Strengthening Success: Supporting the Community Health Representatives Program

A typical day for a Community Health Representative (CHR) is filled with non-stop unpredictability in combination with an indefinite amount of duties and responsibilities. This is because without the fundamental services CHRs provide, the Indian Health Service could not properly fulfill its mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level.

Karen shuffled the paperwork on her desk and sipped her coffee. A quiet start to her otherwise busy day as a Community Health Representative with the Indian Health Service. Karen, like 1,700 of her peers around Indian Country have undergone special training as health para-professionals to both deliver and provide health care, health promotion and disease prevention (HP/DP) services in their Tribal communities to AI/ANs.

Trust is fundamental to the success of her CHR program as Karen works every day with her community. Often, CHRs are trusted members of their community and are the first responders to arrive in a health emergency. They might also function as the provider of...
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THE NATIONAL INDIAN HEALTH BOARD

ESTABLISHED BY THE TRIBES TO ADVOCATE AS THE UNITED VOICE OF FEDERALLY RECOGNIZED AMERICAN INDIAN AND ALASKA NATIVE TRIBES, NIHB SEEKS TO REINFORCE TRIBAL SOVEREIGNTY, STRENGTHEN TRIBAL HEALTH SYSTEMS, SECURE RESOURCES, AND BUILD CAPACITY TO ACHIEVE THE HIGHEST LEVEL OF HEALTH AND WELL-BEING FOR OUR PEOPLE.

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

The 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. The NIHB consistently plays a major role in focusing attention on Indian health care needs, resulting in progress for Tribes.

The 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, the NIHB has advised the U.S. Congress, IHS federal agencies, and private foundations on health care issues of American Indians and Alaska Natives.

The NIHB staff maintains communication with Area Health Boards, national Indian organizations, and Tribes along with American Indian and Alaska Native people. The 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. The NIHB brings Tribal governments timely information to help them effectively make sound health care policy decisions. The 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 2018 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 excited to see many of you in Prior Lake, Minnesota this May for our 9th Annual Tribal Public Health Summit! We also offer a big THANK YOU to our partners in the Great Lakes who have made this event possible — especially the Midwest Alliance of Sovereign Tribes.

In January 2017, I was honored to be elected as the next Chairman of NIHB. Over the past year, I have been humbled and excited to advocate for better health care and stronger investments for Tribal public health infrastructures 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 has brought some challenges for the advancement of Indian health: proposed Medicaid reforms do not reflect the trust responsibility and must not be enacted without a Tribal exemption; and Indian Country had to fight like never before to secure the renewal of the wildly successful Special Diabetes Program for Indians (SDPI).

But there were also new opportunities: this year, Congress will be drafting the Farm Bill, and in March 2018, NIHB joined the Native Farm Bill Coalition to ensure food sovereignty and access to healthy foods for Tribes is included in the Farm Bill. Congress has also taken strong steps to address the opioids crisis and has included several key Tribal priorities in its comprehensive legislation. I am also excited to announce the launch of NIHB’s Center for Indian Health Policy and Research. Turn to page 12 to learn more about how CIHPR will serve as a resource for Tribes and Tribal health advocates.

NIHB also continues to grow in the field of public health. And we will continue reminding Congress and the Administration that the Trust responsibility extends to the Tribal public health system 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 in advocating for health equity, behavioral health programs with a strong emphasis on opioid prevention and treatment, public health emergency preparedness, 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 well-being of our people. NIHB is here to serve you.

Vinton Hawley
Chairperson
NIHB Takes to Capitol Hill Throughout 2018 to Advocate for Tribal Solutions to the Opioid Crisis

While the entire nation is now struggling with the epidemic of opioid addiction, in Indian Country, the epidemic has been at crisis levels for years. Tribal communities are suffering from opioids misuse and addiction at rates far higher than the national average. American Indians and Alaska Natives (AI/ANs) are also more likely to suffer a fatality from an overdose, in part due to long response times for overstretched emergency medical professionals on reservations. From 2015-2016 in South Dakota, 28% of patients treated for opioid use disorder were American Indian or Alaska Native in a state with a 10% AI/AN population. The CDC has released reports conveying the sad truth of these statistics, including that AI/AN individuals are more than twice as likely to overdose on opioids and more than three times as likely to die from such an overdose.

The 115th Congress has been particularly active on healthcare issues, debating legislation on the Affordable Care Act, Medicaid reforms, and solutions to the opioid epidemic that affects every community in America. In recognition of the opioid crisis, both chambers of Congress have introduced and debated many pieces of legislation funding treatment and prevention programs for opioids since the beginning of 2018.

Many of these pieces of legislation contain components that are tailored to Tribes and hold promise for aiding Indian Country’s ability to prevent the crisis from getting any worse and treat those already suffering from addiction. In particular, Tribes NEED dedicated, formula funding directly from the federal government, just like states receive. Tribes also need set-asides in behavioral health programs that address opioids to ensure that the resources Congress provides reach the communities that need it most! Resources to improve Health IT on reservations are also vital to improve integration for electronic health records and improve prescription monitoring.

In March, NIHB Board Member and Bemidji Area Representative Sam Moose flew to Washington D.C. to testify before the Senate Committee on Indian Affairs to provide information about the opioid epidemic’s impact on Tribes across the country and in the Great Lakes region, and how Congress can better support Indian Country. Mr. Moose shared that Tribes have shown they have the knowledge and traditional best practices to address this issue. They just need support from Washington — support that has long been promised them.

The House of Representatives, meanwhile, spent most of Spring 2018 gathering feedback from stakeholders, including Tribes, on what steps Congress needs to take to tackle the opioid epidemic. The Energy and Commerce Committee, which oversees healthcare legislation, held a hearing on public health and prevention efforts on March 21, 2018. NIHB provided written testimony to reflect how these efforts are unfolding all across Indian Country and what Tribal communities throughout the nation need to ensure adequate prevention and treatment coverage for AI/AN people.

In written testimony to the Energy and Commerce Committee, NIHB voiced support for Rep. Markwayne Mulinn’s (R-OK) Tribal Addiction Recovery Act. This bill, H.R. 5140, would create Tribal-specific funding under the State Targeted Response program. NIHB also called on Congress to enhance state-run Prescription Drug Monitoring Programs (PDMP) to ensure patients do not abuse limited prescriptions to purchase more opioid medication than recommended by their doctor. In short, states must be required to consult with Tribes to ensure the state PDMPs can integrate with Indian Health Service (IHS) and Tribal programs.

Several Senate committees held a hearing or multiple hearings on the topic, and the National Indian Health Board (NIHB) submitted testimony for the record at each hearing. The Senate Health, Education, Labor, and Pensions (HELP) Committee has developed a bipartisan opioid response bill, the Opioid Crisis Response Act of 2018. NIHB has been engaging with Indian Country’s allies on that committee, such as Sens. Lisa Murkowski (R-AK), Tammy Baldwin (D-WI), Susan Collins (R-ME), and Tina Smith (D-MN) to ensure the bill includes Tribes. By and large, these efforts were successful. The Opioid Crisis Response Act is very favorable
to Tribes, including Tribes in direct funding for State Targeted Response (STR) programs for the first time since STRs were created by the CURES Act in 2016. As Mr. Moose said during his testimony before the Indian Affairs Committee, “This Tribal set aside is a long standing priority and will make a significant difference in Indian Country’s fight against opioids.” The HELP Committee’s bill is the first substantial opioids package to gain significant bipartisan support, and a committee markup was held on April 24, 2018.

NIHB has also relayed to Congress the Tribes’ support for S. 2545, the Native Behavioral Health Access Improvement Act. This legislation from Senator Tina Smith (D-MN) would create a Special Behavioral Health Program for Indians, modeled off of the Special Diabetes Program for Indians, to fund behavioral health programs at the Tribal level. These can include drug addiction prevention and treatment for substance use disorders. The bill would fund IHS, Tribes, and Urban Indian Health Centers for $150 million per year for the next five years.

Indian Country loses men, women, children, and elders every day to opioid addiction and overdose. Tribes everywhere are holding Washington accountable to ensure the federal government meets the trust responsibility and provides adequate resources and support for Tribal solutions to a national problem. Indian Country needs YOU to advocate to your Representatives and Senators to ensure that Tribes are not overlooked when it comes to tackling the opioid crisis.

Pine Nut Picking: A Healthy Tradition

Pine nuts have historically been an important part of the traditional diet for a number of Tribes living in the Great Basin region, including the Pyramid Lake Paiute Tribe. The pine nut is a great source of amino acids and iron, and served as a staple in the diet for Native people in this region.

To encourage a healthy diet and prevent diabetes in their communities, many Tribes are looking to their traditional foods. The Pyramid Lake Paiute Tribe, as well as many other Tribes in the region have incorporated pine nut picking events into their diabetes prevention programs as a way to honor their traditions, eat healthier food, and engage in physical activity.
Pyramid Lake Paiute Tribe’s SDPI Program

The goal of the Pyramid Lake Paiute Tribe’s (PLPT) diabetes prevention program is to “provide diabetes/preventive education to the lives of the at-risk youth/adult, pre-diabetics and diabetic patients that reside within PLPT boundaries.” PLPT does this through embracing best practices for diabetes prevention while incorporating the Tribe’s traditions. Diabetes Program Director, Jenell Fellows, stated, “We can make the ‘old ways’, traditional ways, work in the modern world.”

PLPT was declared a federally recognized Tribe in 1874, however it has been established as a reserve since 1859. The community includes rural townships with up to a 20 mile commute between towns. As of 2017, 1,300 people were living on the reservation, and PLPT has approximately 2,288 enrolled members. One of the most valuable assets for the Tribe is Pyramid Lake, which is entirely enclosed within the boundaries of the reservation. The lake has significance to the Tribe as both part of their cultural history, and as a major part of the Tribe’s economy.

THE IMPORTANCE OF PATIENT-PROVIDER RELATIONSHIPS

“I want to know the provider cares about me.” This has been heard at the Pyramid Lake Tribal Health Clinic and is a common sentiment expressed by patients across Indian Country when asked about the quality of care they receive. In the medical literature, this experience is called patient-centered care (PCC) whereby patients are partners with their healthcare providers and providers treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective. It can be noted that the characteristics of PCC, sharing, caring, communicating and developing a therapeutic relationship with the client is not unlike what is experienced with traditional healing. As Chairman Vinton Hawley once said, “Science is finally catching up with us.”

PCC has been associated with many positive patient outcomes such as better self-management of A1c levels, blood pressure and weight, a higher satisfaction with care and lower mortality rates. With a history of high physician turnover at Pyramid Lake Tribal Health Clinic well as a regional shortage of other providers such as certified diabetes
educators, developing trust and bridging the provider-patient communication gap can be challenging. Sometimes it takes a third party to intervene and SDPI Program Director, Jenell Fellows often takes on the role of patient advocate. As one patient, Sandra Garcia who, after years of getting sicker and sicker from diabetes but benefited from Janelle’s intervention, states “[In] this program, Jenell, has been the biggest advocate. She will fight the fight. We have no one else doing that.”

Jenell is originally from PLPT. She went away for nursing school, then returned as a diabetes program assistant. She has now been the Diabetes Program Director for 3 years. Jenell works to address historical trauma, incorporate data and tradition into practice, and to develop partnerships with other Tribes and IHS. Janell stated, “I always wanted to come back and serve my people.”

EATING HEALTHY IN A MODERN SETTING
Two areas of need identified from the annual Diabetes Management Audit were that diabetes patients were lacking in nutrition education

While the PLPT work to elevate traditional healthy foods through harvesting traditional foods such as pine nuts (see the sidebar for more information), holding recipe contests, and incorporating traditional food into modern recipes, they also acknowledge outside influences, and help their clients navigate different food environments. One of the PLPT Diabetes Program’s most innovative programs is providing community members classes on eating healthy in a modern setting. Participants are given a $25 gift card for a chain restaurant in the area, and diabetes staff meets them there. The staff and participants work together to examine the menu, and talk about the nutrition of different food options. Participants then can make healthy choices for their meal on their own, while working on controlling cravings and considering lighter options. Children often help their parents, and learn from them. This program has allowed diabetes program staff to assess their client’s progress, and current understanding of nutrition. Jenell and the diabetes staff are looking forward to continuing this program. In the future, they plan on bringing participants to a grocery store to provide similar information while they shop.

PARTNERING FOR PHYSICAL ACTIVITY
PLPT has been working to bring physical activity to their community as that was another area of need identified by the annual diabetes audit. Leon Kuelersoff, a certified personal trainer, has been instrumental in implementing these programs. Leon, who is an enrolled member of PLPT, has been funded under SDPI for the past 3 years. Partnerships with other Tribal departments have been very helpful for the Diabetes Program. Leon helps with home visits and falls prevention in partnership with the senior center, and provides physical activity training and classes in fitness facilities shared with the junior and senior high school. The program also offers a variety of activities outside in partnership with their parks and recreations office, including snowshoeing, swimming, hiking, white water rafting, indoor sports, fun runs, and pine nut picking. The program plans to invest in a new 33,000 sq. ft. modular fitness facility.

Though the challenge of treating and preventing diabetes in Indian County is great, this small staff at the Pyramid Lake Paiute Diabetes Program is maximizing their SDPI funding to meet that challenge. With the recent delay in the reauthorization of SDPI by Congress, they had to put some activities on hold and cancel some. With increased SDPI funding, which Tribes have been advocating for, the PLPT’s Diabetes program, as well as others across Indian Country, could fully meet the need for diabetes treatment and prevention.

1 https://catalyst.nejm.org/what-is-patient-centered-care/
American Indians and Alaska Native People See a Rise in Health Coverage

A review of findings from the US Census’ American Community Survey depicts success in increasing the number of insured American Indian and Alaska Native (AI/AN) people.

**Graph A** depicts large health insurance enrollment increases nationally. The number of AI/AN people with health insurance rose from 3.8 million in 2012 to 4.48 million in 2016. The increase of 639,000 from 2012 to 2016 of American Indians and Alaska Natives represents a 17% increase in the number insured. The number of insured males increased by 18%, slightly more than insured females, who saw a 15% increase. Slightly more males than females (52% to 48%) made up the increase in insurance coverage from 2012 to 2016 as additional insured included 332,000 males and 306,000 females.

Nearly 1.1 million American Indian and Alaska Native people were uninsured in 2012. By 2016, this number had dropped to 750,900; representing a 31% decrease in the number of uninsured people. When comparing the sexes, 413,800 AI/AN males were uninsured (55% of all uninsured AI/ANs), compared to 337,000 AI/AN females. Males represented 56% of the decrease since 2012. **Graph B**

The American Community Survey also depicts success in increasing the number enrolled in Medicaid since the roll out of the Affordable Care Act. The number of American Indians and Alaska Native individuals with Medicaid rose from 1.46 million in 2012 to 1.77 million in 2016. Medicaid coverage increased by 317,000 from 2012 to 2016. This represents a 22% increase. **Graph C**

34% of the nation’s American Indian and Alaska Native population had Medicaid coverage in 2016 up from 30% in 2012. Both males and females increased by 4%, as well. 35% of all American Indian and Alaska Native people with access to IHS have Medicaid coverage, up from 30% in 2012. **Graph D**

The number of AI/ANs with access to IHS and enrolled in Medicaid increased by 99,300 from 317,000 in 2012 to 416,300 in 2016. This represents a 26% increase in Medicaid-covered patients at IHS funded health programs.

Nationally, the ACA was successful in increasing the enrollment of American Indians and Alaska Native people in Medicaid. Nearly 317,000 gained Medicaid coverage, an increase of 22%. Seemingly, Medicaid expansion is the most significant driver for the increased enrollment as both the newly eligible and previously eligible enrolled in the program.

An examination of variation across the states is advised to further understand the factors that explain the variation between states. Medicaid played an important role in reducing the number of uninsured AI/ANs by 317,000 between 2012 and 2016. The rate of uninsured American Indian and Alaska Natives likewise declined from 22% to 14%, and Medicaid played a large part in that decrease.
The number of AI/AN people with health insurance **ROSE** from 3.8 million in 2012 to 4.48 million in 2016.

**Medicaid Enrollment Among AI/ANs, 2012 and 2016**

- **Total Pop**: 2012: 317,011, 2016: 1,775,819
- **Male**: 2012: 1,058,746, 2016: 820,249
- **Female**: 2012: 1,457,754, 2016: 955,570

**Percentage of AI/ANs with Medicaid, 2012 and 2016**

- **Total Pop**: 2012: 30%, 2016: 34%
- **Male**: 2012: 28%, 2016: 32%
- **Female**: 2012: 31%, 2016: 36%
Indian Health Funding in 2018 and Beyond

The second year of the 115th Congress, and President Trump’s Administration, saw many changes in funding levels for Indian health. From an hours-long government shutdown, to a series of Continuing Resolutions (CRs), to a bipartisan budget agreement, there was much uncertainty followed by critical victories for Indian health this year.

The federal government’s Fiscal Year (FY) runs from October 1 to September 30. FY 2018 had begun with a series of short term CRs that only funded the government for a few months, or even weeks, at a time. This funding process led to a brief government shutdown, which occurs when Congress fails to pass a spending bill funding the government. Congressional leaders came together to pass a short term CR to reopen the government through February 8, 2018 and to buy themselves time to negotiate spending levels for the rest of the year. After the hours-long shutdown ended, Congress had to act again to fund the government after February 8. Plans quickly emerged for another CR through March 23. However, renewal for the Special Diabetes Program for Indians (SDPI) had not been included in the last CR, and SDPI was going to expire on March 31 unless Congress acted. The fate of this highly-effective, non-controversial, bipartisan program was in doubt for the first time in years. Due to strong Tribal advocacy and relentless pressure from Indian Country’s allies on Capitol Hill, SDPI was included in the February 8 CR. SDPI was thus funded at $150 million each year through September 2019.

The Senate’s budget agreement included funding for other public health programs, including two years’ worth of funding for Community Health Centers, which had also expired in September 2017. These centers provide services to rural and underserved patients. Many centers operate in or near Tribal communities. These centers saw a total of 26.5 million patients in 2016. The new budget agreement expanded CHIP renewal for 4 additional years, for a total of 10 years, as part of a cost saving measure.

The budget deal did include funding for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). This program helps promote maternal and child health and includes a 3% Tribal set aside. Since 2010 Tribal grantees have received $21 million to develop programs to address maternal and child health. The program has not been funded since September 2017; the new agreement includes 5 years of funding.

On March 23, Congressional leaders unveiled a $1.3 trillion spending bill to fund the federal government through the rest of FY 2018. The Consolidated Appropriations Act of 2018, also known as the Omnibus, contained funding for most of the federal government agencies including Department of Health and Human Services (HHS), and the Indian Health Service (IHS).

In the Omnibus agreement, HHS received a total of $88.1 billion, which is $10.1 billion over the FY 2017 level. The bill also contained $4 billion to fight the opioid crisis. HHS received a total of $5.5 billion, which is an increase of $500 million (10%) from the FY 2017 enacted level. The legislation contains an extra $1 billion for the state response to opioid grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Within this funding there is a $50 million for Tribes and Tribal organizations. Tribes and tribal organizations will receive a $5 million set-aside in this funding. Other Tribally-focused health programs such the Good Health and Wellness in Indian Country program, Tribal Behavioral Health Grants, and the Zero Suicide Prevention Initiative, also received funding. This was a major victory for the Indian health system.

The FY 2018 Omnibus also included $4 billion to treat the opioid epidemic across the nation. The funding is spread across agencies including HHS, Homeland Security, Justice, and Veterans Affairs for prevention, treatment and law enforcement. Under HHS, about $1 billion would go toward state and Tribal grants created under the 21st Century Cures Act to respond to the crisis. Almost $500 million more is slated for the Centers for Disease Control and Prevention’s (CDC) prevention and surveillance activities, and another $500 million would go to the National Institutes of Health (NIH) for research on opioid addiction and new non-addictive pain therapies. An additional $130 million is carved out to address opioid addiction in rural areas and $94 million would help FDA expand its efforts to crack down on shipments of synthetic opioids at international mail facilities.

As noted above, the omnibus included a $50 million set aside for Tribes and Tribal organizations under the State Targeted Response to opioid grants. Previously, this funding had only been available to states. With the passage of the omnibus, $50 million went to Tribes and Tribal organizations under this program. The program addresses the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (including prescription opioids as well as illicit drugs such as heroin).

The Omnibus bill appropriated $84 million for the Medication-Assisted Treatment for Prescription Drug and Opioid Addiction programs. The purpose of this program is to expand/enhance access to medication-assisted treatment services for persons with an opioid

The National Tribal Budget Formulation Workgroup recommended $6.4 billion for IHS.
use disorder seeking or receiving MAT. Out of the $84 million, $5 million is specifically targeted for Tribes and Tribal organizations. This is vital funding to Tribes implementing MAT programs in order to provide treatment to the opioid crisis.

In the FY 2018 Consolidated Appropriations Act, the Indian Health Service received $5.5 billion for IHS which is an increase of just under $500 million (10%) above the FY 2017 enacted level. The legislation allocates $3.9 billion for services, $867 million for facilities and $718 million for Contract Support Costs.

**The Indian Health Care Improvement Fund** (IHCIF) received $72.3 million in the legislation. This fund has been authorized by Congress to improve funding discrepancies across the IHS. This is the first time funding has been made available since FY 2012. The IHCIF Workgroup continues to meet to discuss the formula for distributing these funds.

The legislation also included $58 million for IHS to address "accreditation emergencies" at Direct Service facilities. This includes those facilities who have or have the potential to lose the ability to bill the Centers for Medicare and Medicaid Services due to deficiencies in the system. It also encourages IHS to share information about these cases with the Tribes and with Congress.

Funding was also allocated for domestic violence prevention ($4 million); and $1 million to continue prescription drug monitoring programs (equal to FY 2017). Alcohol and Substance Abuse programs would see an $8 million increase including $6.5 million for the Generation Indigenous Initiative; $1.8 million for the youth pilot project; and $2 million to fund essential detoxification and related services provided by the Service’s public and private partners to IHS beneficiaries. Purchased/Referral Care would get an increase of $33 million for total funding of $962.7 million.

The agreement also directed IHS to report to Congress about the progress they are making on patient wait times (as outlined in IHS Circular 17-11) within 90 days of enactment. The report should include how Health IT issues impact patient wait times. The legislation also requires the agency to report to Congress on detailed funding amounts it would take to fully implement the Indian Health Care Improvement Act. This was also requested in the FY 2017 appropriations bill, but IHS never provided the information to Congress.

The spending agreement also contained language that allows IHS to provide a housing subsidy for medical personnel at IHS operated sites. It also required IHS to conduct additional training for all IHS personnel on how to improve quality of care, so that staff understand their obligations to improve quality of care.

The agreement also has language that "encourages" IHS to provide funding for the Substance Abuse and Suicide Prevention Program, Domestic Violence Prevention Program, Zero Suicide Initiative, and aftercare pilots at Youth Regional Treatment Centers through contracts and compacts rather than through grant based programs to ensure that Contract Support Costs are available.

The spending agreement appropriated a total of $867.5 million for facilities funding which is an increase of $303.4 million over FY 2017. This includes $243 million for Health Care Facilities Construction, which is 106% more than the FY 2017 enacted amount. Within that amount, there is $15,600,000 for small ambulatory clinics and $11,489,000 for staff quarters.

The spending agreement also directed the HHS Secretary to prioritize Indian Health Services facilities from the Nonrecurring Expenses Fund which include Indian Health Services facilities. This fund is comprised of unobligated appropriations at HHS since FY 2008.

Finally, the legislation contained funding for several other programs important to Indian health including:

- **Good Health and Wellness in Indian Country (CDC)** — $16 million
  ~Equal to FY 2017 Funding

- **Tribal Behavioral Health Grants (SAMHSA)** — $15 million
  ~Equal to FY 2017 Funding

- **Zero Suicide Initiative for American Indians and Alaska Natives (SAMHSA)** — $2 million
  ~Equal to FY 2017 Funding

Had the 2018 shutdown lasted as long as the 16-day shutdown in 2013, Direct Service and Self Governance Tribes would have seen disruptions in healthcare provision. There are several ways for Indian Country to avoid these disruptions in the future, the fact remains that government shutdowns harm Tribal healthcare.

The federal government funds its trust responsibility for health by funding the Indian Health Service through the annual discretionary appropriations process. This process funds most federal agencies. However, entitlement programs such as the Social Security Administration, Medicare, and Medicaid are funded through mandatory spending. Meaning that Congress does not have to appropriate funds each year for these programs to function. Placing IHS and other programs vital to Tribal health needs under mandatory spending would lessen the impact on Tribal health during future shutdowns.

A second way to avoid this situation would be for Congress to enact Advance Appropriations. This is a very straightforward method of providing funds: Congress simply enacts appropriations a year in advance. IHS, and thus the Tribes, would know how much money will be available for their 2019 health programs in 2018. Advance Appropriations would prevent last minute decisions in preparation for a shutdown and allow administrators to plan out the year ahead with more clarity than is available to them under the current appropriations process.

Visit NIHB.org/legislative/appropriations.php to learn more!
Good Health and Wellness in Indian Country – CDC’s Largest AI/AN Public Health Investment Under Threat

The Centers for Disease Control and Prevention (CDC) is the largest national public health agency in the U.S., with a mission to “protect America from health, safety, and security threats, both foreign and in the U.S.”

Part of this mission includes improving the health and wellness of American Indians and Alaska Natives (AI/AN) by investing in public health in Indian Country. Those investments are greatly needed. AI/AN populations have higher rates of disease, injury, and premature death than other populations in the United States. In recent years, the Agency’s largest investment in AI/AN public health has been the CDC’s Good Health and Wellness in Indian Country (GHWIC) program. Established in 2014, this $78 million initiative provides critical support to Tribes, Tribal organizations, and Tribal epidemiology centers (TECs) to administer various public health activities with the long term goals of:

- Reducing rates of death and disability from tobacco use by 5%;
- Reducing the prevalence of obesity by 3%; and
- Reducing rates of death and disability from diabetes, heart disease, and stroke by 3%.

Currently, twelve Tribes are funded to work on various public health interventions and strategies alongside eleven Tribal organizations and twelve TECs. These public health interventions and strategies include focusing on improving nutrition and physical activity, reducing tobacco use, and strengthening team-based health care and community-clinical links to achieve the program’s long-term goals.

The success, and cost-effective investment, of GHWIC stems from its Tribally-driven, holistic approach to strengthen public health capacity to improve the health of AI/ANs. This includes the use of community-chosen, culturally adapted policies, systems and environmental improvements. Furthermore, the eleven Tribal organizations are instrumental in providing leadership, training, technical assistance, and resources to sub-awardees within their respective IHS service areas to further strengthen public health capacity in Indian Country.

While the program was initially funded through 2019, its imminent future is currently at stake. For FY 2018, GHWIC will receive just under $16 million. Despite the demonstrated success of the program and need for greater CDC investment in Tribal public health, the President’s FY 2019 budget request zeros out this funding. This funding has been an important resource for Indian Country, and one that many Tribal advocates wish to see expanded so that more Tribes can get funding. Eliminating this program will not only have a detrimental impact on public health capacity in Indian Country; it threatens the overall health and wellness of AI/AN populations.

CIHPR is under the direction of Jessica Steinberg, a member of the Little River Band of Ottawa Indians, with past experience in Indian Health provision as a health director, tribal administrator and as an elected tribal leader. CIHPR works exclusively on matters surrounding federal regulations, policy analysis and data analysis. CIHPR will work with our member organization and Tribes to advocate for changes in Indian health care at the systems level. Through analysis of appropriations, regulatory amendments and policy deployment, CIHPR will provide tribes with up to date information to assist them in their advocacy efforts, programmatic concerns and to understand the relationships between tribes, agencies and the people we serve. Key team members include:

- Devin Delrow, JD, Director of Policy, Navajo
- Sooner Davenport, Direct Service Tribes (DST) Policy Coordinator, Kiowa, Apache and Navajo
- Kristen Bitsui, Tribal Health Reform Outreach and Education Program Associate, Navajo
- Dominique Covelli, Policy Associate
- Ed Fox, Director of Tribal Data Project

Roll-out of the Center is anticipated June 1, 2018. The roll-out will include the deployment of an accessible data platform for use by our Tribes. CIHPR will also utilize existing expertise to assist Tribes to understand the significance of data trends, implications of those trends in their communities, along with creating position statements, talking points and white papers for use in their advocacy and education efforts.

Along with the data roll-out, CIHPR will offer training and technical expertise in the field; embedding staff with our communities to better understand their issues and needs. CIHPR staff will experience the challenges our Tribes face in obtaining health care for the people from the perspective of the leadership, the providers and the recipients of the services.

Watch for the CIHPR website and Data Lodge announcement!
Tribal Inclusion in the 2018 Farm Bill

On March 1, 2018 the National Indian Health Board (NIHB) became official members of the Native Farm Bill Coalition. The Coalition consists of over 140 Tribes and 11 intertribal and Native organizations working to improve access to healthy food, and improve education and research on nutrition. NIHB’s work on improving the health outcomes of American Indian and Alaska Natives is deeply tied to improving access to healthy and traditional foods. The Farm Bill — set to expire on September 30th, 2018 — will have significant implications for the overall health and nutrition of Tribal communities and NIHB will work throughout the year to advocate for Tribal inclusion in this legislation.

Tribal communities are often plagued by scarce access to traditional and healthy foods, resulting in negative, nutrition-based health issues such as obesity, diabetes, and shortened life expectancies. The Native Farm Bill Coalition offers a unifying message that advocates for improving traditional and cultural food practices as a way to address these problems. Including food sovereignty for Tribes in the Farm Bill will empower Tribes and ultimately create healthier Tribal communities. NIHB will continue to participate in upcoming Farm Bill discussions and advocate for prioritization of food sovereignty, healthy traditional foods in federal policy, and self-governance for federal food programs like the Supplemental Nutrition Assistance Program (SNAP).

One of the most controversial aspects of the House bill is the stricter work requirements for all able-bodied individuals to participate in the Supplemental Nutrition Assistance Program (SNAP). The requirement to work or be enrolled in job training at least 20 hours per week to receive benefits, could impact up to 7 million SNAP participants. In addition to the work requirement for SNAP, many of the major policy recommendations that relate to the health of Tribal communities are not included in the bill. In order to address food sovereignty and improving the health of Tribal communities, NIHB will continue advocating for our policy recommendations, which include:

- Authorize Tribes to enter into self-determination contracts pursuant to P.L. 93-638 for administration of food assistance programs.
- Exempt Tribes and Tribal members from work requirements and corresponding time limits for receiving SNAP benefits.
- Expand the Food Distribution Program on Indian Reservations (FDPIR) through increased funding for purchasing of traditional foods, infrastructure development, and nutrition education.
- Provide Tribes with base funding to develop or expand traditional foods programs.
- Require a Congressional Budget Office (CBO) or Congressional Research Service (CRS) inquiry into the impact of drastic cuts or elimination of food assistance programs on the overall food security of Tribes.

Discussions on the Farm Bill will continue throughout the year for both the House and the Senate. The leaders in the Senate Agriculture Committee say they intend to write a bi-partisan bill and NIHB intends to work with the Senate Agriculture Committee and its members to ensure the health concerns of American Indians and Alaska Natives are addressed in the final version of the Farm Bill. Traditional and cultural food practices are one of the many ways to create healthier Tribal communities and the Farm Bill is a great opportunity for Tribes to move closer to accomplishing that goal.
Climate change impacts Tribal communities across Indian Country, and poses a threat to the health and wellness of American Indian and Alaska Native individuals, communities, and nations. Climate change also negatively impacts Tribal lands and the practice of culture and traditional lifeways.

Tribes, however, are taking action to both mitigate damages and advocate for changes that can reverse these conditions, even as they recognize the road ahead may be long and difficult. The National Indian Health Board (NIHB) is honored to partner with three Tribal climate health projects as part of the NIHB’s Climate Ready Tribes Project with support from the Centers for Disease Control and Prevention (CDC): the Village of Wainwright, the Swinomish Indian Tribal Community, and the Blackfeet Nation, featured in this project spotlight.

The Blackfeet Reservation is headquartered in Browning, Montana, bordering Glacier National Park and Canada. It is the third largest reservation in Montana, encompassing approximately 1.5 million acres (2350 square miles). The reservation is home to 75% of the enrolled Tribal members and is the largest American Indian population in Montana. Blackfeet people have lived on the Rocky Mountain front lands for more than 10,000 years. Their traditional lifestyle was nomadic and cyclic in nature. The Blackfeet groups followed the cycles of the four seasons and the buffalo. There were originally four major bands — Blood, Siksika, North Piegan, South Piegan. To this day, they use the land for cultural and spiritual purposes. The Blackfeet people cherish their personal relationship with Creator (Nahdoosii), Indian culture, religion, tradition, language, and living on the ‘red path’ of their ancestors. To continue on, this way of life depends upon sharing from generation to generation, continually passing down knowledge and practice from Elders to the youngest generations.

The Blackfeet Nation has always lived closely with the natural environment. The Blackfeet people are traditional hunter-gatherers, farmers, and ranchers and their harmony with the ecosystem has promoted physical and mental health for the Tribe. Subsistence activities are still very important for food security, recreation, and cultural activities. As climate change causes seasonal shifts, growing cycles change and gathering techniques and schedules are affected. Water is the lifeblood of the West and is critical on the high, arid plains of the Blackfeet Reservation. However, nowadays the Tribe is experiencing issues with drought, extreme weather, and water contamination.

Water is one of the natural elements that the Blackfeet people hold sacred. Waterways, wetlands, and associated groundwater are important for the large number of ranchers, farmers, and all Tribal members in general. Water is also fundamentally important for fish and wildlife species, with watersheds in the area hosting threatened species including the grizzly bear, Canada lynx, piping plover, and bull trout. Unfortunately, climate change is bringing significant changes to the Blackfeet water supplies, including decreased snowpack in the mountains, melting glaciers in the Glacier National Park, and precipitation changes ranging from additional precipitation in winter and spring to a decrease in late-summer rain. Because of these changes, water is becoming scarce in some areas or seasons and over-abundant in others, leading to both drought and flooding.

As flood risk increases, so do risks of storm surges that can contaminate water and food supplies. Additional precipitation damages residences and infrastructure. Excess moisture leads to mold, breathing problems, stress and worry, and financial difficulties. It can also increase standing water, leading to increased issues with vector-borne disease. Exposure to pathogens like norovirus, Giardia, and others are expected to increase. Increased run-off may expose more people to contaminants like heavy metals, herbicides, and pesticides as they move into freshwater systems used for drinking and recreation. Meanwhile, droughts also pose problems with water treatment by increasing concentrations of pathogens in discharged sewage. Changes in water availability for plants, wildlife, and human consumption have caused the Blackfeet people to change their seasonal hunting, gathering, cultural and spiritual uses. Climate change is also predicted to increase harmful algal blooms. Additionally, community members have noticed changes in wind and less moisture in the forest areas, as well as impacts on agricultural production. Dangerous animals and invasive species...
such as rattlesnakes, brown recluse and black widow spiders, aquatic zebra mussels, and milfoil are also moving onto the reservation.

The Blackfeet Tribal Environmental Office has been working to address climate change related issues. First, the Tribe has worked to research and catalogue relevant climate change-related resources and communicate climate change impacts and existing and ideal adaptation opportunities, sharing these online and through the Blackfeet Climate Change Adaptation Plan. The Tribe has also assembled a Blackfeet Climate Health Advisory Team (focus group) made up of Tribal representatives and other partners. With help from the focus group, Blackfeet has so far completed a climate change communications plan to guide outreach as well as a suite of handouts that emphasize different aspects of climate-related health concerns (e.g. water quality, air quality, heat, food security) and identify impacts, vulnerable populations, and adaptation opportunities within each theme. Blackfeet also completed a public website called Blackfeet Country and Climate Change focusing on health and environmental impacts and youth involvement in Blackfeet climate change initiatives. This website demonstrates links between health and broader climate change issues. To ensure the broadest reach possible, this website is public so that Blackfeet Tribal members and also interested others can benefit from this important information. View the website here: https://blackfeetclimatechange.com/. Additionally, Blackfeet offers an internship program for young Climate Warriors.

Blackfeet Nation looks to continue and expand climate change mitigation strategies. These include water quality monitoring, especially after high levels of precipitation; upholding high drinking water standards and practices; issuing advisories if water contamination is suspected or confirmed; keeping drinking water, wastewater, and stormwater infrastructure in top condition and prioritizing replacing aging infrastructure. The Tribes also aims to restore and protect wetlands to reduce impacts from high precipitation events.

The Tribe has shown commitment to moving this important work forward, sustaining the gains already achieved. Connections forged through the Climate Health Advisory Team allow ongoing partnership, the website and other materials developed will continue to educate the community, and providing opportunities for young people to learn and grow can help plant a seed of promise to raise the next generation of climate advocates.

Gerald Wagner is the Project Director and the Director of the Blackfeet Environmental Office. He has worked in the Blackfeet Environmental Office for 26 years and has served as Director for 23. Gerald is directly overseeing the Climate Change Health Impact project but emphasizes the project is really a combined effort involving several groups and individuals whose interests are bringing Climate Change concerns to the Blackfeet community. The following are interested staff and groups that have assisted or are assisting with the project: Jenna Loring, Ron Ingraham, Kim Paul, and interns JoVonne Wagner and Shawn Davis, as well as consultants from the Center for Large Landscape Conservation.

Learn more about NIHB's Climate Ready Tribes project at www.nihb.org.
follow-up care after discharge from a hospital or provide critical health services, such as patient assessment of medical conditions, health screenings, facilitated patient safety and the provision of transportation for medical care. Both CHRs and patients alike understand that the health of a Tribal community relies on these frontline workers who serve as the eyes, ears and heart of their Tribal communities. Without CHR’s, not only would the quality of services provided to Karen’s community suffer, but most individuals would be unable to access their healthcare system.

Despite the immense amount of work CHRs do to meet the unique healthcare needs of their people, President Trump’s budget proposal for fiscal year 2019 (FY 2019) is seeking to discontinue the CHR program. This contrasts greatly to the recommended increase by Tribal Leaders on the national Tribal Budget Formulation Workgroup (TBFW) to fund the CHR program at $29.5 million above the funded amount of $60 million for 2018.

According to the Indian Health Service (IHS), the reason for this budget proposal is to prioritize clinical health care services and the staffing of newly constructed health care facilities. CHRs also provide health education, which is an essential part of preventative services. This funding line has also suffered a proposed budget cut. And while the effort to increase funding is both commendable and much needed, many Tribes have voiced their concerns with the proposed cut to the CHR Program. The NIHB Board of Directors has also passed resolution in support for the CHR and Health Education Programs (NIHB Resolution: 18-10), in direct opposition to the attempt to cut the CHR and Health Education programs, and requesting Congress to continue their funding to the Indian Health Service.

Tribal communities understand that the value of the CHR program is not limited to the services they provide during a transport, delivery or home visit. The support they provide to the Indian Health delivery system is filled with immeasurable contributions that ensure culturally competent performance, service, functions and activities. According to Karen, one way that she ensures quality care for her Tribal Elder is by speaking with them about their state’s Medicaid program:

“We had an elder that never wanted to sign up for Medi-Cal (California’s Medicaid Program). Ultimately, due to his advanced age, the time came for him to be admitted to a Skilled Nursing Facility. He had Medicare, but was unable to pay the out-of-pocket costs. He was very untrusting of the Medi-Cal program and felt it was IHS obligation to pick up all co-pays/deductibles. I was assigned as a Community Health Representative and slowly, overtime, I gained his trust. I consulted with the Benefits Coordinators and the other Community Representative as to the best course of action. I felt it was my duty to help this elder secure care through our state Medicaid program. After some discussion I was able to get the Elder to agree to sign up!

The elder willingly signed up with me, his CHR, and with help from his family, all pertinent documentation was submitted to our Benefits Coordinator. Shortly thereafter he was granted Medi-Cal and all of his SNF and other medical services costs were fully covered by his Medicare and Med-Cal without any cost to himself or the Purchased Referred Care (PRC) program.”

This story is one of many that the NIHB has received, regarding the additional roles and responsibilities a CHR takes on to provide services to their community, and how the additional services they provide to their communities may not always be accurately quantified or reported. In a recent survey collected by NIHB, CHR workers have also reported that some will pay additional expenses out of their pocket or donate their personal time to ensure that the needs of their community are met. The CHR model continues to work for Tribes because it is rooted in the understanding that representatives know their communities best, and thus understand the unique healthcare needs of AI/ANs. CHRs are also able to foster trust between patients and their providers, and meet the needs of providing culturally competent healthcare delivery, doing so with limited funding. The CHR program is powerful because it allows Tribes to use their limited funds to provide holistic approaches to service delivery that includes Tribal values and addresses health in all facets of the individual.

From the stories NIHB has collected, the unified Tribal voice suggests that cost-saving measures which strengthen the Indian Health system are what Tribal communities need. And thus far, Tribes have been quite clear that cutting the CHR program would cause more harm than assistance.

The CHR Program is successful because Tribes are empowered with flexibility to tailor their programs in a good way — one that best meet the needs of their people, and is inclusive of each Tribal communities’ unique cultural and traditional perspectives. Without CHR’s providing culturally competent care, the Indian Health Service and Tribally compacted health systems would lose their ability to provide comprehensive healthcare to American Indians and Alaska Natives.
Taking Steps to Address Environmental Impacts on Tribal Community Health

On April 18, the House Natural Resources Committee Ranking Member Raul Grijalva (D-AZ) and Representative Nanette Barragan (D-CA) hosted a Natural Resources Roundtable Conversation on Environment and Public Health. The roundtable brought together a broad coalition of stakeholders working to improve the health of communities impacted by environmental damage. The group highlighted the health challenges faced by communities across the United States related to air pollution, water contamination, and irresponsible mining and land management practices, among other concerns.

Stacy Bohlen, CEO of the National Indian Health Board (NIHB) participated in the roundtable to advocate for the environmental public health concerns of Tribes across Indian Country. Ms. Bohlen stated, “American Indian and Alaska Native people have lived for thousands of years in harmony with our surrounding environments, taking what we needed from the land for physical, cultural, and spiritual purposes. Tribal practices and lifeways were sustainable over time, and protected the health of current and future generations.” She shared that, despite this tremendous respect for the environment, Tribes now find this harmony and balance slipping away as industry creates negative impacts that are far reaching and long lasting.

Although Tribes contribute little to environmental degradation, Tribal populations feel the impacts keenly. Due to already existing health disparities, the underfunding of the Indian Health Service, and the rural locations of many American Indian and Alaska Native (AI/AN) communities, Tribes are often the first and most severely affected by impacts to the environment. For example – AI/ANs suffer from much higher rates of chronic lower respiratory diseases. When air pollution increases, those people are much more vulnerable to dangerous asthma attacks and other acute respiratory disorders.

Sometimes the impacts are indirect, but equally damaging. For example, AI/ANs have higher rates of type 2 diabetes. Traditional foods are one of the successful approaches that keep AI/AN people from becoming diabetic, and for those that already are diabetic, traditional foods help manage diabetes. Unfortunately, damage to the environment almost always harms traditional food practices, taking away an extremely important tool to address this health disparity.

An underfunded Indian health care system also makes environmental damage more devastating to Tribal communities. This system is funded at less than 50% of need, and health impacts from environmental damage create an even greater need for health care, adding more pressure to already over-stretched system.

Furthermore, environmental damage causes significant harm not only to health but also to general wellbeing, including damage to homes, cultural sites, and sources of income and subsistence for AI/AN people and their traditional ways of life.

For all of these reasons, environmental damage and strategies for mitigation are extremely important to Indian Country. The need for Tribal consultation in regards to public health also was stressed by Ranking Member Grijalva, who emphasized that Tribal public health concerns should not be considered after the fact – rather, Tribes should have the opportunity to share their unique perspectives, needs, and experiences before any decisions or actions are taken.

Both Ranking Member Grijalva and Representative Barragan look to continue dialogue with organizational partners, to highlight environmental impacts on health, and galvanize action that can disrupt and prevent these health impacts from harming community health, especially those most vulnerable among us like children and elders. The National Indian Health Board requested that the Natural Resources Committee consider the special needs of Tribes and work to develop policies that can benefit Tribal communities and help protect them from the harmful environmental impacts of a rapidly changing climate and world. NIHB will continue to work partner organizations and with the House Natural Resources Committee to ensure that the public health concerns of American Indians and Alaska Natives are addressed.
Federal Advisory Committee Act: What is it?

One of the many ways that Tribes engage in the government-to-government relationship with the United States federal government is through participation in federal Tribal advisory committees and workgroups. These committees and workgroups provide an opportunity for Tribal representatives to establish and advance priority issues and recommendations with federal agencies on health-related issues. However, many times Tribes will receive communication from federal officials that these committees and workgroups must comply with the Federal Advisory Committee Act (FACA). So what exactly does that mean?

FACA was enacted in 1972 to ensure that recommendations by various advisory committees to the federal government is objective and accessible to the public. Ideally, the goal of an advisory committee under the act is to examine an issue, achieve consensus on how to proceed, and provide recommendations to executive branch officials. However, since Tribes are sovereign governments, meetings between U.S. government officials and Tribal members (or their designees) do not necessarily trigger FACA. They are considered inter-governmental meetings according to the Unfunded Mandates Reform Act of 1995 (UMRA). Additional guidelines issues by the Office of Management and Budget (OMB) says that FACA exemptions (Tribal leaders and their designees) should be read broadly to facilitate intergovernmental communications on responsibilities or administration. This is consistent with principles of meaningful Tribal consultation and congressional intent, as well as the Department of Health and Human Services (HHS) Tribal Consultation Policy that says all joint Tribal/federal workgroups and/or task forces must be FACA compliant unless exempt.

This may still sound a little confusing. NIHB staff are pleased to provide technical support to Tribes in any way that we can. NIHB routinely attends these advisory committee meetings and is capable of providing briefing materials, talking points, and notes on key issues. For further information about FACA and the Tribal exemption, please contact NIHB's Director of Policy, Devin Delrow, at ddelrow@nihb.org.
Upcoming Events

National Congress of American Indians Mid Year
June 3-6, 2018
Kansas City, MO

National Council of Urban Indian Health Annual Leadership Conference
June 26-28, 2018
Arlington, VA

2018 National UNITY Conference
July 5-9, 2018
San Diego, CA

Direct Service Tribal Advisory Committee Quarterly Meeting
July 10, 2018
Minneapolis, MN

Direct Service Tribes 15th Annual National Meeting
July 11-12, 2018
Minneapolis, MN

CMS Annual Strategy Session
July 12-13, 2018
Tulsa, OK

Tribal Self Governance Advisory Committee Meeting
July 17, 2018
Washington, DC

CDC Tribal Advisory Committee Meeting
July 23-25, 2018
Location TBD

NIHB Medicare, Medicaid, Policy Committee Meeting
July 24, 2018
Washington, DC

National American Indian/Alaska Native Annual Behavioral Health Conference
July 25-27, 2018
Washington, DC

CMS Tribal Technical Advisory Group
July 25-26, 2018
Location TBA

Association of American Indian Physicians Meeting & National Health Conference
July 26-29, 2018
Scottsdale, AZ

WIB National Tribal Health Conference
September 17-20, 2018
Oklahoma City, OK

3rd Annual Native American Nutrition Conference
October 2-5, 2018
Prior Lake, MN

Alaska Federation of Natives Annual Convention
October 18-20, 2018
Anchorage, AK

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