Screening and treatment triage
- Prevention of incipient lesions (secondary prevention)
- Prophylaxis
- Education (diet and self care)
- Sealants
- Fluorides
- Atraumatic Restorative Treatment (ART)
- Emergency dental care for pain/infection under direct dentist supervision.

Adults

- Examination, detection, and assessment
- Treatment triage
- Primary and secondary prevention of caries
- Prophylaxis and scaling
- Atraumatic Restorative Treatment (ART)
- Emergency dental care for pain/infection under direct dentist supervision.

**Attachment E**
**Integration of Community Oral Health Provider**
**Into Village Dental Delivery System**

**Village Size:** The following plan is for large villages with 500 or more residents. For smaller villages the staff, equipment, and other resources are reduced, but the operating principals remain the same. Since most villages have fewer than 500 residents, two chairs will be the most common configuration.

**Chairs in Village:** 4 -5 (portable and/or fixed)

**Prior to visit:** Then COHP team take x-rays, screen all children and adults, provide personnel preventive services (e.g., sealants), excavate caries and place temporary restorations (ART), provide prophylaxes and scalings for children and adults with mild periodontal disease, estimate dental team treatment time, and schedule patients for treatment by the visiting dental team.

**Visiting Dental Team:** Dentist, dental hygienist, and three dental assistants.

**Visit:**

- Dentist verifies screening exams, prepares teeth for permanent restorations, completes complex restorations and assigns simple restoration placement and finishing to specially trained dental assistants and provides other services as needed.

- CPHP and hygienist provide local anesthesia for dentist's patients and hygienist provides prophylaxes/scalings to patients with moderate to severe periodontal disease.

- Dental assistants support dentist, insert and finish permanent restorations, and assist dental hygienist.

- COHP – Organizes patient visits and assists dentist and hygienist as needed.

**Team Productivity:**

- The combined team of dentist, hygienist, COHP, dental health aides, and dental assistants are expected to treat at least 30 patients per day.
- The team will remain in the village until all scheduled and available patients are seen.
- The team will visit each village or grouping of villages at least two times per year.

**After Team Visit:** COHP (and dental health aides) follows-up on high risk patients with intensive preventive services (e.g., fluoride varnish, prophylaxes, education) and directs community education programs.