TESTIMONY OF ARNE SORENSON BEFORE THE NORTH DAKOTA LEGISLATIVE MANAGEMENT HEALTH SERVICES COMMITTEE, REGARDING THE FEASIBILITY AND DESIRABILITY OF PLACING THE ENTIRE FORT BERTHOLD RESERVATION IN A SINGLE PUBLIC HEALTH UNIT – GOVERNANCE MODEL.

Wednesday October 26, 2011, State Capital Building.

Good morning Chairman Lee and Members of the Committee, My name is Arne Sorenson. I am a Commander in the US Public Health Service and the Director of the Diabetes Prevention Program for the Mandan Hidatsa and Arikara Nation. I am honored to present testimony on behalf of the MHA Nation. Our Chairman, Tex G. Hall, supported Concurrent Resolution 4012, because it called for a study to determine whether the health care needs of citizens who live and work on the Fort Berthold Reservation would be more efficiently served by designating the Reservation as a single Public Health Unit (PHU). The Fort Berthold Indian Reservation is currently part of the Aberdeen Area of the Indian Health Service. The failure of the Aberdeen Area to deliver effective health care at Fort Berthold is well documented. Much of this is due to a severe decline in federal funding, but there are other reasons as well. In my view, any additional benefit to the residents of the Fort Berthold Reservation that could come as a result of designating the Reservation as a single PHU would undoubtedly be a positive step toward better tribal and state relations.

FEASIBILITY AND BENEFITS

It is my understanding that Concurrent Resolution 4012 sprang from a study done in 2006. One of the recommendations that came out of the study was the potential of accessing health care through the services of a PHU, which possibly could be located on the Reservation. The study recommended a PHU on Fort

Berthold, and Concurrent Resolution 4012 in turn calls for such a study. I am hoping for all concerned that it will be a positive study for the good of our Reservation residents. I am here today to discuss a governance model that will allow this project to succeed in improving the public health status of residents of our Reservation.

Several organizational models for tribal public health delivery were suggested by Allison, M. in the Journal of Public Health article entitled Future public health delivery models for Native American tribes[1]. The MHA Nation is progressing towards the suggested small tribe model discussed in this article primarily through the process of self determination in our PL 638 contracting process with the Indian Health Service. The MHA Nation Health Authority was recently created to address the governing body requirements for our healthcare systems. The board includes representation from across healthcare disciplines. This board will serve as the primary accounting and finance, auditing, legal, and personnel management authority for the proposed public health unit reporting directly to the MHA Nation tribal business council. The addition of public health unit functions and required reporting would involve some changes to chartered business functions of the board and involve consideration for appointments to represent the added population served by the public health unit.

As outlined in the North Dakota Department of Health executive summary, potential services provided by the present Public Health Units are as follows:

1. Environmental health program

[1] Allison M. et al. Future public health delivery models for Native American tribes. Public Health (2007), doi:10.1016/j.puhc.2006.11.005

2. Maternal and Child Health program
3. **Health Promotion**
4. **Communicable Diseases**
5. **School Health**
6. Occupational Health Nurse activities
7. Mental Health
8. **Skilled Nursing Activities**
9. MCH Initiative Grants

Health Promotion (screenings for BP, Scoliosis, and Vision), Communicable Diseases (Immunizations for all ages), School Health (screenings), and non certified Nursing Home visits comprise the majority of services as outlined in this summary.

MHA Nation Healthcare services are arranged to provide these services such that formation of a single Public Health Unit would augment the delivery and continuity of care for all residents of our reservation.

We have again attached a copy of the 2010 Census to this testimony. The Census puts the population of the Fort Berthold Reservation at 6,341, a figure that I believe to be much higher because of the ongoing oil boom which has engulfed our Reservation. Of this number, the Census lists 4,556 residents as Native American and 1,511 as White. Again, this latter number is likely low because of the hundreds and probably thousands of non tribal members working on the Reservation in the oil and gas industry, some of whom currently reside in so called "man camps". Our staff has informed me that there may be a correlation between this increase in population and a higher incidence of sexually transmitted diseases

(STDs) on the Reservation. Because of the strong growth in population on the Reservation due to oil, it is important for the State to have a strong presence as the number of non natives has increased dramatically and this is going to cause public health issues. It is in the MHA Nation and the States best interest to work closely and keep up on these issues before they become major health problems. Further, because of the inherent danger associated with working on oil and gas rigs and the increased truck traffic that has significantly increased our traffic fatalities and injuries, injury prevention and emergency response services are now more important than ever.

Chairman Lee and members of the Committee, I will state my belief that district health units historically have had major difficulty in reaching tribal members within the boundaries of the Reservation. I believe that this would not be such an obstacle if Fort Berthold were designated as a single PHU. Such a designation would likely enhance the State's ability to service all residents of the State, including members of the MHA Nation. I emphasize here that the Mandan Hidatsa and Arikara people are also State citizens and are entitled to the same services as other State citizens.

There are public health benefits that I believe will come from the designation of the Reservation as a single PHU. They will come in the form of better tracking of diseases like Tuberculosis, STDs, Hepatitis C and other communicable diseases. There will undoubtedly be improved communication between the two governments, improved immunization rates for influenza, measles, and other childhood diseases.

The MHA Nation would have enhanced continuity with a single Reservation PHU which would be able to better serve the native population which

is afflicted with higher health disparities such as diabetes, tuberculosis and heart disease. The MHA Nation would be able to administer public health services with cultural sensitivities in mind. We would have ownership over our own data for therapeutic purposes. I believe there would be increased patient compliance related to elimination of cultural barriers, transportation and poverty and demographic barriers. Currently our data is dispersed into the different counties in which the health unit is located and given to the state as such; however, we are one Reservation and to have our statistics and health disparities fragmented causes difficulty for eradication of diseases and illnesses.

CHALLENGES

There are admittedly challenges and barriers that we face. There are always jurisdiction issues that come with the provision of services like these. Will the sovereignty of the MHA Nation be diminished or affected, if at all by a coordinated effort? We will need to find ways to protect this interest going forward.

Another challenge will be increased staff and funding issues. I understand that much of the funding for the existing district health units comes from district wide mill levies and the general fund of the counties and cities within each district. Our Reservation land base is a checkered board, with trust land and non-trust land, also known as fee land. The Tribe and Tribal members do pay property taxes on fee land that they own. For example, there are tribal members whose homes are on non-trust land (lots) in the towns of Parshall and New Town who pay property taxes to the counties.

Energy development and impact on roads, along with the geographical division of our communities by the Garrison reservoir have complicated the logistics of providing care to our residents. This increases the need for systematic

application of health care resources in improving the health care status of those living on the reservation.

From our standpoint, many of us agree that a single Reservation PHU is in the best interest of the State of North Dakota and the MHA Nation. But the devil will be in the details, and the commitment to follow through with an agreement, with both the manpower, and the financial backing. The MHA Nation has demonstrated governance structure capable of supporting these PHU functions

On behalf of the MHA Nation, thank you again for the opportunity to appear and offer this testimony. I am happy to answer any questions.

U.S. Census Bureau

GCT-PL1. Race and Hispanic or Latino: 2010

American Indian Area/Alaska Native Area/Hawaiian Home Land within North Dakota

Note: For information on data collection, confidentiality protection, nonsampling error, and definitions, see http://www.census.gov/prod/cen2010/pl94-171.pdf

		Race								
		One race								
Geographic Area	Total population	Total	White	Black or African American	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Some Other Race	Two or More Races	Hispanic or Latino (of any race)
Fort Berthold Reservation	6,341	6,127	1,511	13	4,556	4	1	42	214	272
Lake Traverse Reservation and Off-Reservation Trust Land (part)	169	167	159	0	8	0	0	0	2	8
Spirit Lake Reservation	4,238	4,181	580	0	3,587	0	1	13	57	48
Standing Rock Reservation (part)	4,153	4,034	525	7	3,492	4	2	4	119	82
Turtle Mountain Reservation and Off-Reservation Trust Land (part)	8,656	8,564	223	10	8,320	3	1	7	92	69

Source: U.S. Census Bureau, 2010 Census Redistricting Data (Public Law 94-171) Summary File
Tables P1 and P2