Dr. Donald Warne

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Female: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds who are shaping the health care of the future. This week Mark and Margaret speak with Dr. Donald Warne, Director of Indians Into Medicine at the University of North Dakota School of Medicine and Health Sciences. A finalist for Surgeon General under President Obama, Dr. Warne looks at the deep inequities impacting outcomes for American-Indian populations by COVID-19. The impact of centuries of cultural trauma on nation's native peoples and the need to address gaps in the Indian Health Service, which Congress is treaty bound to do.

Lori Robertson also checks in, the Managing Editor of FactCheck.org she looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and well being in everyday lives. If you have comments please e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcast. You can also hear us by asking Alexa to play the program. Now stay tuned for an interview with Dr. Donald Warne here on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Donald Warne Director of Indians Into Medicine or INMED at the University of North Dakota School of Medicine and Health Sciences, a family physician. He's also Director of the Public Health Program and Associate Dean of Diversity, Equity and Inclusion at the UMD School of Medicine.

Margaret Flinter: Dr. Warne is descended from a long line of traditional healers and medicine men of the Oglala Lakota Sioux tribes. He earned his MD from Stanford University School of Medicine and his master's in Public Health from Harvard. He was a finalist for US Surgeon General under President Obama and was a senior fellow in American-Indian Health Policy at the Robert Wood Johnson Foundation. He's won numerous awards and distinctions for his important work. Dr. Warne, welcome back to Conversations on Health Care.

Dr. Donald Warne: Thank you very much, happy to be here.

Mark Masselli: Yeah, it's great. The COVID-19 pandemic has claimed now 130,000 lives in the country. The cases are accelerating, particularly across the south in the Midwest. From the beginning the coronavirus is claiming more lives of people of color, especially native communities at a much higher rate than the non-native population. I'm wondering if you could help our listeners understand the toll the pandemic has had on American-Indians and Alaskan Native communities as well.

Dr. Donald Warne: Yeah, so one of the challenges when you have something like a pandemic or a public health crisis is that the populations that have less public health infrastructure are at much greater risk for bad outcomes. We know that many of our tribal communities, American-Indian, Alaskan Native communities are very impoverished. As a result, don't have the same type of public health infrastructure that we'll see in cities or suburbs, for example. Quite often the marginalized populations, impoverished populations also have less infrastructure in terms of being able to mount a public health response to a crisis.

When we think about public health infrastructure, we need to have a good public health workforce, so people who are well trained, they also need to have facilities that -- buildings and equipment, laboratory capability, those types of things, and then also very good information systems. We're seeing some of the challenges in coordinating data in the middle of trying to respond to the pandemic. I think the public health infrastructure, kind of in terms of the muscular system, which is the people, the skeletal system which is the buildings and equipment, and the nervous system which is essentially the information systems. Unfortunately, across the board our infrastructure is just not as good. That has a direct impact on responding to a public health crisis.

We see that in many communities of color many impoverished communities and particularly in rural populations, it's even more magnified. There's all kinds of challenges that put American-Indians and other marginalized populations at greater risk for things like COVID-19. In addition to that, we have higher rates of chronic diseases like heart disease, lung disease, and diabetes. All of those chronic disease put people at higher risk for hospitalization and higher risk for death from COVID-19. It's kind of the perfect storm of lack of infrastructure, meeting a population with significant health disparities.

Margaret Flinter: Well, Dr. Warne, we know that the people are strong, but the social determinants really seem to all grow in the wrong direction. We've certainly seen this as you say, in rural and urban areas with different populations, but I'm not sure people realize just what a heavy burden that more than five million American-Indians bear in all of this around challenges with just access to food, to housing, to economic security. During this time of the pandemic, also basic utilities like electricity and running water become really important. Maybe just talk a little bit for our listeners about how all of these come together as kind of deeply entrenched challenges that have impacted health outcomes in the American-Indian communities.

Dr. Donald Warne: Yeah, so when we think about social determinants of health, we know

that impoverished populations have shorter life expectancy and a higher disease burden. Unfortunately for American-Indians we have among the highest rates of poverty in the nation. When you have poverty, you also tend to have less access to healthy food. We also have a lot of food deserts, and a food desert is essentially a community that does not have a local supermarket. Where I'm from in Kyle, South Dakota, we do have a convenience store, but the closest supermarket is actually 90 miles away. Just imagine having to do a 180-mile round trip every time you wanted to go to the supermarket, and then so on top of that poverty, less access to transportation. I would not be surprised if inadequate nutrition also places people at much greater risk for bad outcomes from COVID-19.

In addition, where we have poverty we tend to have overcrowded housing. We see that in a lot of our tribal communities, so we could have multiple generations living together. When you are facing a pandemic, if somebody has been exposed, you need to be able to quarantine. It's almost impossible to quarantine when you have overcrowded housing. Then when someone is diagnosed as positive with COVID-19, they need to isolate, so how do you isolate when housing is overcrowded? It’s all of those social factors and the social context in which populations live that puts them potentially at much greater risk for bad outcomes.

Mark Masselli: Dr. Warne as you say, the crisis of health disparity in American-Indian population can be put on the shoulders of Congress, and its failure to fulfill its obligations laid out in the treaties with tribes who exchanged millions of acres of land for future guarantee of housing and health care. I'm wondering if you could help our listeners understand what was promised, and what was not delivered in terms of funding for the Indian Health Services. How did that bring us to today?

Dr. Donald Warne: It's a little known fact that American-Indians are the only population that is born with the legal right to health services. That's based on the treaties which are signed between the tribal nations and the federal government. I know that if another nation were to violate a treaty, the federal government would not be very happy about that. Well, the federal government has been in breach of contract or violation of treaty with tribal nations for hundreds of years. Those treaties guarantee various types of social services including housing, education and health care. That's why we have a BIA a Bureau of Indian Affairs. That's why we have an IHS Indian Health Service. But the Indian Health Service has been terribly underfunded since its inception. The Indian Health Service doesn't have the resources to adequately provide care that we might expect if we go to a veteran's health facility, or if we're on Medicare or Medicaid, or even if we're a federal employee, we would expect a certain minimum quality of care and access to services. We don't get that in Indian Health Service.

If we think about populations that have a legal right to health services, American-Indians are not getting equal protection under law, because we don't have the political clout within our populations to change that. To have political clout, you need to either have money or votes, and we tend not to have very much of either. We need advocates to recognize that this really is a travesty that the US government has been underfunding Indian Health Service for decades and people are dying as a result, bad policy kills people, and Congress shares a lot of the blame.

Margaret Flinter: Well, Dr. Warne, I understand the CDC has issued additional funding to Indian Health Services to address pandemic related challenges, but I'm sure you're looking not just at the immediate situation, but a little longer term. Perhaps there's an opportunity to remedy some of the shortfalls within the care delivery system itself. What are your thoughts about how some of these new resources might help make a meaningful impact and maybe not just now in response to the crisis, but creating a better infrastructure for care delivery going forward?

Dr. Donald Warne: Well, I'm hoping that if there is a silver lining with the pandemic that will shine a bright light on the disparities, I think that there's just a lack of awareness, generally speaking, of the American-Indian right to health care, but also the underfunding of the Indian Health Service and how that leads to bad outcomes. I'm hoping that we can create more awareness of these challenges and develop more advocates to help us build the infrastructure and resources that we need to have a high quality health and public health system.

In terms of the resources, they've been very helpful in terms of doing things like setting up incident command centers and the kind of emergency response. Using resources to train more contact tracers, those resources could be used to train and hire people from all communities, including tribal communities to work in those settings. A one time infusion of resources to respond to a pandemic does not address the infrastructure problem. We need a longer term investment. We need Congress basically to take the responsibility seriously and live up to their legal obligations to fully fund American-Indian health programs.

Mark Masselli: We're speaking today with Dr. Donald Warne, Director of Indians Into Medicine INMED at the University of North Dakota School of Medicine and Health Sciences. He is also the Director of the Public Health Program and Associate Dean of Diversity, Equity and Inclusion at UND School of Medicine. Dr. Warne, you were just saying that there was a silver lining in the pandemic and telemedicine seems to be one of those things that all of a sudden opened up. The regulatory relief was given by CMS and various states did it. I think on the whole it's been a transition that many safety net providers have a move towards. I

think patients have welcomed it, but the reality is there's a digital divide in our country that not everyone can have access to broadband activity. I'm wondering if you could share with us your thoughts on telehealth, its potential for reaching out to those rural American-Indian and Alaska native communities for both primary and behavioral health care. What do you see the opportunities are and what are still the hurdles that we need to overcome?

Dr. Donald Warne: Well, ironically, just earlier today, I was on a teleconference call with the Governor of North Dakota and several other stakeholders. We were talking exactly about this issue, that there is an opportunity because of more waivers and less regulation around telemedicine, we could potentially expand its utilization. In a state like North Dakota, where we have a lot of rural communities, telemedicine really is the future. We're not going to have a circumstance in the near future anyway, where we have adequate numbers of physicians and hospitals and intensive care units and cardiologists and pulmonologist and all those services in every rural population, just simply not possible.

One simple technology is telemedicine and it is true, there is a digital divide. Some populations have better access to internet than others. If you need high speed internet or ability for high definition video that certainly is a challenge in many of our populations, including tribal populations. But in true for much of telehealth and telemedicine, we do not need high definition imagery. There's a lot of good evidence particularly in behavioral health that psychiatry telecounseling is very effective. It really is just a matter of utilizing it and evaluating the outcomes because my sense is that for much of the work that needs to be done, we just need to connect with people.

When I think about opportunities under telebehavioral health, we still have an opioid crisis in the US and particularly in tribal populations as well. It's not getting a lot of attention now understandably because of the pandemic, but I could envision a future in which we have more access to things like medication assisted treatment through telemedicine and hopefully save lives. I think again, another silver lining might be increased access to telemedicine, telehealth programs for all populations, including the travelers.

Margaret Flinter: Well, Dr. Warne, we have followed your program and your work Indians Into Medicine or INMED at the University of North Dakota School of Medicine and Health Sciences as a way to prepare American-Indian students for careers in medicine and public health. I think you're up to, what, 250 graduates of the medical school at this point which is a wonderful achievement. Certainly for every student of the health professions or training in the health professions over these last several months, this is a generational challenge to them,

watching and learning and practicing how we respond in a pandemic. Maybe share with our listeners a little bit more about INMED and how you've been inspiring young people to think about careers in medicine and public health and also, maybe give us a little bit of insight into how your trainees and students have responded and then environment to both learn and serve during this pandemic?

Dr. Donald Warne: Yes certainly, and for clarification, actually INMED has been around since 1973. The new programs that we've launched at UND since I joined faculty there are the Indigenous Health Master Public Health program and the Indigenous Health PhD. Those are brand new programs. In terms of medicine, we have anywhere from six to eight American-Indian medical students per year, that actually places us at the 100th percentile of medical schools nationally in terms of the percentage of American-Indian and Alaska native medical students. I'm very proud of that. We have a terrible shortage of physicians in rural communities, but particularly tribal communities.

As American-Indians, we're somewhere between 1 and 2% of the overall US population. We're only about 0.2% of physicians. We have a terrible under representation in the physician workforce. I think that one of the things that students are cognizant of is that they know the schools that are Indian friendly, and those that might not be. In addition to that we have quite a few indigenous health professors. I think probably the best way to recruit and retain and inspires students who are American-Indian is to have American-Indian faculty members and most medical schools don't have that. When we look at full professors of medicine around the nation there's nearly 40,000 professors of medicine. Of that number there's only around 30 who are American-Indian. We're just terribly underrepresented in those sectors.

It's a big challenge for other schools as well in terms of where we're going to hire and retain American-Indian faculty who can then help with recruiting students. We're trying to build that pathway from elementary school all the way through residency programs. We have a summer Institute, where we bring about 40 to 50 students per year to spend the summer with us on campus. They take courses in chemistry, biology, physics, math, health and communications, we keep them very busy. We know that they're very engaged and enjoying it because more than half that cohort always applies to reenter the summer institute the following year. We're trying to really build that pathway from grade school into medical school.

One of our big challenges, though, is that we just don't have enough resources. Again, we're funded through Indian Health Service. Indian Health Service itself is underfunded. We haven't had an increase in our funding in 12 years. As the cost per student goes up the numbers

of students that we can engage each year goes down. It's just heartbreaking we have to turn so many of them away simply because we don't have the resources to support all of them.

Mark Masselli: You know, Dr. Warne, I want to sort of pull the thread on sort of a vision that you have, and, we're looking at pandemic that will be with us for a while. But there's also, I think, a right time sort of inflection point for opportunities. I'm wondering if you could share with us how you envision a new kind of health system. You talked a little bit about sort of the availability of mental health services, but also maybe some more substance on what does it mean to be under funded at IHS? What's your sort of bold vision in addition to funding but how these dollars should be used?

Dr. Donald Warne: Yeah. Just in terms of the underfunding, Medicare is funded at about $12,000 per beneficiary per year. IHS is funded at about $5,000 per person per year, so less than half of what was received in Medicare. Even the Bureau of Prisons gets more money per person for health care. Think about that. Federal prisoners get access to more resources for health care than American-Indian children. It really is remarkable to me that, one, that this is well known, generally speaking, it should be. It's a huge challenge, and we're looking at under funding. I've heard a lot of people say that the Indian Health Service is broken. I don't see it as a broken system. I see it as a starved system. It's never been fully resourced.

The corollary that I'd liked to use, if you have a car that needs a full tank of gas to get to its destination, but every day you only put a half a tank of gas in there, you can blame the driver, you can blame the car, you can blame the road, but in truth, you should blame the people who were responsible for filling it up, and that's Congress. Congress has been underfunding it every year, and is been more than happy to complain about it and bring the IHS director to testify before the senate and say all kinds of things about how they're inept. But in truth, Congress has the blame here. They are the ones who are responsible for filling the tank of gas, and they've never done it. They need to be held to account.

I'm hoping we're living in a timeframe where awareness of inequities is growing, awareness of racism is growing. What we have here is institutional racism where American-Indians are getting substandard health care in the wealthiest nation in the world in which they were the first occupants. What I would envision in the future, but things that we could do not just an Indian country, but across the board, we really should have more homing community based services. It shouldn't just be hospital based health care, we should have wellness programs. We should have more community health workers. We should all be invested in keeping each other healthy, but we just have

a system in which the payers pay for treating disease. The health system makes money by treating disease. We need a better system and it's we're incentivized to keep people healthy not to just simply treat diseases after they occur.

Margaret Flinter: We've been speaking today with Dr. Donald Warne, the Director of Indians Into Medicine or INMED. He's also the Director of the Public Health Program an Associate Dean of Diversity, Equity and Inclusion at the University of North Dakota School of Medicine and Health Sciences. You can learn more about his important work by going to med.und.edu/indiansintomedicine or follow him on twitter @donaldwarnemd. Dr. Warne we want to thank you for your incredible contribution to addressing health inequity for advancing public strategies for under served communities and for taking the time to join us again on Conversations on Health Care.

Dr. Donald Warne: Thank you for having me.

[Music]

Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: Noting that the United States accounts for about one quarter of global COVID-19 cases and deaths. House Speaker Nancy Pelosi said the US has, "The worst record of any country in the world. While the US has the most confirmed cases and deaths by a wide margin, it does not have the most in either category on a per capita basis." Pelosi emphasized the US share of coronavirus related cases and deaths, "We are 4% of the world's population. We are 25% of the cases and the deaths 25%, we have the worst record of any country in the world." Pelosi got the percentages right, but where the US ranks in dealing with the pandemic depends on how one looks at the numbers.

As of June 28th, the day Pelosi made her claim, nine other nations including Chile and Peru had more confirmed cases per capita. Eight other nations including the UK, Italy and France had more confirmed deaths per capita. The US case fatality rate was 5%. That's not the lowest rate in the world, but it's lower than the rate in dozens of other countries. Pelosi's claim reminded us of President Donald Trump's claims that the US leads the world in testing for COVID-19 simply based on the sheer number of tests performed. In Trump's case, we also pointed out that the US wasn't the leader in test per capita. Pelosi no doubt has a point about the large number of

confirmed cases and deaths in the US. It is no way our intention to minimize the seriousness of the situation. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

MUSIC

Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. According to statistics from the Centers for Disease Control and Prevention, Native Americans are 60% more likely to suffer from diabetes, obesity and a sedentary lifestyle, but inspiring change in these cultures with conventional approaches, that's proven to be a challenge. A tribe in northern Idaho may have found a workable solution right in their own backyard. Leaders on the Coeur d'Alene Reservation have created a fitness program called Powwow Sweat an exercise program comprised of a series of their traditional dances performed to traditional drumming music.

[**Music**]

Shedaezha: [Native American's language] Hello my friends and relatives, my name is Shedaezha and in this segment we will be learning movements from the women's traditional dance Category. A basic steps 1, 2, 3, 4, 5, 6, 7, 8.

Margaret Flinter: LoVina Louie is the Director of the Tribes Wellness Center and says the Powwow Sweat fitness program brings an often underutilized component of more broadly deployed wellness approaches the tribes own cultural heritage. She says it carries a lot of potential for ongoing motivation.

LoVina Louie: If you don't do it regularly, your calves will hurt. It sounds like jump roping for 25 minutes straight.

Male: Far more attractive than doing jogging or the bicycle because it also relates to my culture and my people.

Margaret Flinter: That was Louis speaking to local reporter Emily Schwing [PH]. The Coeur d'Alene tribe has received a grant from the CDC to not only develop and expand the Powwow Sweat exercise program, but also to build a large communal organic garden incorporating a community wide approach to wellness. In the ensuing months since the program launched, a number of participants like Ryan O'Tevez Ortivez have

begun to incorporate other healthy habits such as quitting smoking and eliminating soda.

Ryan Ortivez: I'm aiming to lose 40 pounds by the end of the year.

[**Music**]

Margaret Flinter: The Powwow Sweat workouts breakdown a half dozen traditional dances into a series of repetitive moves designed to build up endurance over time, as well as preparing the tribal members to partake in the summer's upcoming Powwow, a community based culturally relevant fitness program that incorporates cultural traditions into the process of achieving health and wellness goals.

Shedaezha: Drop the Pringles and let's jingle. 1, 2, 3, 4 --

Margaret Flinter: Now that's a bright idea.

[**Music**]

Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

Female: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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