

## FRIENDS OF INDIAN HEALTH

Good Morning Chairman Dicks, Ranking Member Simpson and Committee Members. I am Dr. **Daniel Szekely, MD, FACOG**, an Assistant Professor in the Department of Obstetrics and Gynecology at the University of Michigan and currently serving on the American College of Obstetricians and Gynecologists (ACOG) American Indian Affairs Committee. From my experiences with ACOG and from six years as the Medical Director of the Alaska Native Medical Center (ANMC) in Anchorage, I have witnessed first-hand both the importance and challenges of the Indian health care system.

I am representing the Friends of Indian Health – a coalition of over 50 health organizations and individuals dedicated to improving the health care of American Indian/Alaska Native (AI/AN) people. A key element of that goal is to adequately fund the Indian Health Service (IHS) so that health care programs accessed by AI/ANs are funded at levels equal to the rest of the nation's citizens.

The Friends thanks you, Mr. Chairman and the Committee for the additional IHS funding secured in both the FY 2009 Omnibus bill and the American Recovery and Reinvestment Act (ARRA) of 2009. This increased funding will help build badly needed health care clinics, develop health information technology for these centers, and provide additional health care services in underserved areas.

Without knowing the specific IHS funding levels in the Administration's FY 2010 budget, the Friends would like to take this opportunity to highlight concerns related to improving health care for AI/ANs, and hope to work with the Committee to ensure that FY 2010 appropriations will address these areas of need.

The most urgent outstanding need of AI/ANs is to address contract health services. Patients requiring cancer treatments, surgeries, treatment for injuries and additional mental health services need medical care that cannot be provided in IHS or Tribal facilities. The IHS is required to reimburse this care when patients receive it from providers outside of these facilities, but contract health services (CHS) funding is woefully underfunded.

Quite literally, unless an American Indian or Native Alaskan is facing loss of life or limb, he or she is likely to be denied needed care outside of the IHS or Tribal facility. In 2008, 35,000 health care needs were denied and 1.6 million were deferred.

We know that the Committee is well aware of the saying, "Don't get sick after June 1<sup>st</sup>", which refers to the date when the CHS account usually runs out of money. **The IHS estimates that it needs an additional \$1.2 to \$1.8 billion to cover needed contract health services for one year.**

The Friends has for many years advocated for additional funding for programs that use proven prevention strategies that could over time reduce the need for contract health services. But to implement them, the IHS has to have a sufficient health care provider workforce. Currently, the IHS has 1,500 vacancies. We fear that this is only going to increase because the IHS also has a

graying workforce. For example, the average reported vacancy rate for registered nurses in 2006 was 18 percent while nearly 80 percent of nurses serving in the IHS are over the age of 40.

Loan repayment is IHS' best recruiting and retention tool, but this account is also chronically underfunded. Last year, due to a lack of loan repayment funds, the IHS had to turn away 231 health care professionals already working in the IHS who wanted to stay in the Service, as well as 95 new recruits. **The Friends requests an additional \$18.5 million for the loan repayment account to allow the IHS to hire and keep needed health care providers.**

Before loan repayment can be offered, dedicated, qualified health care professionals have to be recruited. While some of the IHS divisions are very effective at recruitment others are not. We urge the Committee to require the Director to develop an **effective recruitment program** that can be used by all IHS program recruiters. The Director should collect successful approaches currently used in some areas, and encourage other IHS programs to adopt those strategies.

We also hope the Committee can require the Director to **improve and streamline the hiring process**. Recently, an Oklahoma facility lost a potential obstetrician/gynecologist hire because the Area office took over 6 months to process the applicant's paperwork, after the facility had already interviewed and offered him the job. The candidate became discouraged and took a position in the private sector.

This is not a unique experience. Other members of the Friends not only report similar delays in processing accepted health care providers but also concern that many potential candidates are discouraged before they even apply. The complaints include candidates not being able to find anyone to give them information about vacancies in specific locations and never hearing back from the IHS, even when they have applied for a vacancy. IHS should be in the business of recruiting and welcoming needed health care providers, not turning them away because of bureaucratic red tape.

IHS also needs a **strong network of both clinical and support staff**. These are workers who have completed health education training and are capable of providing needed patient support and health education services. These positions are usually filled by Tribal members, providing a crucial cultural link to patients. However, the salaries offered for some of these positions are below clerical positions; a receptionist earns more than a dental assistant. An experienced nurse midwife will take a 50 percent pay cut and an experienced nurse practitioner will take a 30 percent cut to work in the IHS. Licensed Practical Nurses (LPNs) in Oklahoma are paid more at Wal-Mart than at an IHS facility.

This situation could be improved if the Office of Personnel Management (OPM) would release its recommendation for a new 600 Series pay scale, something it has been working on for six years. The Friends strongly urges the Committee to **direct OPM to release this new pay scale** and work with IHS to provide sufficient funding for these positions.

More must be done, to **eliminate health disparities** faced by AI/AN. We know that others testifying before the Committee will discuss this and we have included specific health facts on

this at the end of our statement. The facts show how improving Indian health care can lead to cost savings as well as improved health and quality of life. We encourage the Committee to do what it can to target more funds to prevention and wellness to reduce the incidence of suicide, substance abuse including tobacco use and diabetes among other health issues.

At the beginning of our testimony we noted that the ARRA legislation included additional funding for the IHS to install Health Information Technology (HIT). It is our understanding that the Service needs approximately \$200 million more to support accelerated deployment of the RPMS- the Electronic Health Record (EHR) solution for the Indian Health Service at local facilities, additional development of RPMS, and expanded participation in the Nationwide Health Information Network. These funds would help ensure that direct and tribally operated facilities would have adequate resources to support local integration of the EHR into business processes prior to the start of the 2011 CMS incentives.

The Friends thanks the Committee for the opportunity to testify today and is grateful to you, Chairman Dicks, and your Committee for your leadership and strong commitment to the health care needs of the AI/ANs. We look forward to working with you to strengthen the IHS health infrastructure and decrease mortality and morbidity rates of American Indians and Alaska Natives.

## **Appendix A**

### **Women's Health**

- Although AI/AN women across Indian country have lower cancer death rates than U.S. citizens of all races, in Alaska and the Northern Plains, the cancer death rates for AI/AN women are 22% and 42% higher, respectively, than for U.S. citizens of all races.
- The 2002 U.S. prevalence of diagnosed diabetes in women 20 and over was 7.1%. For AI/AN women, it was 15.9%, more than double, the rate. This disease increases complications in childbearing, and elevates the risk that their children will also become diabetic.

### **Mental Health**

- Poverty is a significant contributing factor toward mental and substance abuse disorders. The poverty rate for American Indians and Alaska Natives (AI/AN) in 2001 was 24.5 percent, compared to 7.8% for non-Hispanic whites. The median household income estimate for AI/ANs was \$32,000 compared to \$46,000 for non-Hispanic whites.
- Inadequate mental health and substance abuse services contribute to a suicide rate for AI/AN that is about 1.7 times the rate for all races in the U.S.; the suicide rate for males 15 to 34 years of age is over two times the national rate.
- The suicide rate for Indian people is 60% higher than the general population.
- Studies have shown that 69.9% of all suicidal acts (completions and attempts) in AI/AN country involved alcohol use.

### **Kidney Disease**

- American Indians have one of the highest rates of chronic, irreversible kidney failure or End Stage Renal Disease (ESRD) of any population, with a prevalence rate 3.5 times that of white Americans.

- Diabetes is the leading cause of all new cases of kidney failure for all Americans, and the explosion in the incidence of type 2 diabetes among American Indians is the driving force behind the AI/AN kidney disease prevalence rate.

### **Diabetes**

- Today diabetes has reached epidemic proportions among Native Americans. Each year 54,000 people lose their feet or legs to diabetes. Amputation rates among Native Americans are 3-4 times higher than the general populations. An Arizona tribe has the highest rate of diabetes in the world. About 50% of the adults between the ages of 30 and 64 have diabetes in this tribe.

### **Podiatric Medicine**

- The annual incidence of lower-extremity amputation is 5 to 8 per 1,000 individuals with diabetes
- Amputation rates among Native Americans are 3-4 times higher than the general population.

### **Vision and Eye Health**

- A recent three year study of Navajo people (the largest Native population) revealed that within the prior two years only about 33% had an eye exam and that only 20% had visual acuity good enough to qualify for a driver's license, even with their present eyeglasses.
- With the high rate of diabetes, it is imperative that timely detection and treatment be available in Indian country. Diabetic retinopathy occurs in 24.4% of Oklahoma Indians.

### **Oral Health**

- 79% of AI/AN children aged 2-5 years had a history of tooth decay
- 78% of AI/AN adults 35-44 years old and 98 % of elders 55 years or older had lost at least one tooth because of dental decay, periodontal (gum) disease or oral trauma.

### **Pharmacy**

- Pharmacists play an important role in disease state management, particularly the monitoring of patients suffering from diabetes and other chronic diseases.
- Through the pharmacy residency training program, now in 16 sites, the IHS plays a significant role in the education of pharmacists interested in pursuing careers in the IHS.

### **Children's Health**

- More than one-third of the nation's AI/AN population is under the age of 15, and the health of these children consistently lags behind other populations. For example, the SIDS rates among AI/AN infants are nearly twice that of the general population.
- AI/AN children are more than twice as likely to die in the first four years of life than the general population, and remain twice as likely to die through age 24.
- The rate of type 2 diabetes among AI/AN teens aged 15-19 has increased 109% since 1990.

### **Cardiovascular Disease (CVD)**

- While the general U.S. population has seen a 50% decline in cardiovascular mortality, the AI/AN population rates are rapidly and dramatically increasing.
- CVD is the leading cause of death among AI/ANs and is double the rate of the general U.S. population.