Health Disparities and the American Indian - Dr. Donald Warne on the Way Forward

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Female: Welcome to Conversations on Healthcare with Mark Masselli and Margaret Flinter, a weekly show where we speak to the top thought leaders in health innovation, health policy, and the great minds who were shaping the healthcare of the future. This week, Mark and Margaret speak with Dr. Donald Warne, Associate Dean of Diversity, Equity, and Inclusion at the University of North Dakota School of Medicine and Health Sciences, a national thought leader on American-Indian health and addressing health disparities in underserved populations. Lori Robertson also checks in, the managing editor of FactCheck.org, 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 wellbeing in everyday lives. If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook or Twitter, we love hearing from you. You can also find us on iTunes or Stitcher. Please feel free to leave a review for us there. Now stay tuned for our interview with Dr. Donald Warne on Conversations on Healthcare.

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Mark Masselli: We're speaking today with Dr. Donald Warne, Associate Dean of Diversity, Equity, and Inclusion at the University of North Dakota School of Medicine and Health Sciences. A primary care physician, he is also director of INMED Indians Into Medicine. Previously he served as chair of the Department of Public Health at North Dakota State University. He's also a senior fellow of American-Indian Health Policy at the Robert Wood Johnson Foundation. He earned his M.D. from Stanford University and a master's in Public Health from Harvard. Dr. Warne, welcome to Conversations on Healthcare.

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

Mark Masselli: Yeah and as a primary care practitioner who comes from a long line of traditional healers, your experience growing up in the reservation exposed you to this time honored tradition of healing practices. As you entered the medical profession you are disheartened that so much of the disease burden you faced was largely preventable. Wonder if you could help our listeners understand the prevalence of disease and poor health in American-Indian populations and why they are so challenging to address?

Dr. Donald Warne: Sure, a lot of our issues that we face in health status are rooted in poverty and marginalization and less access to basic needs in life like good education, good food and economic opportunities. When we look at this from a historical perspective, of course has been a long history of marginalization and loss of land and loss of resources. One of the outcomes of that is less access to services, less access to even simple things like healthy food. Our people are suffering from terrible disparities related to that including much higher

rates of type 2 diabetes, heart disease. We also tend to see higher rates of cancer and other chronic diseases, but unfortunately it does not end there. We also have other high rates of public health issues like even unintentional injuries and accidents. We have very high rates of deaths among our young people due to motor vehicle accidents, but also higher infant mortality rates, so kind of across the whole spectrum we're dealing with disparities and maternal and child health, early child health, and then chronic diseases as people get older. One of the outcomes is that our average age at death is much younger for American-Indians. In North Dakota, the average age of death for American-Indians is about 54 years, so just remarkably low lifespan.

Margaret Flinter: Well, Dr. Warne, I would like to try and put it into perspective the American-Indian health's narrative. We have to look at the foundations of the current state of disparity in native populations, populations whose numbers have dwindled from a high of 25 million prior to the European migration down to just a few million today. Those native people who survived the genocide of the American-Indian have carried it over these generations. Can you talk about the importance of understanding the role of epigenetics and cultural trauma and the impact that that has had on American-Indian health?

Dr. Donald Warne: Sure, and actually just looking at the historical numbers of indigenous peoples in the America and that doesn't really tell the whole story. When we look at estimates of the indigenous population for North America and South America it was in the 20 to 25 million range prior to contact with Europeans, and of that number, it's estimated probably about 5 million lived in what is now the United States in terms of -- so historically, there were probably about 5 million American-Indians and Alaska natives and what is now the United States. By 1900, that number was actually down to less than 200,000, so that was almost a complete genocide. When we look at the numbers now with the 2010 census, there were about 5.2 million self-identified American-Indians and Alaska natives in the census. Our numbers have rebounded but huge impact in terms of historical trauma and community wide trauma and loss of culture, and loss of resources, loss of people between initial contact in 1900. There is emerging scientific evidence in the field of epigenetics that when populations undergo significant toxic stress and traumas it can have intergenerational impact on gene, expression and potentially direct impact on poor health outcomes.

Mark Masselli: I was taken by a longevity being in the mid 50s and it certainly impacted by diabetes, depression and alcoholism. You've talked about the Western medicine approach to this, which are to split these conditions apart and then also split apart the medical side from the behavioral health. Really you come at it from a different vantage point, looking at more holistically and also in cultural context for the American-Indian population. I'm wondering if you could tell us more about that and also tell us about your medicine wheel approach as well.

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Dr. Donald Warne: Sure when I was working as a full-time primary care physician it was in Arizona and with one of the tribal populations that's really devastated by diabetes. Some of our populations, half the adult have type 2 diabetes. It really is remarkable disparity that we see right in Indian country, right in the middle of this nation. What I see among many people with diabetes whether they're American Indian or not is high rates of depression. It's actually is so prevalent I think we should be considering depression a complication of diabetes because it's so common. Now, not everyone with diabetes get depression, but not everyone with diabetes gets kidney failure either, so I think depression is common enough, it really should be considered the complication.

In this nation the most common self-medication for depression is alcohol intake. What I see is lot of people with diabetes who are self-medicating their depression with alcohol intake and the alcohol intake actually makes the blood sugar worse and makes the depression worse, which leads to even more alcohol intake. I see this vicious cycle of diabetes, depression and alcohol intake and it really is a syndrome, I've seen it in hundreds of patients and in thousands of patient visits, We don't treat it systemically or holistically, we treat each individual condition individually, and we tend to look at diabetes management and outpatient depression management as a medical issue, but if someone has major depression and alcohol dependence then we see that as a behavioral health issue.

We essentially cut the patient in half and say that medical side will do its part, the behavioral health side will do its part, but we do not really collectively address this from a holistic perspective. That's very contrary to what we would do traditionally and what was I thought in traditional Lakota approaches to help with it, we would never look at this in just individual parts, we look at the whole and recognize it holistically. What's happening here is there is certainly physical illness, but there is also emotional, spiritual an imbalance that needs to be addressed. If we were to be intelligent as a health system we would address it from the perspective of how the patient is experiencing the disease process. I think that's one area where traditional medicine has much to teach us in modern scientific medicine.

Margaret Flinter: Well, Dr. Warne I know that you were being considered by the previous administration for the post of US Surgeon General and had you been chosen you said you would have used that platform as a chance to highlight the underfunded and under resourced Indian Health Service. Talk with us about the challenges within the Indian Health Services and what solutions you envision to address this significant gap in resources?

Dr. Donald Warne: In the United States people are not born with a legal right to health services except American Indians. We are actually the only population born with a legal right to health services and that's based on the many hundreds of treaties that were signed between tribal nations and the federal government.

Essentially the tribes exchanged land and natural resources for various social services like health, education and housing. That's why there is a Bureau of Indian Affairs, that's why there's an Indian Health Service. The land that is now United States was not lost in a war, it was actually exchanged to treaties and treaties are the highest order of law in the land. We have hundreds of treaties between tribal nations and the federal government and most of the treaties have some sort of component of healthcare included some of the common language was promise of all proper care and protection.

Certainly as American-Indians we have not received all proper care and protection. In a very basic way if you look at these treaties as contracts between tribal nations and the US government, the US government is in breach of contract because they have not held up their end of the bargain. Indian Health Service for many, many decades now has been funded at about 40 to 50% of actual need. We have inadequate resources to provide all proper care and protection as lined out in our treaties. One of the programs that did help a lot is Medicaid expansion under the Affordable Care Act. Of course, not every state expanded Medicaid, but if you look at access to health services comparing North Dakota and South Dakota where North Dakota we expanded Medicaid, South Dakota we did not.

We have much better access to health services and resources. I think Indian Health Service does its best with its limited resources to try to address things holistically. Even their mission looks at the building emotional and spiritual health to the highest level possible. The challenge is we just don’t have the resources to fully invest in protecting health of American Indians and that really is the fault of congress. They should be pointing the fingers at themselves for underfunding this, the whole program for now for decades.

Mark Masselli: We’re speaking today with Dr. Donald Warne, Associate Dean of Diversity, Equity, and Inclusion at the University of North Dakota School of Medicine and Health Sciences. He’s also director of INMED - Indians Into Medicine. Dr. Warne, we recently had North Dakota Governor, Doug Burgum, on the show talking about the state's effort to confront addiction, and you participated in the governor's day of prevention and you said to get the solutions to our addiction dilemma, you have to walk through truth. Tell us more about some of the public health partnerships that are needed to help the American Indian communities get the health they desperately need?

Dr. Donald Warne: As a nation we need to come to terms with the American holocaust and that's exactly what it was. The American-Indian population was almost completely wiped out because of deliberate effort to kill American-Indians. The challenge there is that we don't see a lot of us in our history books because its unpleasant, but if we are ever going to get to health equity, where we can actually raise health to appropriate status for every population, we have to content with the truth. I see a reluctance to do that because it makes people feel

bad, and the truth is there was deliberate attempt at genocide of American-Indians. People may have heard of Amherst Massachusetts or Amherst College, that's named after Lord Jeffery Amherst who is a colonial governor in the colonies. He is the one who ordered the distribution of blankets from a smallpox hospital to the northeastern tribes with the purpose of killing them. Our first documented case of bioterrorism is our own colonial government, but that's not taught in our history books, but that's a part of our truth. I think that if we don't understand the truth of history, what I see is that people blame the victims. They do not understand why we have such high rates of addiction or diabetes or cancer and well from my perspective, if you want to get to equity, you have to walk the truth even when it is unpleasant.

In terms of partnerships, we do have to work with not just the federal government, but also with our states, with Medicaid programs, with private sector agencies. One of our challenges historically is that we are the minority of the minority populations, and we are very underrepresented in leadership positions and in policy making positions. For American-Indians there's nobody in the senate for example. We have to have partnerships with non-Indian populations to improve policy making and law making around access to health services, so that's something we're working on. There's a lot of national and regional agencies that are trying to improve this, but I think most people are unaware of these issues and that's adding to the disparity.

Margaret Flinter: Well, Dr. Warne I really appreciate that you are tackling health inequities with culturally relevant strategies. You are building a curriculum around that at the North Dakota School of Medicine and Health Sciences. You are encouraging through INMED American Indians to pursue careers in the health professions. Talk with us about your approach to training the next generation of healthcare providers, healers in the American-Indian community and, and what are you seeing in terms of success?

Dr. Donald Warne: Well, it's a significant challenge because we have to recognize we have limited pool because of high rates of high school dropout, so much of our work is also focused on building the pipeline of potential future health leaders from our communities because if we have less high school graduates, we will have less college students and therefore less potential medical student. Actually right now we have our INMED Summer Institute going on. We have currently 45 students from across the nation who are American-Indian high school and middle school students here at University of North Dakota for six weeks. We exposed them to all kinds of opportunities and health career they get to actually have a cohort of colleagues who are from similar background and realize that they're not the only American-Indians who are interested in health career.

There's a lot of power in having cohorts of people or groups of people that are trying to work toward a similar goal. It wasn't until I was in college until I finally

met an American-Indian physician and the disparities and the shortages of American-Indian health professionals are just tremendous, so that's really part of my goal now is to try to reverse that. In the United States, there are over 37,000 professors of medicine -- of that number 10 are American Indian, 10 out of 37. Just the need for building role models and leaders within academic health institutions is just tremendous. We're going do our part to try to reverse that.

Mark Masselli: Well, it seems like the populations has grown. Can I assume it's younger population? How in other ways you're describing the successes to young American-Indians who are looking for careers, looking to role models like yourself. What are you seeing that excites you about the population in terms of accomplishments that happened?

Dr. Donald Warne: I mean in addition to high rates of death, and also of high rates of birth, so the result is we have a very young population of American-Indians and Alaska natives. I am very encouraged about this current generation, there seems to be a re-awakening of cultural connectedness, but also this younger generation wanting to do more for their communities, much more social activism, much more inclusiveness. One other thing I find encouraging is that the younger generation of millennials here in the United States, I don't see the same degree of racism, I see much more acceptance. I think this current generation that's now turning 18 is the most diverse generation that we've ever had. This generation moving forward feels like it's much more tolerant of others, so I feel good about the future. What I'm hoping we can do is build upon that and recognize that as American-Indians, but also as members of this nation working toward building equity for all populations. I feel lot of that energy within our young students right now, I believe that as the seventh generation of survivors from Wounded Knee and other terrible outcomes, I see hope for the future in their energy.

Margaret Flinter: You know, Dr. Warne, I wonder given the historical experience of the separation of so many Native American families from their children as they were sent to boarding schools and the like. As you look at our current situation at the border with the separation of parents and children, whether you have any advice or comment for the country on the potential long term impact of that?

Dr. Donald Warne: We know that adverse childhood experiences correlate to poor health outcomes for adults. The worst experiences are in childhood, the worst of health status is as people get older and it's -- it's just remarkable to me that we are allowing this to happen. Again, it's an older generation of people who dehumanize others, and unfortunately in this country there's been a long history of that. Again, I don't think that the millennial generation is on-board with the type of policy makers who would take children away from families, but we have what we have right now so we all need to collectively recognize that this is wrong. It's certainly that they tried to quote the bible, certainly not Christian. It's

horrific circumstances and we are going to harm that entire generation of children who are just simply seeking safety.

Mark Masselli: We've been speaking today with Dr. Donald Warne, 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 work by going to med.und.edu or you can follow him on twitter @Donald Warne MD, Warne is spelled W-A-R-N-E. Dr. Warne, thank you so much for your work, your dedication to addressing health disparities and for joining us on Conversations on Healthcare today.

Dr. Donald Warne: I appreciate being a part of the conversations.

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Mark Masselli: At Conversations on Healthcare, we want our audience to be truly to know when it comes to the facts about healthcare 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 you have got for us this week?

Lori Robertson: We saw a heated rhetoric on both sides of the aisle when house republicans pursued a bill that would expand work requirements for the food stamp program. Let's look at these proposed changes which are part of the foreign bill. In February, the most recent month for which we have figures, 40 million people received food stamp benefits. The GOP proposed work requirements would cause 1.2 million, fewer people a month to access the benefit by 2028. Under current SNAP rules, able-bodied adult between the ages of 18 and 49 and without dependence are required to work at least 20 hours a week or participate in a qualified job training or volunteer program in order to be eligible for more than three months of benefits over a three-year period. The proposed GOP law would raise the age of those subject to the work requirement from 49 to 59 and extend the work requirements to adults with children ages 6 and older. The minimum work required would rise to 25 hours per week, 62% of those who would lose benefits would be able-bodied adults caring for children 6 or older. Another 27% would be able-bodied adult between the age of 50 and 59 without dependence. Another proposed change in the bill would cut off SNAP eligibility for those whose gross income exceeds 130% of poverty, instead of the 200% threshold for SNAP recipients in some states, that would cause another 400,000 households per year to lose eligibility. The bill failed in the house in May but the congress is expected to take up such legislation again. That's my facts check for this week, I am Lori Robertson, Managing Editor of FactCheck.org.

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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've a fact that you would 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 Healthcare.

**[Music]**

Margaret Flinter: Each week, Conversation highlights a bright idea about how to make wellness a part of our communities and everyday lives. According to statistics from the Center 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 challenge. A tribe in North 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 series of their traditional dances performed to traditional drum and music.

**[Music]**

Shadeja: Hello, my friends and relatives my name is Shadeja [PH 00:22:53] and in this segment we will be learning moments from the women's traditional dance category. A basic steps, one, two, three, four, five, six, seven, eight.

Margaret Flinter: LoVina Louie, 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 do not do it regularly, your calves will hurt, some say [inaudible 00:23:27] for 25 minutes straight.

Margaret Flinter: 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 community wide approach to wellness. In the ensuing months since the program launched, a number of participants like Ryan Ortivz [PH 00:23:49] have began to incorporate other healthy habits such as quitting smoking and losing weight.

Male: 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 design to build up endurance overtime. A community based culturally relevant fitness program leading to greater success.

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**[Music]**

Female: Drop the Pringles and let's jingle. One, two, three, four, step turn.

Margaret Flinter: Now, that's bright idea.

**[Music]**

Mark Masselli: You've been listening Conversations on Healthcare. I am Mark Masselli.

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Peace and health.

Conversations on Healthcare is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes or ever you listen to podcast. If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook or Twitter, we love hearing from you. The show is brought to you by the Community Health Center.