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Tuesday, March 19, 2013

Testimony of  
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On behalf of the  
**Friends of Indian Health**  
**American Academy of Pediatrics**

**House Appropriations Subcommittee on Interior, Environment, and Related  
Agencies:**

“Oversight Hearing- Indian Health”

Good afternoon Chairman Simpson, Ranking Member Moran and Committee Members, I am Dr. Kelly Moore, a member of the Muscogee (Creek) Nation of Oklahoma and a board-certified pediatrician. I am currently an Associate Professor at the Colorado School of Public Health at the University of Colorado Denver with the Centers for American Indian and Alaska Native Health.

I am also a retired Captain in the United States Public Health Service Commissioned Corps with 20 years of service to the Indian Health Service (IHS). During my last 10 years with the IHS I focused on diabetes surveillance and quality of care for American Indians and Alaska Natives (AI/ANs) with diabetes.

As a pediatrician, I am a Fellow of the American Academy of Pediatrics (AAP) and the immediate past Chair of the AAP Committee on Native American Child Health.

I am here today to testify on behalf of the Friends of Indian Health - a coalition of over 50 individuals and health organizations, including AAP, dedicated to improving the health care of American Indians/Alaska Natives.

In 1997, the Friends of Indian Health noted that the Senate Interior Committee in its FY97 bill report recognized that the increase provided to the IHS that year was still far below the need. At that time the budget for the IHS was \$2 billion. Today it is over \$4.5 billion.

The Friends appreciates the opportunity to testify today and address the question of whether increased Congressional funding for the IHS has been effective in improving the health of AI/ANs. I can tell you from my own experience that increases in Congressional funding have made a substantial difference in the care and treatment of children and people with diabetes.

From 1991 – 1995, I worked as a clinician among the Pima in the Gila River Indian Reservation in southern Arizona, I came to know approximately 50 teenagers with type 2 diabetes. Foreshadowing the incipient epidemic of type 2 diabetes among young people, another 75 with impaired glucose tolerance or pre-diabetes were being followed by the public health nurse case manager. Many aspects of the diabetes epidemic seemed elusive. Why were children and teenagers so severely affected by this epidemic? What roles did obesity and psychosocial factors such as depression and extreme poverty play in this epidemic? Why was optimal control of diabetes so difficult to achieve in this community? What could I do to make a difference?

Questions such as these were not my primary interest when I first considered medicine as a career. However, my motivation for becoming a physician was always linked to addressing the health needs of American Indian and Alaska Native communities—needs about which I am acutely aware, having received less than ideal care in Indian health

settings. Long waiting times, even for scheduled visits, were common and referrals to outside specialists required complex bureaucratic approvals and extensive justifications.

I chose to become a pediatrician to prevent such long-term health problems as diabetes and its devastating complications among American Indians. During my career in IHS, I interacted with state and tribal health departments. Through collaboration with other health partners, including academic institutions, advocacy organizations, professional organizations, and other government agencies, I worked to reduce health care disparities for American Indians by serving on task forces and other operational appointments, turning these administrative opportunities into real, tangible efforts to make a difference for tribal communities.

Envisioning, articulating, and working towards common goals, recognizing and grappling with limited resources desperately needed by all communities, and creating programs that value individual Native cultures, yet are generalizable and exportable to other communities, were only some of the many sensitive and difficult issues I tried to resolve through the years. Nonetheless, as an American Indian physician, I remain committed to the promotion of culturally sensitive and high quality care for American Indian and Alaska Native communities.

***Diabetes-Related Improvements.*** Diabetes care improvements have been achieved and sustained, particularly with regard to blood glucose, blood pressure and blood cholesterol levels. Improvements have also been realized in preventing the devastating complications of diabetes. For example, AI/ANs have lower-extremity amputation rates 2–3 times higher than other groups. Studies in Alaska and northern Minnesota show that prevention efforts, such as focusing on high-risk individuals for self-care foot education, providing protective footwear and routine podiatry care, have resulted in 20–25% reduction in amputation rates. When these efforts were augmented with system changes, such as team coordination, patient-tracking systems, comprehensive foot care practice guidelines, flow sheets, and outreach programs, amputation rates reduced 50–75%<sup>1</sup>.

A promising diabetes program for youth is the Together on Diabetes (TOD) initiative, a collaboration between Navajo Area IHS, local service units including the Shiprock Service Unit, and many community partners. TOD uses a Family Health Coach model and is developing a youth and family focused intervention curriculum for the prevention and treatment of diabetes among youth. TOD has involved youth focus groups, youth employees, and key community informants in their community based curriculum development. While TOD patient enrollment only started in late 2012, improvements have already been realized in the ability to provide important medical care to youth with type 2 diabetes. The overwhelming barrier to care often is dis-engagement from care. Families and patients simply sometimes do not continue to stay engaged with the care team. The Family Health Coach has accompanied pediatric patients to visits, has helped the families

navigate our often difficult health care system, and has helped the families take steps towards effective patient empowerment. This is an essential first step in achieving better health status for our youth with diabetes.

**Public Health Programs.** Throughout the IHS health system, programs have been identified to address specific health priorities. The AAP Committee on Native American Child Health has observed these programs on the ground including several facilities in Navajo that are on the verge of filling all requirements to become baby friendly hospitals. In addition, immunization rates are at an all-time high. Many sites have expanded the use of fluoride varnish and their use of school based clinics.

In addition, we have observed many programs to address healthy weight promotion in culturally-appropriate and youth-friendly ways. Those programs include the Zuni Youth Enrichment Program that works to empower youth to promote physical and emotional wellness; the Hopi running program, that incorporates youth soccer and supports its “Be Hopi, Be Healthy” Camps; and the Navajo Nation’s IINa’ Bahozho (The Good Life) Clinic, a biweekly wellness clinic taking a comprehensive team approach to addressing weight and obesity issues through the utilization of a pediatrician, exercise specialist, dietician, and a behavioral specialist to provide families with resources to promote nutrition and healthy living.

**Investments in Technology.** Telehealth is rapidly emerging as a method to improve health care in geographic areas with low population density and limited access to primary care and specialists<sup>2</sup>. Because ENT specialists are rare and ear infections and ruptured ear drums are still common, especially for children, Alaska has developed a telehealth solution—the Alaska Federal Health Care Access Network (AFHCAN)—to provide telehealth services to 248 sites across Alaska. This innovative use of a telehealth tool has improved access to care, reduced the cost of care delivery, and improved the efficiency and productivity of providers.

A 16-year review of patients referred to an ENT specialty clinic in Nome, Alaska, has shown that telehealth via AFHCAN has reduced waiting times for patients to see an ENT specialist at a field clinic. Prior to telehealth, almost half of all patients in Nome and surrounding communities waited at least five months to see a specialist. Now, waiting times have been dramatically reduced, and only 3 percent of all patients wait more than four months to see a specialist. Moreover, a recent cost analysis demonstrated for every dollar spent by Alaska Medicaid to reimburse store-and-forward telehealth, \$11.50 has been saved in avoided travel costs for beneficiaries requiring specialty care. These savings present opportunities for additional care for an already underserved population.

Another successful telehealth initiative for the Indian Health Service is the Joslin Vision Network. Diabetes is the leading cause of blindness among adults. AI/ANs with diabetes are

particularly susceptible to diabetes-related blindness, largely because only half of them get an annual diabetic eye exam. The Indian Health Service-Joslin Vision Network (IHS-JVN) Teleophthalmology Program uses telemedicine technology to provide accurate, cost-effective annual eye exams to AI/ANs. Blindness caused by diabetes can be prevented. Early diagnosis and treatment of diabetic retinopathy can reduce severe vision loss by more than 95%. Since the inception of the IHS-JVN program, the number of annual retinopathy exams has increased. The IHS-JVN Teleophthalmology Program has provided nearly 60,000 eye exams in over 80 primary care clinics to AI/AN in 23 states. Furthermore, eye exams and laser treatment of high-risk individuals are very cost effective, saving hundreds of millions of dollars each year by preventing diabetes-related vision loss.

The Friends has not only seen improvement in pediatrics and diabetes but comparing mortality rates for AI/ANs served by the IHS for the years 1996-1998 with the most current available findings from 2005-2007 show reductions in overall mortality of 11 percent, 15 percent for diabetes, 29 percent for diseases of the heart, and 30 percent for cerebrovascular disease.

But just as the Senate Interior Committee noted in 1997 there is still much to do. For example, according to the Center for Native American Youth, suicide is the second leading cause of death among AI/AN youth between the ages of 15 to 24 years old. Native teenagers experience the highest rates of suicide of any population. Alcoholism and substance abuse among AI/AN youth are also high. 22.9% of AI/AN youth aged 12 and older report alcohol use, 18.4% report binge drinking and 16% report substance abuse dependence or abuse. According to SAMHSA, AI/AN teenagers, young people and middle-aged adults have the highest rates of methamphetamine use and associated trauma in the United States.

The choice of drug use can vary from tribe to tribe. For example, in Keweenaw Bay its marijuana, in White Earth it is heroin, and in Quapaw it is meth. Rather than putting the emphasis on meth to the exclusion of other drugs flexibility and coordination of multiple approaches is needed to help individual tribes. Funding from Congress should be about establishing a Treatment/Prevention/Recovery/Law Enforcement infrastructure. A successful plan should also focus on the family. Prevention is most effective when the whole family is involved.

One rarely recognized and emerging area of concern is the disproportionate burden of health disparities experienced by AI/AN males. The most current findings reveal death rates for some age groups two to five times greater than AI/AN females for suicide, HIV/AIDS, homicide, unintentional injuries, diabetes, firearm injury, and alcohol-related deaths and 10 to 50 percent higher for cancer, heart disease, and liver disease. Of great concern but more difficult to measure, before the lives of AI/AN men are taken by alcohol, suicide, injuries and chronic diseases, they suffer from multiple debilitating physical and

mental conditions and have experienced high levels of violence and sexual abuse that appear to predispose them to much higher rates as perpetrators of domestic violence and sexual abuse. The resulting suffering and costs to their families and communities are enormous, as are the costs to the Nation's medical and judicial systems, and losses of productivity and quality of life for the many people affected.

**Contract health services.** For several years the Friends has testified before this committee about the urgent need to fully fund 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. In FY 2010, over 217,360 contract health services were denied.

The Committee is to be commended for addressing this concern through an increase in funding for this account by over \$64 million since 2010. But in spite of these increased funds, we believe that the Contract Health Services account is going to be a continuing need because the IHS and Tribal health care delivery system is predominately a primary care medical system. The IHS and Tribes operate over 600 facilities, including 45 hospitals. But only 19 of these hospitals have operating rooms. The majority of IHS and tribal sites must depend on the private sector for secondary and tertiary care.

The need to rely on private care is not going to change. But a redesign of the Contract Health system could result in care that is more timely, safer, effective, equitable and patient centered at a lower per capita cost. We strongly encourage conversations among key stakeholders to address and explore the IHS Contract Health Service system.

The Friends has for many years advocated for additional funding for prevention and early treatment programs to reduce the need for contract health services. But to implement them, the IHS has to have a sufficient health care provider workforce. Filling vacancies through loan repayment has proven to be an effective recruitment and retention tool.

**Loan Repayment.** In FY 2012, the IHS had 1,158 requests for loan repayment and awarded 507 new contracts and 316 contract extensions. Due to a lack of funds, 338 requests were denied. We are pleased to see that over 300 providers were able to continue their IHS service beyond their original obligation because this helps to build a steady workforce and provide continuity of care. In 2008, the IHS reported that the average retention period for loan repayment recipients was over seven years.

Last year the Administration did not recommend an increase for the loan repayment account. Because of the nation's fiscal crisis more graduating health professionals are looking to the public health service as an alternative to private practice. We believe, therefore, that this is an ideal time for the IHS to recruit more providers. **The Friends urges the Committee to increase funding for this account by at least \$17 million in order to fund all applications.**

Before loan repayment can be offered, dedicated, qualified health care professionals have to be recruited. Three years ago, the IHS Director commissioned a report on recruitment and retention. We were very pleased to see this action because the Friends strongly believe that if the recruitment process were improved it would have a positive effect on filling vacancies. **We urge the Committee to encourage the Service to put into action recommendations made in the report.**

Recently we were made aware that the severe cuts experienced by the agency with regard to travel and relocation expenses are creating an additional barrier to recruitment. The challenge of recruiting physicians and nurses to remote and often isolated locations is adversely affected if facilities are unable to offer candidates opportunities to visit the sites while they are making decisions about career options. Along those same lines, the lack of reimbursement for relocation expenses to move families makes it less advantageous to accept assignments farther from home. Travel restrictions not only affect recruitment programs of healthcare providers at conferences but they also have the unintended consequence of forcing facilities to use more expensive ways of filling vacancies that are not conducive to continuity of care for patients.

You have asked us to comment on actions the Subcommittee should consider within the current constrained funding environment to reduce the disparity of disease among AI/ANs.

**Early care and education.** The key to reducing disparities begins with investments in early care and education programs. For example, as outlined in the policy statement titled *Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health*, developmental, behavioral, educational, and family problems in childhood can have both lifelong and intergenerational effects<sup>3</sup>. Many American Indian and Alaska Native (AI/AN) children live in economically depressed neighborhoods of the country. Nearly one in four Native American children live in poverty, experience four times higher rates of abuse and neglect and have lower rates of educational achievement than other racial and ethnic groups in America<sup>4</sup>. During this time of budgetary restrictions, we encourage the committee to consider the importance of investing in early childhood initiatives. **Early education and care programs such as Head Start and home visitation have proven successful in improving maternal and child health**, identifying developmental issues, promoting social-emotional development and improving safety outcomes. Evidence-based programs have been proven to produce savings in health care costs and reduce the use of child and family services. Initiatives such as **Reach Out and Read** have also been effective in promoting early literacy and school readiness. Early education, combined with the increasing use of culture-based strategies should be maintained as priorities to address the effectiveness of historical trauma in individuals, families and communities.

**Research.** To effectively reduce the disparity of disease among AI/ANs the IHS health care system needs to be brought more fully into the 21<sup>st</sup> century. A key element of this goal is to employ the best and most up-to-date research possible because it is vital to understanding disease patterns and how to target newer treatments. It is difficult to effectively address health problems without scientifically defining the problem and its determinants, testing potentially promising interventions, and systematically monitoring the impact in communities which includes not only changes in health status but also community acceptability, and sustainability/costs.

You cannot determine progress unless you can measure it.

It is well-recognized that AI/AN children have a much higher burden of many infectious diseases. A well-documented example illustrates how research helped to eliminate one disease that struck AI/AN children differently than other populations.

In the 1970s the rate of *Haemophilus influenzae* type b (Hib) meningitis in AI/AN children in Alaska and the Southwest was 10 times higher than the U.S. population. The first vaccine developed for Hib disease was released in 1982. It was a single dose and given at age 2. It had no effect on rates of Hib disease in AI/AN children though it was effective in the general U.S. population. A second generation Hib vaccine was developed in the mid-1980s. This vaccine was very successful and eliminated Hib meningitis in the general U.S. population. It decreased, but did not fully eliminate Hib meningitis in AI/AN children. Why not?

Research revealed that AI/AN infants acquired Hib disease at a much earlier age (before 6 months) than the general U.S. population. The infectious organism was the same, and the pathophysiology of disease was the same, but the epidemiology of the infection was very different in AI/AN infants. The breakthrough was the development of a third type of conjugated Hib vaccine that was effective as early as 2 months. With the use of this vaccine in AI/AN infants, the rates of Hib meningitis have been reduced 99 percent and are now close to those of the general population.

For many years the IHS tracked the health status of Indian people in a publication called *Trends in Indian Health* and *Regional Difference in Indian Health*. The last issue was based on data gathered for the 2002-2003 report. We understand that the IHS has plans to resume surveillance research in several areas and we hope the new reports will examine the prevalence of disease patterns that have emerged since the last reporting like the incidence of HIV/AIDS, the determinants of the disparities plaguing AI/AN males, and drug overdoses and alcohol abuse throughout Indian Country. **The Friends recommends that the Committee not only provide additional resources for this important surveillance research but strongly urge the IHS and tribal epidemiology**

**centers to reinstate ongoing and timely surveillance research reports as a means for the IHS and Tribes to better target resources to improve the health status of Indian people.**

In conclusion, the Friends of Indian Health thanks the Committee for its continued strong support of the IHS during difficult financial times. Your actions have made a difference. According to the most recent performance measurement reports, the IHS has achieved its targets in the following areas: proportion of diabetes patients who have achieved blood pressure control; percent of diabetes patients who received good glycemic control; percentage of patients ages 1 – 15 who received topical fluoride applications; rates of children and adults who were immunized; number of patients screened for alcohol use and the number patients screened for domestic violence<sup>5</sup>. These improvements have come about due to investments in programs that improve access to care and promote health. But because the IHS program has been underfunded for so many years, there is much more that needs to be done to close the disparity gap.

We encourage the Committee to do what it can to support and go beyond the Administration’s FY 2014 budget proposal to assure that the IHS is fully staffed and will allow it to fulfill its mission to “raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level.”

We look forward to working with you to strengthen the IHS health infrastructure and improve the health care of American Indians and Alaska Natives.

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<sup>1</sup> Rith-Najarian S, Dannels E, Acton K, West Indian Med J. 2001 Mar 1-4;50 Suppl 1:41-3.Preventing amputations from diabetes mellitus: the Indian Health Service experience.

<sup>2</sup> Carroll M, Cullen T, Ferguson S, Hogge, N, Horton M, Kokesh J, *Perspect Health Inf Manag.* 2011 Jan 1;8:1d.Innovation in Indian healthcare: using health information technology to achieve health equity for American Indian and Alaska Native populations.

<sup>3</sup> Garner, Andrew, MD, PhD, et al. *Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health.* American Academy of Pediatrics. *Pediatrics.* Vol. 129. 1. January 1, 2012.

<sup>4</sup> Satkowi,Christina, New America Foundation, Early Ed blog, October 28, 2008, accessed online at: <http://www.newamerica.net/blog/early-ed-watch/2008/boosting-early-ed-services-native-americans-8001>

<sup>5</sup> Indian Health Service, FY2011, 2012 and 2013 Performance Measure, Tribal and HIS Direct Programs, accessed online at [http://www.ihs.gov/crs/index.cfm?module=crs\\_gpra\\_reporting](http://www.ihs.gov/crs/index.cfm?module=crs_gpra_reporting)

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**Kelly Moore, MD**

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Dr. Moore is a retired Captain in the United States Public Health Service Commissioned Corps with 20 years of service to the Indian Health Service (IHS). Her last 10 years with the IHS were devoted to diabetes surveillance and quality of care for American Indians and Alaska Natives, as a Clinical Specialty Consultant for the national IHS diabetes program in Albuquerque from 2002 - 2007 and as an Area Diabetes Consultant for Billings Area IHS in Montana from 1997 - 2002. She is a former member of the American Diabetes Association Awakening the Spirit Team and a former Chair of the American Indian/Alaska Native Work Group of the National Diabetes Education Program.

Dr. Moore served as the Chair of the American Academy of Pediatrics Committee on Native American Child Health (2006 – 2012) and is a Fellow of the American Academy of Pediatrics. She is a graduate of the University of Oklahoma College of Medicine and completed a pediatrics residency at the University of Oklahoma Tulsa Medical College. She also completed post-graduate training in the Native Investigator Program of the Centers of American Indian and Alaska Native Health at the University of Colorado Denver in 2006. Her research interests include urban Indian health, childhood obesity, and youth-onset type 2 diabetes.

Dr. Moore has been married to Jon Wilson for more than 30 years. They have two grown children, Matthew and Tava, and a 3-year-old grandson Dante.