



Testimony
Before the Subcommittee on Human Rights and
Wellness
Committee on Government Reform
United States House of Representatives
Caucus

**HHS Health Care Activities in the Pacific
Island Territories**

Statement of
Nathan Stinson, Jr., Ph.D., M.D., M.P.H.
Deputy Assistant Secretary for Minority Health,
Office of Public Health and Science
U.S. Department of Health and Human Services



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I. INTRODUCTION

Good afternoon. I am Dr. Nathan Stinson, Deputy Assistant Secretary for Minority Health and Director of the Office of Minority Health (OMH) in the Department of Health and Human Services (HHS). I want to thank the Committee for the opportunity to testify today on the Department's activities in the United States Pacific Island territories (USPIT), primarily Guam, Commonwealth of the Northern Mariana Islands (CNMI) and American Samoa. In addition, I will provide information on health disparities and the unique challenges associated with delivery of health care and improving the health of the people in this region. The Department sees this hearing as an important opportunity to identify collaborative strategies and actions that can have a positive impact on disease control and prevention in the Pacific Basin.

One cannot stress strongly enough the region's remoteness from the continental United States and the wide time zone differences across the region. This reality is coupled with the characteristics of the population including its youthfulness. A map of the USPIT appears in Appendix 1. Background on the region's demographics and geography is included in Appendix 2.

As I brief you on the Department's activities to address health disparities in the Pacific Basin, it is important to bear in mind that they are being carried out in the context of Secretary Thompson's national commitment to "close the health gap."

II. BACKGROUND of DISPARITIES and COMMON CHALLENGES in the

PACIFIC BASIN

Over the years, racial and ethnic minorities, including Asians and Native Hawaiians and Pacific Islanders, often have been characterized as “*hard to reach*,” largely due to the socioeconomic, geographic, cultural, and linguistic barriers that can inhibit the communication, receipt of information and services, and understanding of critical health messages.

The 2003 issue of *Health, United States*, the annual report card on the health status of the American people, documented significant progress in the overall health picture of the Nation, but reinforced the fact of the continuing health-related burdens experienced by the racial and ethnic minority populations compared to the U.S. population as a whole. Unfortunately, those communities experiencing disparities suffer worse health status and higher rates of death and disease. This is unacceptable. The real challenge for HHS and the Pacific Basin jurisdictions is not debating whether disparities exist, but in developing and implementing programs to improve the outreach efforts and knowledge, accessibility of appropriate health services, and quality of care.

Cancer and cardiovascular disease (CVD) are typically among the top three leading causes of death in the jurisdictions, but this is not uniform across entities.

- Guam (1995 - 2001): CVD; cancer; accident/trauma

- Northern Marianas (1997 - 2001): CVD; cancer; other
- American Samoa (1998 - 2000): heart disease; neoplasms; diabetes
- United States (2000): heart disease; malignant neoplasms; cerebrovascular diseases

The estimated infant mortality rates for 2003 (CIA World Fact Book):

- Guam
6.46
deaths per 1000 live births
- Commonwealth of Northern Mariana Islands
5.52 deaths per
1000 live births
- American Samoa
9.82
deaths per 1000 live births
- United States
6.75
deaths per 1000 live birth

The total reported AIDS cases in 2002 include:

- Guam

		76
•	Commonwealth of the Northern Mariana Islands	3
•	American Samoa (2001)	1
•	United States	
		42,745

According to the national Behavioral Risk Factor Surveillance Survey (BRFSS), in 2001 the obesity rate in Guam and the United States was 59 percent and 56 percent, respectively. Because the island of Guam is and continues to be the only entity of all the U.S. affiliated jurisdictions included in this survey, data from the other jurisdictions are not available for comparison.

Before describing some of HHS's programs to improve health services and health status in the USPIT, which attempt to respond to the specific challenges in a given jurisdiction, it is important to note common challenges across all jurisdictions, including inadequate health care delivery, the poor infrastructure, limited resources, and isolated location. While these challenges exist in the continental U.S., they are of much greater magnitude in the Pacific Basin. The following observations and anecdotes are from

health care experts in Hawaii, the USPIT, and HHS's Health Resources and Services Administration's (HRSA) Community Health Centers based in the Pacific. These startling stories demonstrate the significant challenges confronting the health care systems and residents:

- Depleted medical supplies and an extended back order is common, which can be attributed to pharmacies not being paid so no orders are delivered, one person doing multiple tasks, distance between the islands, migration of persons from one island to another island to obtain services, and other factors. For example, a physician in American Samoa could not provide insulin to a pregnant diabetic woman because there was no insulin in supply.
- Lack of specialists and tertiary care limits treatment options and quality of care thereby impacting the quality of life. Factors include the low salary, the remoteness of the jurisdictions, the living conditions, and the lack of housing. Health professionals are so profoundly difficult to come by, that organizations in the Pacific Basin must draw from a variety of health education systems in Fiji, Southeast Asia, as well as the United States. As a result, cultural and linguistic differences between patients and providers are not uncommon. In some cases non-physician Medical Officers, rather than fully licensed physicians, are used. The Pacific Islands often recruit

National Health Service Corps providers (another HRSA funded program).

Qualified nurses are often quickly recruited to jobs in Hawaii or other states which pay higher salaries than the jurisdictions can afford.

Women with breast cancer who are treated on Guam are more likely to undergo mastectomy as opposed to breast conserving therapy (lumpectomy and radiation). Therefore the "treatment options" are not "real options" to the women in this jurisdiction. American Samoa, for example, provides dialysis but has no resident nephrologist. Other island jurisdictions have limitations regarding basic services—mammography, for instance, is frequently not available on the island of Saipan because often a properly trained technician is not available for months at a time.

The lack of tertiary hospitals generates enormous costs involved with sending patients off the island for specialty care. For example, because radiation therapy, chemotherapy, and oncologist services are by and large unavailable, cancer patients frequently need to travel to another jurisdiction or Hawaii. The costs associated with such referrals consume a large part of the health budget and benefit only a few patients. Because of unpaid bills for services provided in Hawaii and California, physicians cannot refer many patients off island to these locations for necessary tertiary care.

In particular, the health care systems of the Federated States of Micronesia and the Republic of the Marshall Islands are inadequate to meet the needs of the population, giving rise to inter-jurisdiction travel in order to receive appropriate health care. An extensive GAO Report (GAO-02-40, October 2001), *Migration from Micronesian Nations Has Had Significant Impact on Guam, Hawaii, and the Commonwealth of the Northern Mariana Islands*, found that in 2000, 43 percent (\$4 million) of all identified Commonwealth of the Northern Mariana Islands impact costs were related to health care. A Commonwealth of the Northern Mariana Islands' Department of Public Health Services official noted that neonatal intensive care was a key issue for the Freely Associated States (FAS) migrants—which are the Federated States of Micronesia (FSM), Republic of the Marshall Islands (RMI), and Palau—and that expectant mothers often have no insurance and no prenatal care until they arrive at CNMI Community Health Care.

As a result of the Compact of Free Association between the United States and FAS, these residents are allowed to freely enter the United States, including its insular areas. The House Joint Resolution 63, the Compact of Free Association Amendments Act of 2003, was signed into law December, 2003. The legislation includes “compact impact” funding

earmarked for Guam, Hawaii, American Samoa, and the Northern Marianas, all of which have been burdened by costs associated with migration. Poor education and health care facilities in the Marshall Islands and the four FSM states made migration to locations such as Hawaii and Guam more attractive. Furthermore, not only could FSM and RMI citizens work and study on U.S. soil, they could also use healthcare facilities, as well as apply for public assistance and put their children into CNMI, Guam, and Hawaii schools.

In its 2000 assessment, Guam identified unpaid services by Guam Memorial Hospital to FAS patients, totaling over \$5.4 million, as its largest single area of health impact. Officials reported patients' reliance on the hospital's emergency room for primary health care and not urgent conditions. Although FAS represented approximately 5.0 percent of Guam's population, they accounted for approximately 12.0 percent of the emergency room patients per month. Similar to CNMI, expectant FAS mothers arrive at the hospital close to delivery with no prior prenatal care. The Governor, at the time of the GAO report, stated that the U.S. naval hospital on Guam was underutilized and could provide care for FAS migrants.

- Long distances must be covered to provide care to individuals in remote

areas.

- Lack of potable water, fluoridation of the water supply, and sanitation services.
- Lack of non-profit entities. All health center grants in the Pacific are awarded to the jurisdiction's government which administers the grant and employs the health center staff. Most jurisdictions are heavily reliant on Japanese tourism as its major source of revenue. The weakened Asian economy and reduced tourism in the Pacific jurisdictions have resulted in the plummeting of the government's general fund revenues. As a result, some governments, such as Guam, have implemented hiring freezes, reduced hours, or reduced salary, which affects health center staff. Because most jurisdictions are not set up to accommodate non-profit entities, the government is the only provider of care or services.
- Data may undercount mortality and morbidity. For example, American Samoa reported 9.82 deaths per 1000 live births in 2003. However, many pregnant women from Western Samoa go to American Samoa for the delivery and then return home. The births would be counted in American Samoa data but subsequent deaths would not appear in the infant mortality statistics.

- In Guam, physicians must participate in a “house call” rotation as condition of having hospital privileges. This burden is becoming increasingly problematic with repeated threats from the physician community to refuse to take “house calls.” For example, in the Department of Obstetrics and Gynecology, approximately 40 percent of the deliveries are for “house patients.” The physicians, who are primarily in private practice and dependent on the generated revenue, are concerned about the level of uncompensated care they provide.
- The physical terrain of the Pacific Basin itself poses a threat to residents in receiving care. A physician recently reported in American Samoa that there was one road, parallel with the shore that leads to the hospital. Storms and typhoons cause mud slides that would block transport of health care providers and patients to the facility.

III. HHS-FUNDED PROGRAMS in the U.S. TERRITORIES OF THE PACIFIC BASIN

HHS’s funded programs do contribute to breaking down some access barriers and connecting people to the services they need; informing and educating people to take charge of their health status; and uncovering new knowledge to help prevent, detect,

diagnose, and treat disease by improving the quality of health care delivery.

Examples of HHS-funded programs include the following:

A. ACCESS

1. ***CMS Funding and Grant Programs*** - The Social Security Act specifies the relationship of the Centers for Medicare & Medicaid Services (CMS) with the territories. CMS works closely with the territorial governments to help them in their efforts to provide high quality health care. Medicaid and the State Children's Health Insurance Program (SCHIP) provide significant health care funding for pregnant women, families with children, people with disabilities, and individuals over age 65 in the U.S. territories of American Samoa, Guam, and CNMI. Unlike the funding received by U.S. states, the Medicaid and SCHIP funding for these territories is capped. Federal funding for services to individuals covered by Medicaid and SCHIP in Federal fiscal year 2003 totaled:

	<u>Medicaid</u>	<u>SCHIP</u>
Samoa	\$ 3,727,000	\$ 396,900
CNMI	\$ 2,255,000	\$ 363,825

Guam	<u>\$ 6,321,000</u>	<u>\$1,157,625</u>
Total	\$12,303,000	\$1,918,350

The total amount of Federal Medicaid and SCHIP funding for each of the U.S. Territories is set by law. The Medicaid and SCHIP programs require that Federal funds be matched with State and Territorial funds, and the law sets a specific Federal Medicaid matching rate for the territories. Each of the three Pacific territories provides significant additional territorial funds, beyond Federal matching requirements, to fund additional services.

In addition, CMS awarded competitive grant funds in the Pacific territories to help build the infrastructure needed to assist aged and disabled individuals who live in the community. Guam received both a Community Integrated Personal Assistance grant for \$300,000 and a Real Choice Systems Change grant of \$673,106 in 2001 to improve community long-term care support. CNMI received a Real Choice Systems Change grant for \$1.385 million in 2002 to build a support system for people with developmental disabilities.

American Samoa, CNMI, and Guam operate their Medicaid programs with broad flexibility to accommodate their smaller, public

health dependent systems. Medicaid State Plans of all three Pacific Territories specify that they cover the following services: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, nursing facility services, physician services, home health care, medical and other types of remedial care, optometrist services, other practitioner's services, clinic services, dental services, physical therapy, prescribed drugs, dentures, prosthetics, eyeglasses, and health-related transportation.

Additional Medicaid services are provided by some of these territories, such as private duty nursing, occupational therapy, and speech, language, and hearing services.

Medicare also provides significant resources for health services, to elderly and disabled beneficiaries, although data for FY 2003 are not yet available.

Each year for the past several years, CMS has held a territorial summit with the Directors of the Medicaid programs in the territories. CMS staff in the San Francisco Regional Office, including a Pacific representative at our Hawaii Field Office, have developed expertise and provide ongoing technical assistance to address the unique needs of the Pacific territories, most frequently on Medicaid and SCHIP eligibility, services, and billing issues.

More recently, CMS established one National Account

Representative in the Regional Office and one in Central Office for each territory and state, to devote additional attention to the needs of their jurisdictions. These initiatives focused CMS efforts on issues of interest and concern to the territories. Discussions have centered on the impact of Federal requirements on the territories and the ways health care services can be prioritized when resources are limited, including the provision of Early Periodic, Screening, Diagnosis and Treatment (EPSDT), off island referrals, and Federally Qualified Health Center (FQHC) services. CMS staff assist the territories in obtaining additional Federal funds within the statutory limits of the programs. For example, technical assistance and additional funding were provided to the territories for Y2K preparedness.

The Medicare Modernization Act (MMA) contains special provisions for the U.S. territories. The three Pacific territories plus the Caribbean territories of Puerto Rico and the U.S. Virgin Islands are eligible to share a special pool of funding in proportion to each territory's share of the total number of Medicare beneficiaries living in all five territories. These funds will be used by each territory for Transitional Assistance to help low-income Medicare beneficiaries pay for prescription drugs purchased through the temporary drug discount card program. Each territory has broad flexibility to design

a Transitional Assistance program that best suits its unique circumstances. To receive a portion of the funds, the territory must submit a plan to CMS by March 12, 2004. CMS held conference calls with the territories to provide information on these provisions and developed a template for the territories to assist them in the design and submission of their proposals. Two of the territories (Guam and CNMI) have already submitted their draft plans for CMS review. The MMA contains similar special pools with flexible funding for the territories to share to provide assistance to low-income Medicare beneficiaries under the permanent Part D Medicare drug benefit that begins in 2006. The law gives the Secretary authority to waive Part D requirements to the extent that may be necessary to assure access to Part D drug coverage for Medicare beneficiaries living in the territories.

2. ***Community Health Centers***-- HRSA's Bureau of Primary Health Care (BPHC) funds the Community Health Centers (CHC) in the Pacific. CHCs provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population, and they tailor services to the needs of the community. Guam and American Samoa received

\$403,470 and \$416,663, respectively, in fiscal 2003.

The Pacific Basin health centers have clinical issues that are very different from those in the continental U.S. Prevalent health conditions of Pacific Islanders include those typical for developing countries (e.g., tuberculosis, dengue fever, cholera) as well as health conditions that plague developed countries (e.g., diabetes, heart disease, cancer). Despite these challenges, the health center program is a key part of access to health care in the Pacific. In many jurisdictions, the CHCs are the only providers of care for uninsured patients or the CHC is the sole provider of health care.

4. ***Children's Services Program:*** Funded by the Center for Mental Health Services (Substance Abuse and Mental Health Services Administration - SAMHSA), Guam received \$1 million in fiscal 2002 for a six year project. Guam plans to develop and implement a child-centered, family-focused system of care that delivers effective, comprehensive, community-based, culturally competent mental health and related services for children and adolescents with serious emotional disturbance and their families and to ensure longitudinal studies of service systems outcomes. The system will honor the community's commitment to live true to the island heritage of "taking care of our own" and filling gaps by providing supports on the Island, rather than sending children thousands of

miles away to off-island placements or not serving them at all.

5. ***Maternal and Child Health Services Block Grant (Title V):***

Administered by HRSA's Maternal and Child Health Bureau, the largest portion of Title V goes to the States and territories through a formula-based block grant process. The Federal/State partnership develops service systems to meet challenges in reducing infant mortality, providing and ensuring access to comprehensive care for women, and promoting the health of children through primary care services. All three of the U.S. Pacific jurisdictions received fiscal 2004 allocations, ranging between \$506,369 to \$886,000.

B. HEALTH STATUS

1. **Special Populations Network for Cancer Awareness Research**

and Training: Administered by the National Cancer Institute's (NCI) Center to Reduce Cancer Health Disparities, National Institutes of Health (NIH), the purpose of the Special Populations Networks (SPN) is to build relationships between large research institutions and community-based programs and to find ways of addressing important questions about the burden of cancer in minority communities.

The major goal of the SPN is to establish a robust and sustainable

infrastructure to promote cancer awareness within minority and medically underserved communities, and to launch from these communities more research and cancer control activities aimed at specific population subgroups. The SPN projects cover three phases. In the first year, cancer awareness projects were implemented in the community and project plans were developed. In the second and third years, partnerships between the project and NCI sponsored groups should enhance minority training and minority participation in cancer trials. In the last two years, investigator-initiated research grant applications will be developed.

Examples of projects the SPN is funding in the Pacific territories include:

- **Pacific Islander Cancer Control Network:** Two centers of the University of California, Irvine (the Chao Family Comprehensive Cancer Center and the Center for Health Policy and Research) in collaboration with the National Office of Samoan Affairs (NOSA) and eight community-based organizations propose to establish the Pacific Islander Cancer Control Network (PICCN) that will improve cancer awareness, enhance recruitment to clinical trials, and increase the number of cancer control investigators among American Samoans, Tongans, and Chamorro/Guamanians

in the United States. The community-based organizations (CBOs) are located in California, Washington, Utah, American Samoa, and Guam, where the large majority of Pacific Islanders reside. The CBOs, with the University's centers, NOSA, NCI, and other voluntary groups, comprise a Steering Committee that coordinates the network activities. Some project activities include assessing existing cancer education materials aimed at Pacific Islanders and developing new culturally-sensitive materials when appropriate, enhancing recruitment of Pacific Islanders to clinical trials by establishing relationships with cancer centers, and promoting participation of Pacific Islander scientists in research by identifying candidates and developing a new training opportunity at the University.

- **ʻImi Hale, the Native Hawaiian Cancer Research and Training Network:** This project aims to reduce cancer incidence and mortality among Native Hawaiians through the establishment of a sustainable infrastructure to:
 - 1) promote cancer awareness within Native Hawaiian communities; and
 - 2) initiate cancer research, training, and control activities. In Hawaii, the target population are Native Hawaiians who reside in the State of Hawaii.

Through an administrative supplement to the `Imi Hale SPN grant from the Center to Reduce Cancer Health Disparities and the NIH National Center on Minority Health and Health Disparities, a project entitled “**Pacific Islands Cancer Initiative**” was funded in 2002 to begin addressing the cancer health needs in all the U.S. associated Pacific Island jurisdictions. The strategy to achieve the goal depends on creating a team that can articulate the cancer health needs of indigenous Pacific Islanders, strengthening and sustaining community capacity, and including Pacific Islanders in NCI and NIH programs and services that address those needs. Accomplishments to date include completed cancer assessments in all the jurisdictions that document current capacity in cancer prevention and control, convening of three meetings with clinical and public health representatives from the jurisdictions to discuss and set priorities in cancer prevention and control, establishment of the Cancer Council of the Pacific Islands with elected officers, and adoption of implementation plans based on regional priorities (i.e., increase laboratory capacity, develop resources, improve cancer care services, and establish cancer registries) and jurisdiction/state-specific actions.

2. **State-Based Diabetes Prevention & Control Program (DPC):**

Administered by HHS's Centers for Disease Control and Prevention's (CDC) Division of Diabetes Translation (DDT), this program operates in all jurisdictions. Several of the recent activities supported by the territorial DPC program include:

- **Guam** is preparing a program to identify and conduct meetings with pertinent partners, as they are required to complete an assessment and prepare a program improvement plan for DDT. Pacific Diabetes Today training continues for community based diabetes prevention and control program activities.
- **Northern Mariana Islands** developed a diabetes prevalence registry of persons receiving diabetes care by age, sex, ethnic group, insurance coverage, and complications, thus providing information on the burden of diabetes among the Chamorro and Carolinians, the CNMI's indigenous population. A conference for Primary Care Provider and Community Members was held October 17-18, 2003. Standards for Diabetes Care and how to perform a complete foot exam were the focus of the conference for the providers, and food demonstrations and physical activity was the focus for community members. The Northern Marianas also participated in an immunization program to assure that at least 100 influenza vaccinations will be given on Saipan and 50 doses for

each of the outer islands. Another accomplishment was development of a diabetes awareness education program for the media and lay person leadership.

- **American Samoa** improved a patient registry through collaborative efforts between the DPC Program coordinator, the hospital diabetes coordinator, hospital dietitian, the medical clinic staff, and the hospital quality management. They address sharing responsibilities for the entry, maintenance, and sharing of data collected through the Diabetes Care Monitoring System. The DPC Program has completed the Diabetes Guidelines for use in hospital-based physicians' offices, private clinics, and dispensaries, which improved the adherence to care standards. Continuing media outreach efforts aim to increase public awareness and diabetes information in the community. The DPC Program, in collaboration with the National Diabetes Education Program (NDEP) representative facilitates a weekly 30-minute TV Program of care improvement topics, which are drawn from quarterly reports of the Diabetes Care Monitoring System.

- 3. ***HIV Prevention Projects for the Pacific Islands***: The CDC is providing funding to support HIV Prevention Projects for the U.S. associated Pacific Island jurisdictions. Six awards are expected to

be made this April. Project activities focus on delivering evidence-based HIV prevention interventions, including preventing perinatal HIV transmissions; increasing the proportion of HIV-infected persons who know they are infected by increasing the number of providers who routinely provide HIV screening in health care settings, increasing the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services; and strengthening the capacity of health departments and community-based efforts to implement effective HIV prevention programs and evaluate them.

C. QUALITY

1. ***Disparities Collaborative:*** The CDC is working with HRSA's BPHC and the Institute for Healthcare Improvement to improve diabetes care within federally funded health centers. To increase access and decrease health disparities among medically underserved populations, Centers participating in this collaborative agree to adopt shared national measures, as well as local measures based on proven guidelines. Guam has been of the Pacific West cluster since 2000, and has completed the 12 months of intensive learning sessions on the elements of providing good chronic care and on a method for testing and implementing changes. Some of the preliminary results show challenges. For

example, approximately 40 percent of patients' seen at the participating health centers in Guam have a hemoglobin A1c average of 10.0, which is above the goal of 7.0 average. Less than 20 percent of the patients received the annual dilated eye exam.

As part of the collaboratives, the teams noted some strengths and challenges. Strengths include using locations and communities where people congregate and collaborating within their own communities. Several of the challenges are similar to those previously mentioned, as well as:

- Diabetes is much more prevalent in these populations compared to those in continental U.S. Diets have moved away from the “traditional” Pacific diet towards a more “westernized” diet consisting largely of tinned/packaged convenience and fast foods. Difficulty with technology, including cost and reliability of phone and Internet connections, affects the collaborative teams' ability to communicate as well as maintain their registries.
- Problems in getting some medications and test reagents also persist.

2. ***Data Infrastructure Grants:*** The Commonwealth of the Northern

Mariana Islands, Guam, and American Samoa each received \$50,000 in FY 2002, which was awarded by the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration (SAMHSA). The Commonwealth of the Northern Mariana Islands will develop its capacity to produce information to assess and improve the quality of care for mentally ill adults and children with emotional disturbances. Guam is committed to the development and implementation of an automated information system that will provide statistical data to be used to improve community mental health services for its residents.

3. ***Office of Minority Health Resource Center (OMHRC) HIV Team:***

The OMHRC HIV Team has extended its programmatic efforts to the Pacific Island Jurisdictions with its sessions on Guam during FY 2004. Two regional capacity building trainings will be held, as well as direct technical assistance (TA) to agencies working in the field of HIV/AIDS prevention and treatment. The trainings will include:

- Obtaining salient information to perform TA services through *a needs assessment process*;
- Working with local providers and other government agencies and federal partners who already have a presence on the islands;
- Identifying what type of technical assistance can be

provided;

- Creating a strategic plan to implement services with local partners; and
- Finding appropriate resource persons to provide these services.

The TA will cover: 1) organizational infrastructure; 2) cultural competence; 3) community outreach; 3) programmatic design; 4) training initiatives; 5) communications assistance.

4. ***Ryan White CARE Act:*** The Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, enacted in 1990 and reauthorized in 2000, is administered by the HIV/AIDS Bureau, HRSA, and provides funding to states, territories, and other public and private nonprofit entities to develop, organize, coordinate and operate more effective and cost-efficient systems to people living with HIV/AIDS and their families.

- Title II helps health departments improve the quality, availability, and organization of HIV/AIDS health care and support services. This title also contains the AIDS Drug Assistance Program (ADAP), which provides low income

individuals with life-prolonging medications. In FY 2003, Guam received \$142,612, which includes a proposed \$91,319 for ADAP. As of February 2003, Guam's ADAP faced capped enrollment and four people are on the waiting list. In FY 2002, for the first time, the other two Flag Territories, American Samoa and the Commonwealth of the Northern Mariana Islands, received Title II awards. In FY 2003, each of the two jurisdictions continued to receive approximately \$50,000 in funding.

- Title IV focuses on the operation and development of primary care systems and social services for women and youth, two groups that represent a growing share of the epidemic. In FY 2002, the Northern Mariana Islands were awarded \$50,000 under Title IV.

5. ***Inclusion of the Pacific Islands in Vital Statistics Data and National Surveys:*** In 2003, the National Committee on Vital and Health Statistics' (NCVHS) Subcommittee on Populations held two hearings on health data needs for the Asian and Native Hawaiian and Other Pacific Islander (ANHOPI) populations. The hearings were attended by academic researchers and community representatives. Each group stressed the need for developing

statistical methodologies that would increase the numbers of ANHOPI in national surveys so that data could be reported yet avoid survey participant disclosure. The NCVHS' recommendations for HHS action are relevant for Pacific Basin populations. They include:

- a. Develop a long- term data collection, analysis, and dissemination plan to ensure that the Nation's system for monitoring the health status and health care of its subgroups, especially those concentrated in geographically distinct areas.
- b. Devise sampling frames for national health surveys that would increase sample sizes for racial and ethnic minority groups that would support appropriate analysis and information dissemination.
- c. Conduct targeted surveys to collect detailed, timely, and accurate data on specific subgroups of specific racial and ethnic minorities, especially those concentrated in geographically distinct areas.

The Subcommittee also urged collaboration with States, territories, Tribal governments, private foundations, and other stakeholders to develop methods, procedures and resources to accurately collect

health data that ensures that the diversity of the U.S. population is fully reflected.

Also, the ANHOPI community has expressed frustration over what they perceive to be the Federal agencies' noncompliance in collecting racial and ethnic data in accordance with the revised Office of Management and Budget categories. The HHS Data Council's Working Group on Racial and Ethnic Data is developing a data primer that will be written in plain language to assist all, including the general public, to better understand the data collection and reporting process. The data primer will provide clarifying information regarding how data are collected, factors that impact the release of data, and the meaning of some key terminology, (e.g., data not statistically reliable, data not stable, data not collected, etc.). The data primer is planned to be disseminated widely and could be useful for the USPIT.

As previously mentioned, Guam is the only jurisdiction included in national surveys, such as BRFSS. Including the other territories for track and comparison would also be useful for the USPIT.

6. In 2001, President Bush signed **Executive Order 13216**, entitled "Increasing Opportunity and Improving the Quality of Life of Asian

Americans and Pacific Islanders," which extended the White House Initiative on Asian Americans and Pacific Islanders (AAPIs) and the President's Advisory Commission for another two-year term. The EO calls for a government-wide effort to address the unmet needs of Asian Americans and Pacific Islanders and increase AAPI participation in federal programs where they may be underserved. The Interagency Working Group (IWG) advises the President through the office for the White House Initiative on AAPIs, currently housed in HHS. In 2002, the IWG developed an inventory of programs affecting Asian Americans and Pacific Islanders and a FY 2002 performance report. Additionally, each agency is responsible for developing an annual plan for achieving the mandates of the EO.

Finally, HHS is a focal point in the areas of coordination and collaboration with public/private sector groups, including the Federal Emergency Management Agency, whenever a federal disaster proclamation is issued, and the Pacific Island Health Officers Association. Additionally, HHS chairs both the Federal Regional Council in Region IX and its Outer Pacific Committee. These collaborations enhance discussions of regional issues and concerns, promote interagency resolutions, and improve communication.

IV. CONCLUSION

There are clearly significant health and health care challenges facing the U.S. Pacific Island territories, such as the poor infrastructure of the health care system; limited health care providers, specialists, and resources; limited technology; dearth of community-based organizations; isolated location; and limited funding. These contribute to documented health disparities.

HHS's efforts are concentrating on improving the accessibility and quality of health care and health status of these populations. It seems that our challenge, in a collective sense, is to use strategies that can accommodate the unique aspects of the region—using broader and more flexible approaches, working with the leaders and residents of the Pacific Basin, respecting the governing body and policies, cultures and traditions of the people, to improve the capacity and infrastructure of the health care system and, in turn, the health status of the people.

Again, thank you for the opportunity to testify before you today. I would be happy to answer any questions.

Appendix 1

Geographic Location of the U.S. Pacific Island Territories (Guam, Commonwealth of the Northern Mariana Islands, and American Samoa)