

# **Biron Baker, M.D.**

## **Invited Testimony**

### **United States Senate Committee on Indian Affairs**

#### **The Honorable Byron Dorgan, Chairman**

**February 8, 2007**

Greetings Mr. Chairman and Members of the Committee:

It is an honor to be asked to testify before this distinguished body on an issue of vital importance to Native Americans at risk and diagnosed with diabetes. My name is Biron Baker and I am a Board Certified Family Practice physician. I worked for the Indian Health Service on the Fort Berthold and Standing Rock Service Units in central North Dakota for over three years. I am currently employed by Medcenter One in Bismarck, North Dakota. I am an enrolled member of the Three Affiliated Tribes of western North Dakota. My Hidatsa name is Ah Gu Ga Naha Naish. A loose translation of this would be "Stands Above." I've been asked to provide information on diabetes in Indian country.

According to the Center for Disease Control, American Indian and Alaska Natives are 2.6 times more likely to develop Type 2 diabetes as non-Hispanic whites of similar age.

Type 2 diabetes is the type of diabetes that the overwhelming majority of American Indians are afflicted with. The problem, in simplest terms, is the inability of the body to utilize its own insulin to regulate blood glucose levels. Data that I've read indicates that the prevalence of Type 2 diabetes in American Indians has increased by over 100 percent in the past 15 years, and the complications are worse in American Indians. Greater than 17 percent of all adult American Indians have diabetes and the problem is growing. The total number of diabetics in the United States is at 21 million and another 41 million are "pre-diabetic."

Comorbid conditions in Indians with diabetes outpace that of all other minority groups. When I think of health problems of our country as a whole, I can magnify those problems in Indian country without much effort. Our use of tobacco (not in the religious sense) is near 50 percent. We know that diabetics face the same risk of heart attack as someone who has already experienced a first heart attack. This is compounded by tobacco use disorder. Our rates of alcoholism and alcohol related disorders far outpace the rest of the

country and this can prevent standard of care practices for diabetics. Our diets are high in processed and fatty foods and the obesity rate is staggering. Rapid modernization of diet is implicated by several researchers as part of the problem. Primary prevention is relatively new in Indian country and it's had some success. This is area that holds great potential.

The severity of complications associated with diabetes in Indian people is readily apparent. I once worked for a man 15 years older than me and now because of complications related to diabetes he is a very ill man. He is blind, his kidneys are shutting down and he is approaching dialysis, he has lost parts of his feet, he had cardiac bypass surgery and now has congestive heart failure. At 56 years of age, this once vital retired police officer is living on borrowed time. My youngest patient with complications was a 22-year-old man from Standing Rock who had lost half his kidney function before he was diagnosed with diabetes. I was having trouble impressing upon him the need to change his lifestyle. I finally asked him to accompany me to the kidney dialysis unit so we could pick out a chair for him to dialyze in three times a week for four hours each session. That seemed to get my point across, but this is evidence of the type of resistance clinicians can face.

Quality of care at Indian Health Service facilities has been a documented problem. I have seen this problem from the time that I worked with the Indian Health Service in 1997 until today. I had a diabetic patient from the Standing Rock Reservation see me in the clinic in Bismarck with fluid in her knee joint. She had gone to the Indian Health Service facility for evaluation and was told by the physician to wrap her knee in cabbage leaves for several days. I obtained an MRI of her knee and found a torn anterior cruciate ligament. While enhancing funding for the Special Diabetes Program for Indians and standardization of care has shown some benefit, the quality of clinicians and administrators in the Indian Health Service has not followed suit. The Indian Health Service has become a haven for administrators and clinicians who would otherwise never be able to maintain employment. Sadly, the Aberdeen Area Indian Health Service seems to attract the worst of the lot. This leads to frustration in the ranks of otherwise qualified clinicians, and an exodus of skilled clinicians inevitably occurs. It is the principal reason that I no longer work for the Indian Health Service. During my time with Indian Health Service, I observed what I termed an "any warm body" philosophy. Even if clinicians were inadequate, they were kept on staff because to remove them would overwork the rest of the medical staff. In the long run, this created more problems than it solved, but administration never seemed to recognize this. Perhaps it's because the administrators I dealt with were not healthcare administrators, but rather they were people who were promoted simply because they were still with the system after many years, and surely must have learned something.

Pharmaceutical options remain a problem for Indians accessing care at Indian Health Service facilities. Many of these patients are using older insulin preparations and older oral medications because that is what the pharmacy budgets allow. Typically, Indian Health Service pharmacies run significantly over budget, and disparities still exist.

Diabetes programs can purchase glucometers, but not medications. Prevention and early intervention related to diet and exercise is not used as a standard of care on the reservation. Sulfonylurea medications are now third line oral agents, but we see patients on them as monotherapy, first line agents. Part of this is limited pharmacy budgets, but part of it also lies with medical staff ability. Even with standardized “cook book” approaches to the treatment of diabetes, the clinician must be aware of standard of care practices. Otherwise, we see an example of “the eye cannot see what the mind does not know.”

Significant care disparities exist between insured and uninsured American Indians. The insured population will often seek medical services at an off reservation private practice type of environment, and care follows what typically happens for every other insured American. Medical, diagnostic and therapeutic interventions are more readily available. The uninsured population will seek care at an Indian Health Service facility and will have that care rationed. Any procedure, test, consultation or intervention that is not deemed “life or limb threatening” will not happen. Direct care or care available at the Indian Health Service facility, is provided. Contract Health, or off site care, is doled out by the Contract Health Service committee that meets Monday through Friday mornings. Most requests for referral are impossible after May or June of each fiscal year because of depleted funds. Patients are not unintelligent, and recognize this disparity at once. One patient stands out for me. While at Fort Berthold, I was informed during a Contracted Health Service meeting that a particular patient had been waiting for a shoulder repair for four years, but that we couldn’t approve it because it wasn’t “life threatening.” I asked what he did for a living, and was informed he was a rancher. I successfully argued to the committee that a one-armed 60-year-old rancher was unlikely to be able to earn enough to eat, thus eventually threatening his life. His surgery was approved, and the now two-armed rancher sent me a note of thanks. He waited four years for something that insured Americans take for granted: good care within a reasonable time frame. Serving as the chair of the Contracted Health Service committee was one of my most distasteful duties as a clinical director with the Indian Health Service.

Administrative ineptitude within the Indian Health Service is a glaring problem. During a budget meeting, I met an administrator who did not understand his line items. It was explained to him that the numbers in parentheses were negative, and represented a deficit in that particular line item. He had been with the Indian Health Service for 20 years at that point. I worked with another administrator who was a “washed up” physician’s assistant. To my knowledge, the only decision he ever made was the one he made to retire. I knew administrators from other service units within the Aberdeen Area Indian Health Service as well. At an annual meeting of chief medical officers and service unit directors (CEO’s), one of the clinic CEO’s announced that he had just hired a physician with only one year of residency as his chief medical officer. He was very proud of this, and announced her salary as a GS-11. The rest of us chief medical officers in the room had completed three year residencies, and we were GS-15’s. People familiar with government pay scales will recognize this as a significant disparity. That the Indian Health Service will even hire physicians who haven’t completed residency training

boggles the mind. It represents setting the bar lower for the future, and encourages misfits and miscreants to apply for work with the Indian Health Service. His statement also opened a rift between medical staff present and administrators in the room, and a lively discussion ensued. Never tell an Indian Health Service physician he's overpaid; he makes half to two thirds of what his peers in private practice make. That's just for primary care. That gap is wider with specialties. The fact that the administrator was so out of touch with reality was what saddened me. All he could see was that he saved money in his medical staff budget.

There must be better oversight of self-determination efforts of tribes. Political cronyism and nepotism were in force where I worked. We once were forced to work with a dialysis unit with an unqualified nurse placed in charge. She was the tribal chairman's sister, so we tried to make do. All the staff nurses resigned in protest, and for eight months our 18 dialysis patients were bussed to dialysis units 70 to 160 miles away, several different locations, so the chairman's sister could run the dialysis unit. The chairman's solution to all this was to place his sister in charge of tribal healthcare. The dialysis unit eventually reopened, but our dialysis patients paid for it for eight months. All too often, unqualified personnel are placed in charge of self determination efforts, to the detriment of the populace. With better oversight, self determination could work. It could be mandated that such a venture not take place until qualified personnel with a plan are in place.

As bad as things seem, there are solutions. The Indian Health Service must make it a priority to hire and retain competent administrators and medical staff. The scholarship program currently in place could be expanded to include healthcare administration as well. It would seem that strong leaders in these positions would be able to eventually recruit and retain competent physicians. If those two areas were addressed seriously, quality of care would improve immeasurably. This would impact diabetes and other health issues in Indian country. While I don't usually advocate throwing money at a problem, this is a case where I make an exception. The Indian Health Service is funded at roughly 40 percent of the level needed. In some areas, the Indian Health Service has done well. With administrators and medical staff, they have not. Increased funding for enhanced and expanded training programs would make a world of difference.

The Area Offices seem to provide another layer of administration without real function. All area offices should be eliminated, and service units should have the autonomy and authority to tailor their needs to fit the needs of the population they serve. During my time with Indian Health Service, at no time was the Area Office any help; in fact, they were a constant hindrance. Any real problems I had as a clinical director or chief of staff were sent to headquarters, and I worked with them to resolve issues. Many times I found myself wondering how much more Contracted Health Service funds we would have at the service unit level if all those FTE's at the Area Office simply didn't exist. I wondered how many more patients would have "optional" joint replacement surgery, "optional" CT scans, "optional" consultations with a specialist, and so on. With completely qualified

leaders of the reservation clinics, the Indian Health Service wouldn't need Area Offices for anything.

Tribal governments and Indian Health Service administrators must work together. Poorly planned tribal ventures are based directly on poorly run Indian Health Service clinics. With qualified administrators who are real leaders, the tribal governments will learn to trust their counterparts in the Indian Health Service. I don't believe this is actually anyone's job presently. No liaison currently exists, simply mutual dislike and distrust. Cooperation would enhance patient care by preventing duplication of services, and coordination of resources.

Thank you again for allowing me to participate this morning. I would welcome the opportunity to work with any of you on these issues, and I invite your questions.