Government Shutdown Prompts Renewed Efforts to Achieve IHS Advance Appropriations

At the end of 2018 and start of 2019, the Indian Health Service (IHS) (and other agencies serving Indian Country like the Bureau of Indian Affairs) experienced a 35-day shutdown due to the failure of Congress and the President to agree on the remainder of FY 2019 appropriations. This action put the health of American Indians and Alaska Natives (AI/ANs) at risk. Tribes struggled to find ways to pay medical staff and ensure that their care was maintained. Some had to shut their doors entirely. In short, the shutdown destabilized Native health delivery and health care provider access; as well as Tribal Governments, families, children and individuals.

Because IHS is funded by Congress through the annual appropriations process (also called “discretionary” spending) Congress and the President must pass a law by September 30 of each year for the agency to remain funded. If they fail to do that – as happened this year – the agencies that have not received appropriations will shut down, creating significant disruption in the delivery of health care for AI/AN patients.

Continued on page 10

CHRs, CHA/Ps and the Special Diabetes Program for Indians

Since 1997, the Special Diabetes program for Indians (SDPI) has supported drastic improvements in diabetes outcomes among American Indians and Alaska Natives (AI/ANs). SDPI has been responsible for a 54% reduction in End Stage Renal Disease and a 50% decrease in diabetes related eye disease in AI/AN populations. The program serves over 780,000 people a year through 252 Tribal, 20 Indian Health Service (IHS), and 29 Urban programs across 35 states.

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National Indian Health Board

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The National Indian Health Board (NIHB) represents Tribal governments — both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS).

Located in Washington DC on Capitol Hill, the NIHB, a non-profit organization, provides a variety of services to Tribes, Area Health Boards, Tribal organizations, federal agencies, and private foundations, including:

- Advocacy
- Policy formation and Analysis
- Legislative and Regulatory Tracking
- Direct and Timely Communication with Tribes
- Research on Indian Health Issues
- Program Development and Assessment
- Training and Technical Assistance Programs

Project Management

NIHB continually presents the Tribal perspective while monitoring federal legislation, and opening opportunities to network with other national health care organizations to engage their support on Indian health care issues.

Raising Awareness

Elevating the visibility of Indian health care issues has been a struggle shared by Tribal governments, the federal government and private agencies. NIHB consistently plays a major role in focusing attention on Indian health care needs, resulting in progress for Tribes.

NIHB advocates for the rights of all federally recognized American Indian and Alaska Native Tribes through the fulfillment of the trust responsibility to deliver health and public health services. Since 1972, NIHB has advised the U.S. Congress, IHS federal agencies, and private foundations on health care issues of American Indians and Alaska Natives.

NIHB staff maintains communication with Area Health Boards, national Indian organizations, Tribes, and American Indian and Alaska Native people. NIHB gives voice to American Indian and Alaska Native health policy concerns through participation in national organizations ranging from the Association of State Medicaid directors to the Indian Health Service Leadership Council.

A Shared Goal - Quality Health Care

The future of health care for American Indians and Alaska Natives is intertwined with policy decisions at the federal level and changes in mainstream health care management. NIHB brings Tribal governments timely information to help them effectively make sound health care policy decisions. NIHB provides a vehicle to keep the flow of health care information in front of policy makers and Tribal governments manifesting progress in health care and strengthening Tribal sovereignty.
DEAR INDIAN COUNTRY FRIENDS AND ADVOCATES,

Welcome to the Spring 2019 edition of the National Indian Health Board’s (NIHB) Health Reporter! As always, we are excited “to advocate for the rights of all federally recognized American Indian and Alaska Native Tribes through the fulfillment of the trust responsibility to deliver health and public health services.” We are pleased to see many of you in Albuquerque, New Mexico this May for the Tribal Public Health Summit and American Indian and Alaska Native National Behavioral Health Conference! We also offer a big THANK YOU to our partners in the Albuquerque Area who have made this event possible – especially the Albuquerque Area Indian Health Board.

In February 2019, I was honored to be elected as the next Chairperson of NIHB. Throughout my tenure on NIHB’s Board of Directors, I have been humbled and honored to advocate for better health care and stronger investments for Tribal public health infrastructure and health systems in Indian Country. I am looking to you for assistance and encouragement as we, together, fight to improve the health of our people. Together we can achieve anything if we are unified and speaking with one voice.

This year continues to bring challenges for the advancement of Indian health. As we all know, the recent 35 day government shutdown imposed a great deal of undue burden and hardship on Indian health programs, and reaffirmed the need for advance appropriations for the Indian Health Service. In addition, continued challenges to the constitutionality of the Affordable Care Act – which was the vehicle for permanent reauthorization of the Indian Healthcare Improvement Act – threaten to undermine the Indian health system. At the same time, Tribal public health systems face ongoing barriers in emergency preparedness that limit their capacity to respond to emerging health threats.

But there are also new opportunities that inspire us to keep fighting: this year, Congress will need to reauthorize of the Special Diabetes Program for Indians (SDPI) – one of the most successful public health programs ever implemented. In addition, the President’s plan to end the national HIV epidemic will require marked investments in the Indian Health Service and Tribal health systems to ensure they are well-equipped to achieve the goal of HIV elimination among American Indians and Alaska Natives.

NIHB is ramping up its advocacy efforts in the field of public health. As always, we will continue reminding Congress and the Administration that the Trust responsibility extends to Tribal public health systems and that investment in the Nations’ infrastructure must include investment in the public health infrastructure of Indian Country. In this addition of the Health Reporter you will learn about important efforts NIHB is undertaking towards addressing advance appropriations for IHS, emerging environmental and climate-related health threats in Indian Country, behavioral health needs including addressing the opioid overdose epidemic, public health emergency preparedness, dental health, and the SDPI. Now more than ever, it is critical for our Tribal communities to advocate for increased resources for public health. NIHB is engaged with policymakers in Congress and the Administration to advocate for public health funding to go directly to Tribes.

You can read about all these issues and more in this edition of Health Reporter. We encourage you to provide input on this publication and all issues concerning the health and wellness of our people. NIHB is here to serve you.

Victoria Kitcheyan
Chairperson
Opportunities for Indian Country to Stay Informed and Engaged on Health IT

Recent developments in federal health information technology (HIT) have presented exciting new opportunities for the Indian Health System. The current Indian Health Service (IHS) HIT system, the Resource and Patient Management System (RPMS) supports much of the IHS, Tribal, and urban (T/U) programs that serve approximately 2.6 million American Indian/Alaska Native (AI/AN) people. However, RPMS is an older system that has struggled to maintain and keep pace with current health information technology needs.

RPMS uses the same health IT architecture as the Veterans Administration (VA), known as the Veterans Integrated System Technology Architecture (VistA). Currently, VA is undergoing HIT modernization and is adopting a commercial-off-the-shelf system (COTS) known as Cerner. Rightly so, Tribes immediately asked, "what about IHS and RPMS?"

With the VA adopting Cerner, the future viability of RPMS is at risk because the system is dependent on the VA for software development. In recent years, some Tribes have opted for COTS programs given longstanding issues with RPMS such as lack of interoperability with other electronic health records, limited software capabilities, and billing packages that aren’t robust enough to meet operational needs. The IHS, in partnership with the Department of Health and Human Services (HHS), heard Tribal concerns around the potential loss of VA support for RPMS and have begun the process to look at what’s next for Health IT in Indian Country.

In October 2018, IHS circulated a Dear Tribal Leader Letter (DTLL) that announced an initiative to research the Health IT environment of the Indian health care system. The initiative will evaluate the state of health IT identifying clinical, process, and technical gaps in order to better understand how to improve system operations. The research project team will also be looking at third party COTS, the current status of HIT, as well as the evolution into the next generation of HIT. Tribes will need to be involved throughout the process in order to make sure their needs and strengths are truly captured in this initiative.

There are also other ways for Tribes to be involved in ensuring that the Indian health care system is not left behind with the next generation of health IT. Starting last fall, the Office of the National Coordinator for Health IT (ONC) released a request for public comment on their Draft Strategy for Health IT. NIHB worked with Tribes and Tribal organizations to weigh in on the Draft Strategy by providing recommendations to the agency. The final Strategy is still being developed but it is anticipated it will be available in late 2019. In addition, earlier this year, ONC and the Centers for Medicare and Medicaid (CMS) issued proposed rules that describe interagency plans to address interoperability across the Health IT landscape. Once again, Tribes are in a unique position to voice their concerns and recommendations. NIHB is actively working with Tribes and Tribal organizations to provide comments on these important rules. However, as more agencies and departments continue to embrace new technologies and incorporate them into the health landscape, it is critically important that Indian Country stays informed and provides input. Please continue to check NIHB’s website for the latest developments on Health IT.

The Growing Importance of Medicare for American Indians and Alaska Natives and Indian Health Programs

Stay Healthy with Medicare
Preventive Services for American Indians and Alaska Natives

Medicare preventive services
**MEDICARE ENROLLMENT**

A new March 2019 report from the National Indian Health Board (NIHB) documents the level of Medicare coverage in the 37 states with Tribes and/or Indian health programs. The estimates are from the newly released 2017 5-year American Community Survey (ACS). In 2017, 13.2% of all American Indians and Alaska Natives (AI/AN) had Medicare coverage and 96% of those over 65 had some form of Medicare. About 200,000 — or 4.5% — of American Indians and Alaska Natives under 65 also had Medicare coverage due to a disability, such as the need for kidney Dialysis resulting from type 2 diabetes. In comparison, only about 3% of the overall population under 65 are enrolled in Medicare, indicating the higher disability rates for AI/ANs.

In 2010, 11% or 523,000 of AI/ANs had Medicare coverage. In 2017, it increased by 35% to an estimated 714,000 or 13.5%.1 In 2010, 122,000 of IHS patients had Medicare coverage compared to 167,000 in 2017. The 36% increase in Medicare patients at IHS funded health programs rivals the increase for Medicaid in many states.2

**MEDICARE BENEFITS**

Medicare pays for high cost hospital visits and with the addition of parts B or C, and D, Medicare can pay for costs associated with health care services including drugs, physicians, specialists, and related services and equipment needs. In addition, recent changes to Medicare promote preventive services such as screening for diabetes, breast cancer, prostate cancer, or colorectal cancer with no charge to the patient.

Medicare revenue tends to be lower than Medicaid revenue for Indian health programs, but its cost avoidance (payments to specialist, hospitals and for pharmaceuticals) exceeds that of Medicaid for the higher-needs population it covers. Per capita spending on Medicare patients is far higher than for Medicaid patients.

**MEDICARE ADVANTAGE**

The recent expansion of Medicare Advantage Plans nationally has created some difficulties for Indian health programs, including many of the same problems faced in the past with Managed Care Plans in Medicaid. Like Medicaid, Indian health programs can bill for services rendered to Medicare patients. Unlike Medicaid, however, Medicare does not afford the same protections for AI/ANs and Indian health programs. Medicaid guarantees that an AI/AN has the right to choose their Indian health care provider and that Indian health programs are guaranteed the right to be paid for these services. These simple and well-established guarantees are not in effect for Medicare. When an AI/AN chooses a Medicare Advantage Plan and still uses their Indian health care program, that program is often not paid for these services. There is a clear need for improvement in how Medicare includes Indian health programs that serve their Indian communities. NIHB is currently providing technical assistance to Centers for Medicare and Medicaid Services (CMS) to provide better accountability for Medicare Advantage plans. For more information, continue to check NIHB’s website for updates. 3

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1 Year 2017 ACS estimates

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**Are You Up-to-Date on Your Preventive Services?**

- Medicare covers a full range of preventive services to help keep elders (65+) healthy and help find problems early when treatment is most effective
- Ask your doctor about which of these services is right for you

**Preventive Service** | **Date** | **Notes**
--- | --- | ---
One-time "Welcome to Medicare" preventive visit (within first 12 months of enrolling in Medicare Part B) |  | 
Yearly "Wellness" visit (12 months after your "Welcome to Medicare" visit or 12 months after enrolling in Medicare Part B) |  | 
Abdominal aortic aneurysm screening |  | 
Alcohol misuse screening and counseling |  | 
Bone density test |  | 
Cardiovascular screenings (cholesterol, lipids, triglycerides) |  | 
Colonial cancer screenings |  | 
Depression screening |  | 
Diabetes screening |  | 
Diabetes self-management training |  | 
Flu shot |  | 
Glucoma test |  | 
Hepatitis B shot |  | 
Hepatitis C screening |  | 
HIV screening |  | 
Mammogram |  | 
Medical nutrition therapy services |  | 
Obesity screening and counseling |  | 
Pap test and pelvic exam (includes breast exam) |  | 
Pneumococcal (pneumonia) shot |  | 
Prostate cancer screenings |  | 
Sexually transmitted infections screening and counseling |  | 
Tobacco use cessation (counseling to stop smoking) |  | 

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**IHS Patients with Medicare: Estimates from the American Community Survey 2010, 2016 and 2017**

- Medicare and IHS Access (2017)
- Medicare and IHS Access (2016)
- Medicare and IHS Access (2010)
USDA Work Requirement Proposal Puts Tribal Food Programs at Risk

Access to healthy and nutritious foods can be very limited in American Indian and Alaska Native communities. The Supplemental Nutrition Assistance Program (SNAP), as well as the Food Distribution Program on Indian Reservations (FDPIR), have historically offered ways to mitigate this need.

Roughly a quarter of American Indians and Alaska Native (AI/AN) households receive food assistance, reaching as high as 80% in some communities. SNAP offers monthly benefits through electronic debit cards, which are used to purchase groceries from authorized stores. FDPIR is currently administered by the United States Department of Agriculture (USDA) through state agencies or Indian Tribal organizations (ITOs). Through FDPIR, ITOs place orders on behalf of Tribes from a list of about 100 available foods, which FDPIR then purchases and ships. Like SNAP, the FDPIR is meant to supplement a family’s food budget, but recent studies have found that as high as 60 percent of AI/ANs who receive FDPIR rely on it as their primary source of food. Because of the important role played by programs such as SNAP and FDPIR, any disruptions or changes to program eligibility can disproportionately impact AI/AN communities. The devastating impacts of the 2019 partial federal government shutdown on AI/AN communities brought home this point. For example, several Tribal FDPIR programs were strapped for administrative funds during the shutdown, leading to furloughs that caused delays in food delivery and loss of food supplies. These kinds of stories are all too common in Indian Country, and result in part from chronic underfunding of the Indian health system and Tribally-specific food programs such as FDPIR.

Following the shutdown, the Trump Administration issued a proposed rule making changes to requirements for Able-Bodied Workers without Dependents (ABAWDs) who receive SNAP benefits. Under the proposal, the Administration would cease SNAP benefits after three months for ABAWDs who do not work, volunteer or get job training for at least 20 hours a week. Although SNAP work requirements already exist, many states waive that requirement for certain regions of the state, including Tribal communities, or submit a waiver for the entire state. If the proposed rule were to go into effect, states would have a lot less flexibility to submit waivers. For instance, waivers would require the Governor’s approval before submission, and states would no longer be permitted to submit waivers for the entire state. Instead, they would have to focus waivers for areas of high unemployment.

Unfortunately, the USDA has at various times avoided engaging with Tribes on the potential impact of the SNAP rule by first indicating that the new requirements would not have Tribal implications, and later contradicting itself. NIHB sent a letter to the USDA requesting immediate and meaningful Tribal consultation on this proposal.

The ABAWD proposed rule is part of a broader effort by the administration to impose tighter work requirements on various federal programs, including SNAP and other programs including Medicaid. Programs like SNAP play a critical role in sustaining the health of AI/ANs, and it is important that Tribes continue to request exemptions from any work requirements. In addition, an AI/AN exemption must be implemented at the federal level and cannot be shifted to the states.

It is imperative that Tribes continue to request Tribal consultation with USDA over this important issue. NIHB will continue to monitor the SNAP rule as it makes its way through the rulemaking process. Please check NIHB’s website for the latest information.

You can read NIHB’s comment on the proposed rule on our website at: www.nihb.org/tribalhealthreform/wp-content/uploads/2019/04/SNAP-NIHB-comment-letter.pdf


2 Native Farm Bill Coalition, Advancing Tribal Food & Agriculture Production to Build Healthy Tribal Economies and Communities in the 2018 Farm Bill and Beyond (May 24, 2019), https://www.nihb.org/docs/06222016/Advancing%20tribal%20food%20And%20Agriculture%20production.pdf.
On the Horizon: Health Care Updates for Native American Veterans

American Indian and Alaska Native (AI/AN) Veterans are highly respected throughout Indian Country in recognition of what they have sacrificed to protect Tribal communities and the United States. Yet, many continue to give more than is required as they wait patiently for a coordinated healthcare system that can adequately meet their unique health care needs. Native Veterans are underrepresented among other Veterans who access the services and benefits they have earned; as a group, they are also more likely to lack health insurance and receive disability benefits (including but not limited to service-connected compensation).

The federal government’s trust responsibility to provide health care to all American Indians and Alaska Natives extends across each of its departments and agencies and includes the Indian Health Service (IHS) and the Veterans’ Administration (VA).

In 2010, the Indian Health Care Improvement Act (IHClA) was permanently re-authorized and included an amendment that allows the IHS to collect reimbursement payments from the VA and the Department of Defense (DoD) for services provided to eligible Native Veterans by the IHS and Tribal facilities. In October of 2010, an MOU between VA and IHS was renewed to establish coordination, collaboration, and resource-sharing between VA and IHS. Because the IHS system is chronically underfunded, it is heavily reliant on third party reimbursements from 3rd party payers like the VA. In fiscal year 2018, the VA reported its total disbursed dollar amount through reimbursement agreements at $7.69 million to IHS and $12.07 million to Tribally operated systems.

In 2012, the IHS and the VA signed a reimbursement agreement which created the path for the VA to begin financially compensating IHS, as authorized by IHClA, for direct health care provided to Native Veterans that are part of the VA system. Under this agreement, VA copayments do not apply to direct care services provided by IHS to eligible Native Veterans.

In 2017, the IHS signed an amendment to extend the reimbursement agreement with the VA until June 30, 2019. In fiscal year 2018, the VA reported the total number of VA enrolled Veterans served by IHS and Tribally operated programs through their reimbursement agreements as 2,829 (VA-IHS) and 2,531 (VA-Tribal) respectively. As the VA continues to strengthen its relationship with Tribes through the reimbursement renewal process, Tribes look forward to consulting with the federal government on how healthcare delivery to Native Veterans can be improved.

The National Indian Health Board (NIHB) remains dedicated to lifting the unified voice of the Tribes on this important healthcare topic. The following recommendations for improving care for Native Veterans are part of NIHB’s 2019 Legislative and Policy Agenda.

Tribal Recommendations:
• IHS and Tribal providers should be exempted from any value-based reimbursement scheme for other VA providers.
• Exempt all Native Veterans from copays and deductibles at the VA in accordance with the federal trust responsibility.
• Allow IHS and Tribal providers to be reimbursed by the VA for services provided under the purchased/referred care program.
• Pass legislation authorizing a Tribal Advisory Committee at the VA.

Last month, the Government Accountability Office (GAO) released a follow-up report to its 2013 report regarding strengthening care for Native Veterans. The new report, titled, “Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans” (GAO-19-291) provides updates to the 2013 recommendations regarding implementation of the IHS and VA MOU. In the 2013 report, the GAO identified opportunities to effectively implement and monitor the MOU and provided strategies for overcoming key challenges.

In recent years, Congress has sought to address the need for increased visibility of the unique status and concerns of Native Veterans within the U.S. Department of Veterans Affairs. Senator Jon Tester (D-MT) reintroduced legislation to create a Tribal Advisory Committee (TAC) at the Department of Veterans Affairs (VA) to advise the Secretary on Tribal issues. The bill (S. 524) would ensure Tribes have the ability to inform and advise the Secretary of the VA on matters impacting AI/AN veterans. The VA TAC would meet at least twice annually with the VA Secretary under the legislation, and would also submit an annual report with Tribal recommendations to the Department and to Congress.

NIHB looks forward to supporting Tribes as they work to ensure their warriors are receiving the healthcare services they need.
With the goal of preventing and treating diabetes, SDPI is both reliant on and supports a variety of public health and healthcare professionals working in Indian Country. For example, Community Health Representatives (CHRs) have been vital in supporting the prevention and management of diabetes in Tribal communities, and as health navigators, they also work to increase access to diabetes treatment. In Alaska, Community Health Aides/Practitioners (CHA/Ps) work to provide healthcare services to diabetic and pre-diabetic patients in rural Alaskan Native communities.

**COMMUNITY HEALTH REPRESENTATIVES: A CRITICAL PARTNER FOR SDPI PROGRAMS**

Last year, when the CHR program was proposed for elimination in the FY 2019 President’s Budget, the National Indian Health Board (NIHB) collected stories from AI/AN people across the nation to learn about the role CHRs play in their communities, receiving roughly 400 responses from across Indian Country. The responses reiterated what has long been recognized in Indian Country—CHRs deliver vital culturally appropriate health services to people across the nation, including services related to diabetes prevention and management. Fortunately, Congress restored program for the CHR funding for FY 2019 after continued advocacy from Tribes and NIHB. However, the program is again slated for dramatic reduction (62%) in the FY 2020 President’s Budget request.

The Indian Health Service (IHS) established the CHR program in 1968 with the goal of developing a competent public health workforce who directly interact with their community and provide services including health education, care management, and transportation. According to the IHS Principal Deputy Director, Rear Admiral Michael Weahkee, “their work is especially important because they are front-line public health workers who are trusted members of the community. Their understanding of the languages and traditions promotes cultural competence in delivering health services.”

SDPI and Tribal Diabetes Prevention Programs (DPP) employ CHRs to teach classes on diabetes prevention, provide foot screenings, run diabetes clinics, develop and coordinate community programs on healthy behaviors and other public health interventions, and screen for diabetes and co-morbidities such as high blood pressure and blood sugar. They also assist in translating complex health information by teaching diabetes self-management. CHRs often perform these services in patient’s homes, and also provide transportation when needed to medical appointments and serve as a vital linkage for patients and the health care system.

**COMMUNITY HEALTH AIDE PROGRAM: PROVIDING DIRECT ACCESS TO DIABETES CARE IN ALASKA**

Data estimates show that the percentage of Alaskan Native adults with diabetes has increased from 3.4% in 1991 to 7.5% in 2017. Alaska is home to 229 federally recognized Tribes, many of which are located in remote areas with limited critical and health infrastructure, thus complicating accessibility of care, including diabetes treatment.

The CHA/P program has been one of the answers to this challenge. Currently 550 CHA/Ps provide healthcare in over 170 rural Alaska Villages. CHA/Ps receive training in clinical skills, and like CHRs, provide culturally appropriate services as members of the community they serve.

To supplement the basic training all CHA/Ps receive, the Alaska Native Tribal Health Consortium (ANTHC) provides the “Advanced Diabetes Health Aide Course,” a training that covers patient-centered diabetes management, treatment and prevention. SDPI funds the program, which increases access to providers offering specialized experience in diabetes treatment.

**TWO APPROACHES IN THE FIGHT AGAINST DIABETES**

While the FY 2020 President’s Budget proposed $20 million for the creation of a national CHA/P initiative, it also called for roughly $39 million in cuts to the CHR program. While a nationalized CHA/P program would increase clinical healthcare access for AI/ANs across the U.S., cutting the CHR program would likely curtail access to preventive care and other public health services.

IHS’s budget justification explains that they will be phasing out the CHR program, eventually replacing it with the National CHA/P program. The justification fails to acknowledge that CHRs and CHA/Ps provide vital and different services to Tribal communities across the nation. While CHRs serve the community through prevention, education, and programming, CHA/Ps generally work with patients to improve their individual health.

The budget justification does not clarify how the CHR role and programs focused on prevention, education, and self-management training will be sustained with this proposed shift towards a CHA/P model that is more clinical and focused on treatment. It is important for Tribal leaders, advocates and policy makers to explore how primary prevention efforts, such as public health education, might be affected by the phase-out and possible elimination of CHRs. In addition, there are lingering questions about how SDPI programs that rely on CHRs would be affected by such a shift. At the same time, it is critical to also explore how CHAP expansion may work in conjunction with the existing CHR program to provide comprehensive diabetes prevention, treatment, and resources. Diabetes is one of the many health challenges that both CHRs and CHA/Ps tackle. Policy makers will need to consider how they can promote the a comprehensive system of prevention, community engagement, screening, and high quality health care needed to reduce health disparities faced by AI/AN people.
**SDPI Expires on September 30 – What to Expect, and How You Can Help!**

Tribes are once again advocating for Congress to renew the Special Diabetes Program for Indians (SDPI), a widely successful public health program providing funding for diabetes prevention, treatment, and management programs across Indian Country. In early 2018, Congress renewed the program through September 30, 2019.

Congress established SDPI in 1997 to address the disparity in type 2 diabetes rates between American Indians/Alaska Natives (AI/ANs) and other population groups. Together, with the Special Diabetes Program (SDP), which funds research into type-1 diabetes prevention and treatment, Congress structured the program as “mandatory” funding. Unlike discretionary programs, mandatory programs (like SDPI) are not impacted by yearly funding negotiations because Congress funds the program at the same time it authorizes it. But that also means if the authorization expires, there is no more funding available.

Since SDPI’s creation 22 years ago, Indian Country has made remarkable progress in tackling diabetes. According to Indian Health Service (IHS) Tele-ophthalmology data, diabetic eye disease rates have been cut in half. In 2014, IHS reported to Congress that the average blood sugar levels in AI/ANs decreased from 9.0 to 8.1 from 1996-2014, leading to an almost 40% average reduction in risk for diabetes related health complications. That 2014 report also showed the average amount of bad cholesterol in AI/ANs fell from 118 mg/dL to 92 mg/dL, thus reducing the risk of cardiovascular health issues.

Over the lifetime of SDPI, the incidence rate of End-Stage Renal Disease (ESRD) fell by an astounding 54% among AI/ANs, the largest decline of any demographic! ESRD is one of the largest drivers of Medicare costs, costing roughly $88,000 per patient per year for dialysis treatment. Thus, in addition to saving lives, SDPI is also helping reduce Medicare costs. This is a powerful talking point when speaking with lawmakers about SDPI renewal.

As a first step to renewing the program in 2019, Tribes asked their representatives to sign onto a letter from the House Diabetes Caucus, co-chaired by Congresswoman Diana DeGette (D-CO) and Congressman Tom Reed (R-NY). At the time of this writing, over 300 of the members of the House of Representatives signed onto the letter, including at least 69 of the 104 members who represent Tribes.

The Senate Diabetes Caucus, co-chaired by Senators Susan Collins (R-ME) and Jeanne Shaheen (D-NH), also authored a letter that is still collecting signatures as of April 2019. In 2016, the Senate Diabetes Caucus circulated a similar letter in support of SDP and SDPI and received signatures from 75 members of the Senate.

Using the strong support from lawmakers for the letters as a tool, Tribes then advocated for their main priority for SDPI: long term renewal with a funding increase of $50 million per year, so that SDPI would be funded at $200 million each year.

The Senate Committee on Health, Education, Labor, and Pensions (HELP Committee) introduced SDPI renewal legislation early in 2019. The committee’s bill, S. 192, would renew SDP and SDPI for five years—the longest period in recent history— but would maintain its current funding level of $150 million. Historically, Congress renewed the program only in increments of one to two years, requiring continued advocacy by Tribes. The proposed five years of funding would give Tribes the stability and certainty that their funding would remain in place, helping the Tribes recruit and retain top quality staff and plan in the longer term.

Unfortunately, Congress hasn’t increased funding for SDPI since FY 2004. Over the course of that time, more than one-third of the program’s funding has been eaten up by medical inflation. For SDPI to have the same buying power as in 2004, Congress would need to fund the program at $234 million, an $84 million annual increase over the $150 million spent on SDPI in 2019. This does not take into account the additional Tribes who have achieved federal recognition during that time and the skyrocketing costs of diabetes care. Clearly, the increase in funding is long overdue.

SDPI expires on September 30, 2019. Tribes are not waiting until then to show Congress the impact the program is making on their communities. We encourage you to reach out to your Members of Congress and urge them to support long-term SDPI renewal! This can include hosting a site visit for your member of Congress at your SDPI program, talking to legislative staff at their local or Washington DC office, or attending a Congressional town hall in your area.

For additional resources on SDPI, including factsheets for education and advocacy and a SDPI site visit guide please visit www.nihb.org/sdpi.
Continued from page 1 — Government Shutdown Prompts Renewed Efforts to achieve IHS Advance Appropriations

One way to avoid this situation in the future is for IHS to receive “advance appropriations.” For the better part of a decade, Tribes and Tribal organizations like the National Indian Health Board and National Congress of American Indians have been asking for a change to the federal appropriations schedule that would require that the IHS budget be passed one year ahead of when the funding would be spent. This way, IHS and Tribal health programs would not be subject to shutdowns or even short term continuing resolutions (CRs).

Every year since 2006, Congress has not been able to pass the full appropriations bill by the start of the fiscal year, so they provide short term funding through a CR, which grants the agency level funding until the full appropriation can be enacted.

This issue has been studied by the Government Accountability Office (GAO). They noted that IHS and Tribal providers have significant challenges recruiting and retaining health providers with the current system of continuing resolutions and delayed full-year appropriations. GAO also found that IHS and Tribes are given significant administrative burdens due to the fact that the IHS has to modify hundreds of contracts each time there is a CR. In addition, the GAO reported that “uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs” (GAO-18-652).

LEGISLATIVE ACTION

With the devastation of the government shutdown a recent memory, Tribes have doubled down on efforts to get Congress to allow advance appropriations for the IHS. At the time of this writing, three pieces of legislation have been introduced to provide IHS with advance appropriations. S. 229 and H.R. 1128 – the Indian Programs Advance Appropriations Act – introduced by Senator Tom Udall (D-NM) and Congresswoman Betty McCollum (D-MN), respectively, would provide advance appropriations for both the IHS and BIA. H.R. 1135 – Indian Health Service Advance Appropriations Act – introduced by Congressman Don Young (R-AK) – would provide advance appropriations for IHS only. A Senate version of this bill is coming soon. All of this legislation has bipartisan support.

There are also several other procedural hurdles that must be overcome. Each year, Congress passes a “Budget Resolution” with governs how the appropriations process for the coming year will work. Typically, the Budget Resolution has limited how much and for what purpose advance appropriations can be made. Therefore, IHS would need to get a specific exemption in the budget resolution similar to what is given to the Veterans’ Health Administration which receives advance appropriations.

On April 8, 2019, Congressman Markwayne Mullin (R-OK), a member of the Cherokee Nation, offered an amendment on budget legislation resolution that would have allowed for IHS advance appropriations in FY 2020. However, that amendment was not made in order, and therefore, not allowed to be considered by the full House of Representatives by the Rules Committee. It failed on a party line vote.

NIHB has been working with Tribal leaders to make our case at the Budget Committee. In February, NIHB Board Chair Victoria Kitcheyan and several other Tribal leaders met with Budget Committee Chairman John Yarmuth (D-KY) and other members of the House Budget Committee. NIHB also coordinated a letter from the Congressional Native American Caucus that was sent to the Budget Committee in support of advance appropriations. That bipartisan letter garnered 60 signatures including several leaders from the House Appropriations Committee.

We continue to work with our colleagues in the Senate as well. Also in February, the NIHB Board met with Senator Lisa Murkowski (R-AK) who is one of the Senate champions on the measure. We also work closely with staff at the Senate Committee on Indian Affairs to advance this effort. The Board has also met with leadership at the Department of Health and Human Services to ensure that the Department includes support for advance appropriations in future budget requests to Congress.

But we need your help! The challenge to achieve advance appropriations is great. NIHB encourages all Tribes to reach out to your Members of Congress to support the introduced legislation. This change will help honor the federal trust responsibility and greatly improve the care for AI/ANs. You can view resources on our website at: https://www.nihb.org/legislative/advance_appropriations.php
Momentum Continues in Fight for Tribal Oral Health Access

Tribes have long advocated for dental therapy as a solution to Indian Country’s oral health crisis. Alaska Native communities have employed midlevel focused providers under the Community Health Aide Program (CHAP) since 2004, and Tribes across the country have seen the success dental therapists bring. But because of problematic and ambiguous language related to use of dental therapists in Tribal communities in the Indian Health Care Improvement Act, Tribes wanting to hire dental therapists under CHAP need permission from their state.

In 2018, Arizona and Michigan passed legislation related to Tribal dental therapy. In 2019, three new states joined the fold, and now Tribes in nine states can employ dental therapists to lessen a severe provider shortage and restore oral health.

More recently, New Mexico Tribes achieved the passage of dental therapy legislation after over eight years of continued advocacy. In session after session, advocates worked to build support among state lawmakers only to see the legislative session end before a successful vote on dental therapy. In 2018, the state House approved legislation overwhelmingly, but the state Senate did not hold a vote.

Finally, in 2019, Tribes in New Mexico succeeded in passing House Bill 308 into law. The new dental therapy law will allow Tribes to hire dental therapists and tackle their oral health issues. Under the new law, dental therapists working for New Mexico’s Tribes will not have to become dental hygienists first, ensuring that the profession remains accessible and attainable for community members. Tribal educational institutions in New Mexico are already talking about developing dental therapy education programs.

The 2019 legislative session also saw remarkable success in Idaho, where Tribes worked closely with the state legislature to pass Tribal dental therapy legislation. The new law allows Tribes to hire dental therapists following the standards approved by the Commission on Dental Accreditation, the same standards as used in Alaska. With Idaho’s new law, every state in the Portland Area now has Tribal dental therapy. Swinomish Tribe in Washington State hired a dental therapist in January 2016, and Port Gamble S’Klallam followed suit shortly thereafter. Oregon Tribes have employed dental therapists as part of a state pilot project since 2017.

Montana Tribes were successful in passing House Bill 599, a compromise bill that authorizes dental therapists to practice under CHAP with CODA standards like in Alaska. However, negotiations with the state legislature removed the restorative services, such as fillings and extractions, under a dental therapist’s scope, so dental therapists will only be able to perform preventative health services in the state for now.

To further the momentum for Tribal dental therapy, the National Indian Health Board has teamed up with Community Catalyst and the National Coalition of Dentists for Health Equity to form the National Partnership for Dental Therapy. The Partnership will be a key resource for dental therapy advocates, and information has been added to the Partnership’s website, www.dentaltherapy.org. As more and more states see the success that dental therapy has brought to Alaska’s Tribes and the Pacific Northwest, the Partnership will ensure that the Tribal voice remains at the forefront of the dental therapy movement throughout the nation.

Dental therapy works for Tribes because it comes from the Tribes. Across every dental school in America, only four graduates in 2019 are American Indian or Alaska Native. As for Alaska, where dental therapists have worked in Tribal communities for 15 years, the Alaska Dental Therapy Education Program will graduate seven women, all of whom are American Indian or Alaska Native. This empowering workforce model is changing the narrative of Indian health. Dental therapy came from Tribes, and it now provides a path for Tribes in a growing number of states to restore oral health to their communities.

#GoDentalTherapists
At the Intersection of the Opioid Crisis, HIV and Viral Hepatitis – Successes, Challenges, and the Need for Direct Funding

Public conversations around the national opioid crisis have tended to focus on its link to unparalleled increases in rates of substance use disorders and overdose deaths.

Less public attention has been afforded to how the crisis has also triggered alarming spikes in co-occurring infections such as HIV and Hepatitis C (HCV), resulting from increased injection drug use and sharing of needles and other injection equipment infected with the viruses. Last year, when Congress passed the SUPPORT for Patients and Communities Act – legislation that authorized billions of dollars for opioid prevention, treatment, and interdiction efforts, including direct set-asides for Tribal governments – lawmakers omitted new monies for HIV and HCV prevention and treatment. This is despite the fact that, between 2004 and 2014, treatment admission for opioid injection increase by 622% among 18 to 29 year olds, while acute HCV infections increased 400% among the same age group – demonstrating the strong link between the epidemics.

During the 2019 State of the Union address, President Trump announced the goal of eliminating HIV by 2030, and called on Congress to make marked investments in prevention and treatment. Given the close link between HIV and HCV, the President’s plan also requests significant federal funds for HCV. Both of these issues are of great concern for American Indian and Alaska Native (AI/AN) communities, but historically, Congress has not directed funds to Tribes or into the Indian health system to mitigate the burden of these illnesses.

Without adequate and sustained funding, Indian Health Service, Tribal, and urban Indian (collectively I/T/U) facilities have been forced to cobble together limited resources from disparate sources to undertake prevention, testing and even treatment services.

Notably, however, the FY 2020 President’s budget requested $25 million for HIV and HCV prevention and treatment for the Indian Health Service (IHS) – which, if appropriated by Congress, would be the single largest investment ever to address these issues in Indian Country.

The $25 million request is timely and significant. From 2002 to 2016, incidence rates for HCV remained highest among AI/ANs, who also experienced the highest HCV-related mortality rate nationwide at 10.8 deaths per 100,000. From 2010 to 2016, overall HIV diagnoses among AI/ANs increased by 46%. Among Native women, 31% of new infections had injection drug use as the mode of transmission. Not only is this the highest percentage of any demographic, it further conveys the intersectionality of the opioid crisis and infectious disease – a clear call to lawmakers to ensure that federal dollars are flexible enough for communities to address all potential health impacts of the opioid epidemic.

However, the President’s budget request incorporates the $25 million into the overall spending for IHS, and it is unclear how this additional funding would impact services already being received at IHS. It is critical that Tribes tell Congress that this funding should not impact other needed services at IHS, and Tribes should direct how the funding will be disbursed.

Tribal Nations and IHS facilities have found creative ways to reduce the spread of HIV and HCV and expand access and delivery of care, despite a scarcity of funding opportunities. For example, in 2015, the Cherokee Nation of Oklahoma became the first Tribe in the country to launch an HCV elimination initiative. Cherokee Nation set an impressive goal – to screen 80,000 people between the ages of 20 and 65 and link as many of the patients with positive test results to curative treatment. Thus far, the Tribe has reported 1,200 positive test results. Of those, more than 680 were successfully linked to treatment or have been cured of the infection, at a cure rate of 90%. The notable success of the Cherokee HCV Elimination Initiative has achieved both national and international recognition, including an award and honor ceremony for the Tribe’s infectious disease director, Dr. Jorge Mera, during a National Hepatitis Testing Day event held at the White House in 2016.

Two years after the launch of the Cherokee Nation program, in 2017, the Lummi Nation in Washington State launched a similar elimination initiative after discovering disproportionately higher rates of HCV cases in their service population. The Tribe began sending their providers to the University of New Mexico Project ECHO HCV Training Program to build internal capacity for screening and treatment of the disease. And after acquiring new FibroScan Technology – the first FDA-approved medical device specifically for detecting liver disease in adults – Lummi Nation is now also on track towards HCV elimination among their Tribal citizens and patients.

Similarly, the Phoenix Indian Medical Center (PIMC) has been nationally recognized as an HIV Center of Excellence despite relying on a very small amount of competitive grant funding from the Secretary’s Minority AIDS Initiative. With over 300 HIV patients from all across Indian Country, the PIMC HIV Clinic
is the largest in all of the IHS. The program's focus on providing services that align with the HIV continuum of care has been remarkably successful. Ninety-three percent of patients are adhering to treatment and 92% are achieving what is known as viral suppression—meaning the HIV virus is undetectable in their blood, reducing the chance of transmission to near zero.

All of these initiatives showcase the great work being done across Indian Country to address HIV and HCV. Indeed, it is a testament to what Tribes can do despite a lack of consistent funding. While the President’s Budget request for $25 million for IHS to address both issues is certainly a good start, it must be sustained and increased over time to achieve the goal of elimination.

According to the IHS, roughly 40,000 AI/ANs are living with HCV. Because IHS receives discounted prescription drugs through the Veterans Administration (VA) Pharmaceutical Prime Vendor Program, it only costs around $7,700 per patient for a 12-week HCV treatment regimen using a standard medication, which is much lower than the national average. Despite the lower cost of treatment, however, it quickly becomes clear that a one-time $25 million investment will not fully cover treatment for the roughly 40,000 AI/ANs living with the disease. Thus, continued advocacy on part of Tribal Nations and organizations is essential to pursue the maintenance and expansion of these newly created investments.

As Congress deliberates on funding levels for HIV and HCV programs for FY 2020, it is critical that Tribal representatives continue their advocacy efforts to ensure that prevention and treatment funds reach Tribes and the Indian health system directly. Reoccurring and designated funding for Tribes and IHS is the most effective way to turn the tide on these epidemics in Indian Country. As the only national Tribal organization serving all 573 federally-recognized Tribes in the health arena, the National Indian Health Board (NIHB) is committed to working alongside Tribes and Tribal organizations to ensure the federal government is honoring its trust and treaty obligations for healthcare and public health services for American Indian and Alaska Native people. Achieving the highest potential health status for AI/ANs cannot be achieved unless Congress and the federal government also provide direct and sustainable funding to address HIV and HCV in Indian Country.

Tribes were unable to receive IHS funds during the most recent 35 day government shutdown, forcing them to supplement funding from Medicaid, Medicare, the VA, and private insurance to keep facilities open and running. Even though IHS, Tribal, and most urban Indian facilities remained open during the shutdown and essential staff were required to continue providing medical care without pay, non-essential administrative staff were furloughed, placing incredible strain on providers. For example, there were no front desk staff to coordinate appointments or assist with logistics in many locations. Procurement staff could not acquire additional supplies once they were used up. Some Tribal communities even lost medical providers because of the lapse in pay, further complicating access to healthcare for an Indian health system that already faces chronic healthcare workforce shortages and challenges in recruiting and retaining providers. Moreover, the government shutdown forced an even greater reliance on third party revenue, which already constitutes as much as 13% of the IHS budget and an even larger percentage for Tribally-run health systems.

Ever since Tribes were granted the authority to bill Medicaid in 1976, third-party revenue has played a crucial role in supplementing IHS funding for Tribal Health Programs. According to IHS, for FY 2017, third party revenue reached $1.02 billion. This amount does not even take into account the entirety of Tribal health programs collected in third party reimbursement.

NIHB heard from many Tribes that the only reason they were able to stay open and provide services during the shutdown was because of Medicaid. Angie Wilson, Health Director for the Washoe Tribal Health Center, noted that the Washoe Tribe called upon State Medicaid agencies to perform on-site Medicaid determinations at its facilities during the shutdown. Enrolling qualified patients into Medicaid enabled the Tribe to supplement funding to its clinic and keep services available. Ms. Wilson and her staff also identified the 50 most used PRC providers, and embarked on a road trip at the start of the shutdown to meet with the PRC providers in person. "We asked the PRC providers to defer our payments until the shutdown ended, and the vast majority agreed to work with us," Wilson said. This enabled patients who needed specialty care to not fall through the cracks during the shutdown. Brokering these relationships allowed Washoe members to sustain healthcare, which, according to Wilson, is the ultimate goal.

Stories like the one from Washoe are not uncommon. The critical resources that Medicaid and other third party resources deliver to the Indian Health System cannot be overstated. Without third-party funding, staying financially afloat is difficult for many Tribes. While IHS is funded through the end of the fiscal year, there remains the possibility of another federal shutdown in FY 2020 unless Congress passes a full budget or continuing resolution before September 30, 2019. In addition, it is critically important that policy barriers like Medicaid work requirements and cap limits are removed for AI/ANs in order for the Indian health System to continue to access these critical resources in fulfillment of the government’s treaty and trust responsibility to provide health care for all American Indians and Alaska Natives.

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### Third Party Revenue – Lifeline During Government Shutdown

Medicaid and third party resources are critically important in filling the gap created by chronic underfunding of the Indian Health Service (IHS). This was clearly demonstrated by the recent 35 day partial government shutdown.

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*Did you know that your third party money helps support this clinic? Look around and see your "THIRD PARTY AT WORK"*
Tribes More Vulnerable to Climate Change, But Leading the Way to Adaptation

Climate change is impacting health across the US in a variety of ways. Air pollution, rising temperatures, higher levels of pollen, and longer pollen seasons are leading to more severe and frequent respiratory problems including allergies and asthma. Climate change can also lead to extreme weather events such as floods, droughts, and wildfires, which can destroy homes and livelihoods, damage nutritious food supplies, and reduce access to safe drinking water. As climate change progresses, communities worldwide are experiencing harmful changes to their environments. Although climate change will impact all people worldwide, especially as temperatures continue to rise, many American Indian and Alaska Native (AI/AN) communities are being disproportionately impacted, especially in places like Alaska where thawing permafrost, loss of sea ice, and coastal and river erosion are prompting the relocation of Alaskan Native communities.

Tribal communities can be particularly vulnerable to the health effects associated with climate change for a variety of reasons. For example, AI/AN people suffer from much higher rates of chronic lower respiratory diseases. When air quality decreases, our people are much more vulnerable to dangerous asthma attacks and other acute respiratory disorders. Health effects can also be exacerbated by other types of systemic inequities. An underfunded Indian health care system makes environmental damage more devastating to Tribal communities. Health impacts from environmental damage create an even greater need for health care, adding pressure to an already overburdened health system. Many Tribal communities are also impacted by poverty and high unemployment rates, increasing their vulnerability to negative health outcomes and reducing their options for alternative solutions.

Sometimes the impacts are indirect, but equally damaging. For example, AI/ANs have higher rates of type 2 diabetes, with more than 50% of adults in some AI/AN communities diagnosed with diabetes. Traditional foods are one of the successful approaches to prevent or manage diabetes. Unfortunately, damage to the environment almost always harms traditional food practices, taking away an extremely important tool to challenge this health disparity. Purchasing food can also be prohibitively expensive for many AI/AN people due to poverty and high rates of unemployment on many reservations. Nearly one quarter of AI/AN families already live below the poverty line.1

Traditional foods can also provide cultural and emotional benefits for community members. In the Village of Wainwright, in Northern Alaska – as in many rural northern villages – the range of groceries available is generally limited, many options are expensive, and the available food is frequently unhealthy and highly processed. Subsistence activities can be important, not only for food security, but also for recreation and cultural activities as well as spirituality and cultural identity.

“Hunting and sharing food is not just a way to meet your basic needs, but is part of the fabric of social life,” explains Dr. Kirmayer, director of McGill University’s social and transcultural psychiatry unit, quoted in a 2017 New York Times article. 2 “You can find another way to get your calories, but in so doing, you may be losing companionship, solidarity and your sense of self,” he continues, adding that traditional food is closely connected to mental wellbeing and an indigenous “ecocentric” conception of self where “the food ‘becomes you.’” Unfortunately, unpredictable environmental conditions in the Arctic are leading to safety challenges with participating in traditional hunting and gathering activities. In Alaska and across the nation, climate change is causing seasonal shifts and changes in growing cycles and animal migration patterns change, affecting gathering techniques and schedules.

There are other special considerations for the Arctic’s unique communities, which are warming twice as fast as the rest of the

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planet. Eighty-six percent of Alaska Native villages are at risk of climate-related damage such as flooding and erosion, and 31 villages meet the criteria for long-term relocation. Additionally, Alaska Native people traditionally store food in permafrost ice cellars buried in the ground, but the warming Arctic can make this less safe or reliable. In communities with no roads in or out, changing weather patterns can also upend traditional means of transport, leading to isolation and requiring alternate methods of transportation which can lead to unintentional injury or death as well as mental harms such as isolation, depression, stress, anxiety, suicidal ideation, substance abuse, and domestic violence.

Environmental damage causes significant harm not only to AI/AN health but also to general wellbeing, including damage to homes, cultural sites, and sources of income/subsistence for AI/AN people and their traditional ways of life. Consequently, health suffers not only when Tribal people experience physical problems, but also when they are deprived of their connection to their lands, cultures, and traditions.

These examples only begin to address how climate change is impacting Tribal communities. Tribal communities are extremely resilient and many Tribes are working—often with very limited resources—to address these impacts on their communities. As Swinomish Indian Tribal Community Elder Larry Campbell stated, “We have been here for more 10,000 years and we will be here for 10,000 more.” In recognition of the non-physiologic health impacts to traditional ways of life, his community has defined health using factors such as sense of place, self-esteem, and identity.

To help respond to these threats, the National Indian Health Board (NIHB) hosts the Climate Ready Tribes initiative, funded by the Centers for Disease Control and Prevention (CDC). The overall goal of this work is to build Tribal capacity related to Tribal climate health—by increasing Tribes’ knowledge and awareness of climate change, by increasing Tribes’ ability to recognize threats, and by providing support for Tribes to take action. Activities include hosting a Climate and Health Learning Community, sharing national resources, and funding Tribes to conduct local climate and health-related work.

This year, NIHB has selected four additional Tribes to receive funding: Kaw Nation (Oklahoma), Lummi Nation (Washington State), the Pala Band of Mission Indians (California), and the Sitka Tribe of Alaska (Alaska). NIHB is now in its third year of the CRT project and looks forward to welcoming this new cohort of Tribal awardees. The new awardees join the previous cohort: Swinomish Indian Tribal Community (Washington State), the Village of Wainwright (Alaska), and Blackfeet Nation (Montana). This new cohort of Tribes are working on activities as diverse as creating a community-driven adaptation plan, leading inter-Tribal collaboration and resource-sharing by forming an inter-Tribal workgroup, sampling biotoxins generated by harmful algal blooms, creating and implementing a community education campaign, and hosting a regional workshop to address marine threats. Contact Angelica Al Janabi at aajanabi@nihb.org to learn more about this project or join our listserv and stay tuned for more information about this project!

Examples of traditional foods include clams, whale (whole skull pictured), and cloudberries.
Spring Showers Bring More Than May Flowers

Emergency preparedness and response refers to the steps taken before, during, and after natural and man-made disasters or emergencies to ensure public safety. There are four phases of emergency management that complete the life cycle of a disaster/emergency. These four phases are: 1) Mitigation – preventing or reducing the effects of future disasters/emergencies; 2) Preparedness – preparing equipment and resources for when a disaster or emergency occurs; 3) Response – responding to a disaster/emergency and; 4) Recovery – recovering from a disaster/emergency.

Preparing for an emergency before it happens ensures that plans are in place, equipment is available and ready to use, and personnel are properly trained. While public safety and well-being depends on planning and response to help minimize the effects of disasters and emergencies, emergency management is not a one size fits all approach. For example, planning for, responding to, and recovery from manmade or natural disasters and emergencies in American Indian and Alaska Native Tribal communities can pose unique challenges. These challenges are in part due to lack of resources, Tribal jurisdictional complexities, as well as a general lack of understanding of these unique issues among partners working with Tribes. As a result, preparedness and response efforts may differ from efforts outside of Indian Country.

CURRENT EMERGENCY IN INDIAN COUNTRY: FLOODING

Spring storms can bring tornados, heavy rain, and flooding, which recently impacted areas of the Midwest, especially Tribes in South Dakota. Tribes such as the Cheyenne River Sioux Tribe and the Oglala Sioux Tribe were in a state of emergency in March due to rapidly melting snow and severe storms that resulted in massive flooding. The flooding left many stranded for up to two weeks where some areas were only able to receive supplies via horse, boat, or helicopter. Lack of infrastructure, equipment, training and manpower added to the disaster’s impact.

Flooding can have devastating effects on a community ranging from power outages, to loss of clean water and access to food, to losing one’s home. One way to help mitigate the effects is to prepare ahead of time. Below are some tips and suggestions.

PREPARATION BEFORE A FLOOD

Living in a remote area may cause Tribal communities to shelter in place until resources arrive. Some ways Tribes can prepare are:

• Assemble supplies, such as water and food, that don’t require refrigeration or cooking. Have a battery-powered flashlight and radio, plus extra batteries in case the electricity goes off.
• Develop an evacuation plan and a kit containing medicine, money, documents and other items that can be grabbed during an emergency evacuation.

RESPONSE DURING A FLOOD

• Gather emergency supplies and follow local radio or TV updates.
• Unplug appliances to prevent electrical shock when power comes back on.
• Do NOT drive or walk across flooded roads. Cars and people can be swept away.

2 https://www.ag.ndsu.edu/flood/prepare-for-flooding-in-rural-areas
3 https://www.cdc.gov/disasters/floods/index.html
When power lines are down, water is in your home, or before you evacuate, TURN OFF gas, power, and water.

Tie down or bring outdoor items inside.

**RECOGNIZE FLOOD RISK**
- Identify flood-prone or landslide-prone areas near you.
- Know your community’s warning signals, evacuation routes, and emergency shelter locations.
- Know flood evacuation routes near you.

**AFTER A FLOOD**
- Throw away items that cannot be disinfected, like wall coverings, cloth, rugs, and drywall.
- Use fans, air conditioning units, and dehumidifiers for drying.
- For cleanup, wear rubber boots and plastic gloves.
- **Caution**: Flood water can cause exposure to human and/or livestock waste, chemicals and other contaminants, in addition to debris and animals. Exposure can lead to infections, stomach illnesses, and rashes among other ailments.
- Clean walls, hard floors, and other surfaces with soap and water. Use a mixture of 1 cup bleach and 1 gallon water to disinfect.
- Practice Safe Hygiene
  - Wash hands with soap and water to help prevent germs.
  - Listen for information from your local officials on how to safely use water to drink, cook, or clean.

For more additional information on flooding visit:
- https://www.ready.gov/floods
- https://www.fema.gov/national-flood-insurance-program

To assist with emergency preparedness and response in Indian Country, the National Indian Health Board (NIHB), through the Public Health Emergency Preparedness and Response (PHEPR) initiative, is supporting the capacity building of Tribal Governments to ensure effective and efficient emergency preparedness planning and response. To stay up-to-date on activities and to find resources, visit, https://www.nihb.org/public_health/phepr.php. You may also contact Courtney Wheeler at cwheeler@nihb.org to join the PHEPR listserv.

NIHB has long advocated for Congress to allocate direct set-asides for Tribes and Tribal organizations in PHEP funds, and has reiterated this request in recent testimony to the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, which has jurisdiction over the CDC budget. Currently, PHEP grants flow directly to state governments that are much more likely to prioritize the needs of city and county health departments over Tribal health agencies. Without designated funding, Tribes are highly unlikely to receive sufficient resources for emergency preparedness.

Earlier this year, the House of Representatives passed H.R. 269 - Pandemic and All Hazards Preparedness and Advancing Innovation Act of 2019 (PAHPA) - which reauthorizes PHEP grants through 2023. Unfortunately, this reauthorization did not make changes to existing law so that Tribes would also be eligible for PHEP dollars. At the time of this writing, the legislation is held up in the Senate due to unrelated provisions. Tribes and NIHB are continuing advocacy efforts to ensure these critical resources reach Indian Country.
On November 20, 2018, the Oneida Nation from Wisconsin became the second Tribal health department in the nation to achieve public health accreditation through the Public Health Accreditation Board. Michelle Myers, BSN, RN – Community Health Nursing Supervisor, served as the Accreditation Coordinator throughout their 4.5 year accreditation journey and provided an interview with the National Indian Health Board on this major accomplishment.

Public health accreditation is the measurement of a health department’s performance against a set of nationally recognized, practice-focused and evidence-based standards. Accreditation stimulates quality and performance improvement efforts at health departments, and helps to promote the highest standards in providing the 3 core functions of public health, and the 10 Essential Public Health Services.

Congratulations on achieving Public Health Accreditation! How does it feel to be the second Tribe in the nation to receive this status? We are really excited! It was a lot of hard work. But we have gained such valuable knowledge on improving our programs and services to better meet the needs in the community we serve.

Public health accreditation through the Public Health Accreditation Board (PHAB) is different from Healthcare accreditation, such as through (AAAHC) or the Joint Commission. How so? While ambulatory accreditation processes focus on the care of individual patients, public health accreditation focuses on populations and processes to assess and manage the health of populations.

We often hear that accreditation is a journey, not necessarily an end goal. Can you explain why it is described that way? Going through the journey of public health accreditation has been a catalyst for quality improvement. Accreditation standards gave us a baseline of what we should be doing as a Tribal public health department to ensure the 10 Essential Public Health Services are available in the Oneida Community. Incrementally we improved our performance to meet those standards. Some of this improvement involved changes and even the development of new processes. It definitely didn’t happen overnight.

There are standards under 12 domains in public health accreditation which you have to meet. Which domain was the most difficult to meet and why? Honestly, we had struggles with portions of most domains. But it was key for us to ensure domain 12 was in order as governance impacted all the remaining domains. The Oneida Nation’s government is organized differently than that of a typical local health department. For us, those that monitor the Tribal health department’s day to day operations (our Division Directors) were not the same group with the formal authority (Oneida Business Committee) to offer public health services per constitution. By clearly defining how Oneida’s structure accomplished the roles and responsibilities associated with governance as laid out in the PHAB standards and measures, we were able to identify which processes to use for which measures and therefore which documentation to use as evidence.

Also notable about preparation for domain 12, was we had to work within established reporting structure and processes. Public health accreditation was not going to change the organization’s structure. We provided information to PHAB to help them understand our unique governance structure.

Which one was the easiest and why? I would not say any domain preparation was easy [laughing]. But we were pretty efficient in our preparation for Domain 11, Administration and Management. Largely because much of the documentation came from systems and processes that were already in place. For this domain, we partnered with our Human Resource Department and the Health Division Administration. In fact, processes that were refined with PHAB preparation will benefit other accreditation processes the health division is involved.

How has your department changed? Meaning, what do you do differently now than you did before you began this journey? Public health accreditation has brought the five distinct teams within Community Health Services together for a common purpose. Both staff and teams have grown and developed along this journey. We believe a competent workforce improves the quality of programs and services with the goal to improve the health of the Oneida community.

We are purposeful about our actions, programs, and activities. We use evidence based and best practices in our programming and processes. Decision are data driven.

We are committed to maintaining the processes that were developed and/or strengthened due to preparation for public health accreditation. We are in process to hire a position with specific job responsibilities to ensure we remain compliant with the vast requirements.
What changes have you seen in the staff of the department?
Going through the journey, we have spent a great deal of time and effort developing staff. Staff now approach the day to day issues and concerns wearing their accreditation hats. When preparing a new piece of health education, we naturally strive to gather feedback from the intended audience before finalizing. When considering grant funding, we ask what the SMART objective might be as well as the measurable and deliverables. Presentations and articles in the newspaper contain specific pieces of information guided by our external communication policy such as name of submitting department, a contact number and something from the branding strategy. We as a department really embraced the knowledge gained and incorporate evidenced based and best practices where we can.

How was leadership involved in the efforts?
From the beginning, we found great support in leadership. We had consistent leaders from our governing board (Division Directors) the entire journey. However, we did have some change in the governing body with the election of a new Oneida Business Committee only a few months prior to our site visit. We looked at this not as a challenge, but an opportunity to review the project with returning members and education for new members.

What are some of resources you leveraged along the way to help and how were they most helpful?
Once we made the decision to formally seek public health accreditation, we sought out every resource and opportunity we could to prepare us for success. We participated in a mentoring program where we were paired up with an accredited health department in Wisconsin. Oneida was awarded an Accreditation Support Initiative (ASI) grant from the National Indian Health Board (NIHB). The activities from the grant further prepared us. Oneida participated in Wisconsin’s Tribal Accreditation and Quality Forums where tribes gathered to discuss accreditation and challenges, we commonly faced. As the accreditation coordinator, I also participated in regional accreditation forums with local and state health departments. The annual Public Health Improvement Training (PHIT) conference has been one of my favorite learning opportunities. I highly recommend regular participation for continued growth in performance management. I have learned wonderful engagement activities that were implemented through the course of this journey. The conference provides relevant learning opportunities every year.

You serve a community of (insert population- 7,500 + community members in Brown and Oostagamie Counties). We often hear that smaller Tribes would have a hard time achieving public health accreditation. What would you say to that?
There are definite challenges for Tribes and smaller health departments. It’s a balance of managing the day to day, while preparing for accreditation. Everyone wears multiple hats. But there are advantages too. Fewer team members can sometime mean changes are easier to implement. Really, having strong processes in place is key to success. These strong processes don’t always mean complicated processes. In fact, the simpler the more likely you will maintain that process long term.

What would you say are the top three benefits of public health accreditation for your community?
Creditability.
Knowing we are providing quality services and programs to our Tribal members.
Knowing we are continually improving and evaluating our services.

What advice would you give another Tribe who is just starting out on a public health accreditation path?
Ensure leadership is supportive of accreditation. It’s not an easy journey and it’s important to know you will have the support you need, especially when you run into challenges. Having a dedicated accreditation coordinator is ideal, but not required. Designate a team that will be responsible to finding the evidence you will submit. And make sure that team reviews the PHAB Standards and Measures before submitting formal notice. For Tribal nations particularly, really focus on Domain 12. You will want a clear understanding of who fits each role and responsibility from the governance perspective. To help you with this, there is a must-read resource called Public Health Accreditation Board Acronyms & Glossary of terms. Reading this cover to cover may not sound exciting, but it will be well worth the read. A clear understanding of governance will impact all remaining domains.

If someone is interested in learning more about public health accreditation or the Oneida Nation community health services, where should they look?
There is a great deal of information found on the PHAB website. Some of the resources that come to mind include online orientation modules, Guide to National Public Health Department Initial Accreditation Manual, Accreditation Coordinator Handbook, and Supplemental Process and Documentation Guidance for Tribal Public Health Accreditation. The National Indian Health Board is an excellent resource as well. Through the support grant projects, they have maintained examples of documents that may assist a Tribal health department seeking public health accreditation. Oneida has been and will continue to answer questions and assist other Tribal organizations as available. Please feel free to check out our website- contact information available for anyone that wants to connect with us https://oneida-nsn.gov/resources/health/community-health-services. We just uploaded our new Community Health Improvement Plan (CHIP) and are excited to show that off.

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ONEIDA NATION, SINCE NOVEMBER 20, 2018
FOREST COUNTY POTAWATOMI HEALTH & WELLNESS CENTER
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