



National Indian Health Board

Health Reporter

Spring 2022

Emerging Breakthroughs in Behavioral Health Policy

The COVID-19 pandemic uncovered many glaring health disparities in Tribal communities. However, this pandemic exposed something even more alarming, the severe impacts on mental health. In his December 2021 [Advisory](#), the [United States Surgeon General](#) found American Indian/Alaska Native (AI/AN) youth were at a higher risk for mental and behavioral health challenges during the COVID-19 pandemic. While the Advisory focused on youth, these findings could also apply to adults and other health challenges in Tribal communities.

Before the COVID-19 pandemic, Tribal communities were already in a behavioral health crisis. According to the [National Center for Health Statistics](#), AI/AN women experienced the highest increase in suicide rates of 139 percent from 1999 to 2017. AI/AN men between the ages of 15 to 44 had the highest rates of suicide of all race and ethnicity groups.

The overall death rate of AI/AN adults from suicide is roughly 20 percent higher compared to the non-Hispanic White population. Suicides have skyrocketed among AI/AN veterans, from 19.1 to 47 in 100,000 persons. But most shocking, for those aged 18 to 39, it was 66 in 100,000 persons.

The pandemic devastated Tribal communities, made worse by the consequences of chronic underfunding. For example, according to the [Substance Abuse and Mental Health Service Administration](#) (SAMHSA), 13 percent of the Tribal population needs substance abuse treatment, but only 3.5 percent receive any treatment. Congress must tackle these issues head-on with aggressive funding for prevention and treatment measures for Tribes.



Congress has an opportunity to advance behavioral health on several fronts. Congress reauthorized the [Violence Against Women Act in the Consolidated Appropriations Act, 2022](#) (VAWA). The reauthorization empowers and affirms Tribal governments' sovereignty and authority to exercise special Tribal criminal jurisdiction by adding additional crimes of child violence, sexual violence, sex trafficking, stalking, obstruction

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Emerging Breakthroughs in Behavioral Health Policy = *continued*

of justice, and assault on Tribal justice personnel to the list of crimes committed by non-Indians against Indians that may be prosecuted and adjudicated by Tribal governments. It authorizes increased funding, from \$5 million to \$25 million per Fiscal Year (FY), to assist Indian Tribes in strengthening their criminal justice systems and implementing the VAWA Special Tribal Criminal Jurisdiction.

The reauthorization also establishes a pilot program for Indian Tribes in Alaska to exercise the special Tribal criminal jurisdiction over certain crimes committed by non-Indians against Indians within Alaska Native villages. It limits participation in the pilot program to only 30 Indian Tribes, with certain exceptions. The bill otherwise maintains the current jurisdictional authorities of the United States, the State of Alaska, and Indian Tribes in Alaska. It is intended to strengthen Tribal authority to seek justice for native victims for certain violent crimes committed by non-Indians. Justice is an important step toward healing and recovery for victims and communities.

Much more is needed to complement this Tribal authority. Violence reduction and prevention efforts must also focus on the victims' trauma and the underlying behavioral health problems contributing to violence. Sufficient resources remain an issue. Without advance appropriations and full and mandatory funding for health care, Tribes can lose behavioral health care providers during Continuing Resolutions and shutdowns or due to lack of funding, leaving these traumatized victims without treatment and the community without adequate prevention measures.

The [Native Behavioral Health Access Improvement Act](#), H.R. 4251/S.2226, is one piece of legislation that provides important base funding for Tribal communities to address behavioral health issues. The bill would create behavioral health programs for Tribes to develop cultural-appropriate solutions for prevention, treatment, and recovery. Currently under consideration and in the refinement process, this legislation is an emerging method of funding behavioral health programs and complements the comprehensive behavioral health programs in [Title 8 of the Indian Health Care Improvement Act](#). President Biden introduced a mental health initiative in his [State of the Union Address](#) on March 1, 2022 and, as Tribal nations propose for this legislation, the [Native Behavioral Health Access Improvement Act](#) would be an excellent part of that initiative.

In addition, the [Truth and Healing Commission on Indian Boarding School Policies Act](#), H.R.5444/S.2907, would establish a Commission to investigate and document the detrimental Indian boarding school policies and historical trauma resulting from those policies and to make recommendations, among others, for federal resources and assistance to aid in healing from that trauma. This historic Commission is intended to find a path toward healing and justice through examination and emergent recommendations.

The [National Indian Health Board's](#) (NIHB) Board of Directors took action on January 25, 2022 with [Resolution no. 22-01](#) which encourages the United States government to accept responsibility for the boarding school policy, provide direct non-competitive funding to Tribes, assist

with healing from historical and intergenerational trauma from the boarding school policies, provide resources for programmatic services that encourages reclamation of AI/AN languages, and pass the Truth and Healing Commission on Indian Boarding School Policies Act.

NOW THEREFORE BE IT RESOLVED, that the Board of Directors of the National Indian Health Board does hereby encourage the United States government to accept responsibility for boarding school policy and the continuing impact of historical and intergenerational trauma, and to take meaningful steps to provide redress for these harms; and

BE IT FURTHER RESOLVED, that the National Indian Health Board does hereby encourage the United States government to provide direct, non-competitive funding for Tribal Nations in recognition of Tribal sovereignty and in honor of federal trust and treaty responsibilities, to assist with healing from historical and intergenerational trauma caused by Indian boarding school policy, to provide Tribal Nations with necessary resources to create systemic and programmatic services that encourage reclamation and revitalization of AI/AN language, culture and identity that boarding school policy was designed to eradicate; and

BE IT FURTHER RESOLVED, that the National Indian Health Board does hereby support all congressional efforts to pass legislation approving the Truth and Healing Commission on Indian Boarding School Policies Act and similar initiatives; and

BE IT FINALLY RESOLVED, that the National Indian Health Board does hereby encourage Christian churches involved in the establishment and implementation of boarding school policy to accept responsibility for their roles, to formally apologize for their roles, and to support efforts for healing work in their communities and in the reclamation and revitalization of AI/AN identity.

[National Indian Health Board Resolution no. 22-01]

One emerging initiative is the 988 Program. The [National Suicide Hotline Designation Act of 2020](#) designated 988 as a new phone number to ensure easy, universal access to crisis services, through calls, chats, or texts at anytime, anywhere, by anyone in the United States. Individuals would no longer need to call 911 if in a behavioral health crisis. It is intended to go live by July 16, 2022 and transform America's behavioral health crisis care system. The FY 2023 Budget Request for 988 and Behavioral Health Crisis Services is \$696.9 million.

NIHB has advocated for improvements to address Tribal and AI/AN access. The [9-8-8 Implementation Act of 2022](#), introduced by Representative Cardenas (D-CA) on March 28, 2022, is intended to provide more guidance and improvements, including better Tribal involvement and access, for the 988 Program. There are 32 co-sponsors, and it is currently pending before the [House Energy and Commerce Committee](#).

Congress has an opportunity in the FY 2023 appropriations cycle to provide bold and aggressive investments in behavioral health prevention ►

and treatment to confront these problems. Several programs have been funded in the past for behavioral health care, including for HS:

- Suicide Prevention and Care Program
- Zero Suicide Initiative
- Alcohol and Substance Abuse Program
- Substance Abuse and Suicide Prevention Program
- Youth Regional Treatment Centers
- Community Health Aide Program
- Native Youth Program
- Domestic Violence Prevention Program
- Telebehavioral Health Center of Excellence

In addition, SAMHSA has a few programs for Tribal behavioral health care including the Tribal Behavioral Health Grant Program which is intended to address substance use disorders and suicides rates in Tribal communities. The FY 2023 Budget Request is \$23.2 million, a slight increase over the FY 2022 funding. According to SAMHSA’s FY 2023 Congressional Justification, the program “supports Tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance use, trauma, and suicide and by promoting the mental health of AI/AN young people.”

Join NIHB is advocating for these investments, including advance appropriations and full and mandatory funding, and, in so doing, secure a more promising future for AI/AN people and future generations. ❄️

PROMISES TO KEEP: The President’s FY 2023 Budget Request and the Consolidated Appropriations Act, 2022

On March 28, 2022, the President released his Fiscal Year (FY) 2023 Federal Budget Request to Congress. The Budget Request proposes \$9.3 billion in [Indian Health Service \(IHS\)](#) funding, a \$2.5 billion or 37 percent increase above the FY 2022 level. For the first time in history, this Budget Request proposes to shift all IHS funding from discretionary to mandatory and to protect the funding from sequestration. The proposal includes automatic increases to keep pace with the medical rate of inflation, salary growth and population growth, growing to \$36.7 billion by FY 2032, an increase of 296 percent over 10 years. If this proposal is enacted into law, it would create predictability, stability, and adequacy in IHS funding.

The [National Indian Health Board \(NIHB\)](#) Chairman and Alaska Area Representative William Smith, Chief of the [Valdez Native Tribe of Alaska](#), remarked that, “Through this Budget Request, the President appears to be embracing a bold vision to end America’s long-demonstrated health and public health investment inequities for Tribal sovereign nations.” Indeed, it reflects what Tribal leaders have called for in fulfillment of the trust responsibility and treaty obligation for comprehensive health care for AI/ANs. These federal obligations require no less than full and mandatory funding for the promises and implementation of Indian health care as envisioned by our ancestors in exchange for millions of acres of land AI/ANs resources.

This proposal, however, is only a request. It will not be meaningful or come to fruition without extraordinary and united efforts by the Tribes, Administration, and Congress to ensure the required legislation is signed into law. Undoubtedly, this proposal will require substantial education and outreach to Congress. An intensive session on mandatory funding was included in the panel, “Moving the Money” as part of the [National Tribal Health Conference](#) hosted by the NIHB in October 2021. That session was just the beginning and NIHB will build upon this effort in the coming months.

Table 1

IHS Account	FY 2021 Enacted Level	FY 2022 Tribal Request	FY 2022 Congress Proposed Level	FY 2022 Proposed Level Compared to Tribal Request (+/-)	FY 2022 Proposed Level Compared to FY 2021 Enacted (+/-)
Hospitals & Clinics	\$2.238 Billion	\$4.2 Billion	\$2.399 Billion	(-)\$1.801 Billion	<u>+\$161 Million</u>
Purchased/Referred Care	\$975.8 Million	\$2.02 Billion	\$984.88 Million	(-)\$1.035 Billion	<u>+\$9.08 Million</u>
EHR/Health IT	\$34.5 Million	\$95.3 Million	\$145 Million	<u>+\$49.7 Million</u>	<u>+\$110.5 Million</u>
Mental Health	\$115.1 Million	\$714.9 Million	\$121.94 Million	(-)\$592.96 Million	<u>+\$6.84 Million</u>
Alcohol/Substance Abuse	\$251.3 Million	\$778.5 Million	\$258.4 Million	(-)\$520.1 Million	<u>+\$7.1 Million</u>
Facilities	\$917.9 Million	\$2 Billion	\$940.3 Million	(-)\$1.059 Billion	<u>+\$22.4 Million</u>
TOTAL	\$6.23 Billion	\$12.75 Billion	\$6.6 Billion	(-)\$6.15 Billion	\$370 Million

The FY 2023 Budget Request stands in stark contrast to the actual funding provided for FY 2022. On Tuesday, March 15, 2022, President Biden signed into law the omnibus bill, H.R. 2471, the [Consolidated Appropriations Act, 2022](#) which would fund the government through the end of FY 2022 which ends on September 30, 2022. At over 2,700 pages, this omnibus bill contains all 12 of the Appropriations bills which fund federal agencies, including IHS. The bill included numerous earmarks as well as several policy riders and legislative pieces such as the reauthorization of the [Violence Against Women Act](#).

It provides \$6.6 billion for IHS, an increase of approximately \$395 million over FY 2021 enacted levels. This spending measure does not achieve the robust and bold funding levels required to address severe health disparities in Tribal communities and, instead, would essentially underserve AI/AN patients. The funding level failed to consider the true cost of health care delivery by not accommodating population increases, health care facility construction, and other outstanding expenses. As in Table 1, the funding for IHS includes only modest increases from the previous FY 2021 funding levels.

Despite the unprecedented and overwhelming support and engagement of the Administration, many members of Congress, Tribal leaders, NIHB, and allied organizations, Congress did not pass advance appropriations for Indian health care. Since 2013 Congressional leaders have

introduced legislation to achieve this objective and numerous hearings have taken place. Advance appropriations would bring a level of budget certainty for Indian health care funding and is an important step toward full and mandatory funding. It is even more important as an interim budgetary measure while efforts are on-going to achieve mandatory funding for Indian health care.

For nearly a decade NIHB has tirelessly led efforts to achieve this objective. During this attempt, NIHB organized collaborative advocacy efforts with Tribal nations, national Tribal and Tribal serving organizations, national organizations outside of Indian Country, individuals, and allies across the country. Collective efforts are not in vain. NIHB will build on this work and refresh efforts to secure advance appropriations and full and mandatory funding for IHS until Indian Country succeeds. All Tribal nations and friends of Indian health are urged to join NIHB in reminding the federal government of its promises to keep and ensuring that they fulfill those promises to achieve comprehensive health care and health equity for Tribal nations and AI/ANs. 🇺🇸



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THE NATIONAL INDIAN HEALTH BOARD

MISSION STATEMENT: ESTABLISHED BY THE TRIBES TO ADVOCATE AS THE UNITED VOICE OF FEDERALLY RECOGNIZED AMERICAN INDIAN/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

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 AI/AN Tribes through the fulfillment of the trust responsibility to deliver health and public health services. Since 1972, NIHB has advised the United States Congress, IHS federal agencies, and private foundations on health care issues of AI/ANs.

NIHB staff maintains communication with Area Health Boards, national Indian organizations, Tribes along with AI/AN people. NIHB gives voice to American Indian/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 AI/ANs 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.

Health IT Modernization in Indian Country

Across Indian Country and the [Indian Health Service \(IHS\)](#), the need for health IT modernization is well known. The path to get there, however, has been less clear. As the [National Indian Health Board \(NIHB\)](#) Chairman and Alaska Area Representative William Smith, Chief of the Valdez Native Tribe of Alaska, has said, “We all know the critical importance of ensuring our health facilities have access to modern health IT systems. We also know that acquiring the up-to-date health IT systems we need has been a long and rocky road.”

IHS HEALTH IT MODERNIZATION PROJECT

In 2018, the federal government set out to answer questions about a path forward with a research project led by the [United States Department of Health and Human Service \(HHS\)](#) and IHS. The researchers followed a three-pronged approach to better understand the current state of the IHS health IT systems and the unique needs of the users that they serve. This included gathering input from 2000 health IT users from IHS, Tribal, and Urban (I/T/U) sites through interviews, site visits and data calls; analyzing system capabilities; and determining alternative options and best practices through literature review and consultation with the project [Technical Advisory Committee \(TAC\)](#).

The resulting 2019 report included eight recommendations the research team found to be crucial for successful health IT modernization (see Figure 1). After additional deliberation by IHS and further listening sessions with Indian Country, a decision was also reached to fully replace RPMS, the current (and increasingly outdated and dysfunctional) health IT system used by IHS and roughly half of I/T/U facilities overall. Since then, IHS has developed an acquisition strategy and developed a broad Statement of Objectives for the new system through internal deliberation and additional Tribal listening sessions. The agency had originally set the first quarter of Fiscal Year 2022 as their timeline to launch the acquisition process through a Request for Proposals (RFP) for the industry to offer health IT solutions for a new IHS Enterprise System. This timeline has been delayed several times and the RFP has yet to be released as of April 2022. Throughout this project, Tribal leaders have voiced frustration both with the slow pace of progress and what many see as insufficient engagement with Tribal nations.

NIHB NATIONAL TRIBAL HEALTH SUMMIT

In December 2021, NIHB brought Tribal leaders and representatives together to examine issues of health IT modernization from a Tribal perspective. Over the course of the six-hour [National Tribal Health Summit](#), several key themes emerged from the presentations, roundtables, and group discussions about significant factors in health IT modernization for Indian Country. The importance of planning and strategy regarding data sharing, security, and privacy came up repeatedly, as did the vital place of open, deliberate, and effective communication among all stakeholders. Presenters also highlighted the highly complex nature of any health IT modernization effort and the widely varying IT needs among Tribes, types of facilities, and state requirements.

Those with experience in modernizing Tribal health IT systems emphasized the immense impact changing health IT has on every aspect of a healthcare organization. The one-time and ongoing costs are substantial, as is the staff time and training required. Refining and updating the system is an ongoing, never-ending process. On the other hand,

successful health IT modernization can revolutionize healthcare, vastly improving patient experience and health outcomes. Presenters remarked that success depends on early planning and developing a thorough understanding of what the organization will need from its health IT system and electronic health records.

Tribal leaders, health IT experts, and healthcare professionals also reiterated the desire for expanded and improved cooperation and collaboration. Tribal organizations considering moving to a commercial off-the-shelf (COTS) health IT system discussed the possibilities of forming consortia to better negotiate and expand options with health IT companies. Tribes and Tribal organizations who have already switched to COTS systems discussed the potential benefits of forming collaboratives among those with the same system to better learn from each other and work together.

Tribal representatives with widely varying experiences with health IT expressed the need for more collaboration with IHS, as the department works to fully replace the electronic health record system currently used by IHS facilities. Tribes want a greater voice at every step and level of project governance, as well as improved communication from the department. Some participants of the summit stated they had not heard before IHS was pursuing a full replacement of its health IT system. Presenters also discussed the central role IHS’s [Information Systems Advisory Committee \(ISAC\)](#) plays in facilitating communication between IHS [Office of Information Technology](#) and Indian Country and lamented that this committee’s effectiveness is compromised by how many vacant seats for Tribal representatives remain vacant.

WHERE WE ARE NOW

After the Tribal summit and sustained advocacy from NIHB and Tribal leaders, IHS has significantly revamped its plan for Tribal engagement in the health IT modernization project. A Dear Tribal Leader Letter from February 2022¹ announced a new plan for ongoing quarterly Tribal consultations on Health IT modernization, which began in March with a consultation on project governance. The revised plan for project governance includes three steps, each involving different groups. The first, which has already been set up, involves governance of responsibilities IHS views as inherently federal functions; these are overseen by a Health IT Modernization Executive Steering Committee and a Project Management Office. IHS is now in the process of launching step two of its governance model, which intends to use at least three “Focus Groups” made up of Tribal subject matter experts to provide direction on high level issues of Interoperability, Data Management and Analytics, and Health IT Implementation. IHS is currently soliciting names from Tribes

¹ See https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2022_Letters/DLUIOLL_02222022.pdf

for these subject matter experts who will volunteer to participate in these groups. Step three of the model involves over a dozen specialized groups of I/T/U end users who will contribute to the build and ongoing functionality of the new Enterprise System; this step will not fully launch until after the acquisition.

IHS appears to be on the cusp of launching the RFP for acquisition. While much of Indian Country remains frustrated with the continued delays and slow pace of the process, some Tribal leaders remain concerned that this step is moving forward without more engagement from Indian Country beyond the listening sessions on the Statement of Objectives that will be used in the RFP. IHS has responded to these concerns by emphasizing that I/T/U organizations will be involved in both reviewing the acquisition proposals and the later 'build' process, in which the contracted vendor fully configures and customizes the Enterprise Health IT Solution.

Significantly, the 2019 HHS/IHS report emphasized as separate priorities the need for both Tribal participation in governance and significant engagement with end users. Some concern remains that the current plan for project governance conflates the two; robust mechanisms exist for input from I/T/U end users, but it is less clear the extent to which Tribal nations will be involved in project governance and in setting the direction of IHS health IT modernization. It remains to be seen whether this new governance model and plan for quarterly Tribal consultations will fully meet the needs and expectations of Tribal leaders for engagement and communication regarding the IHS Health IT Modernization Project.

THE ROAD AHEAD

IHS has said that after the acquisition process is complete, the agency expects the 'build' process to take 12-18 months to complete. IHS expects deployment of the new health IT system to begin in 2024 and to take several years to reach all participating I/T/U sites. IHS continues to emphasize that all Tribal and Urban organizations retain the autonomy to choose whether to use this new system or to separately purchase and maintain their COTS system.

Funding continues to be both one of the most significant variables and one of the greatest unknowns. Much uncertainty remains around the potential and ongoing costs of a new IHS health IT system, let alone any full accounting of what health IT costs across the I/T/U system have been, as many Tribal organizations continue to invest in their COTS systems in the face of the ongoing delays of IHS health IT modernization. Important questions remain about how to ensure all Tribes and I/T/U facilities receive fair and sufficient resources to support the critical functions of their health IT systems.

NIHB looks forward to working with Tribes as they continue their advocacy efforts to secure a strong Health IT system for American Indian/Alaska Natives. A truly modernized Health IT system should emulate the resilient traits of its patients and their unique health systems. Tribes look forward to the implementation of a Health IT system that can keep pace and is reflective of their innovative communities that require sustainability throughout diverse healthcare settings. 🏠

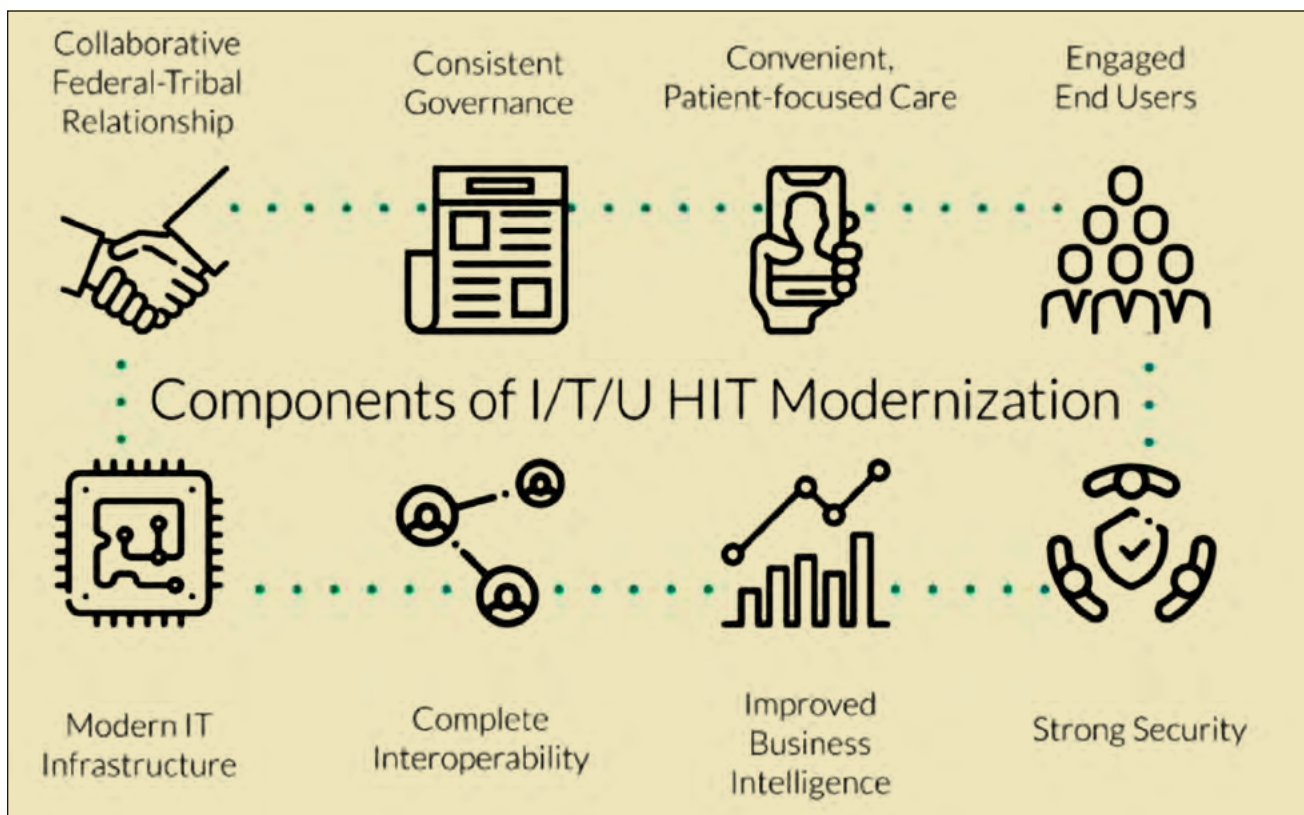


Figure 1. From Strategic Options for the Modernization of the Indian Health Service Health Information Technology: Final Report by HHS/IHS

MATERNAL MORTALITY PREVENTION: Protecting American Indian/Alaska Native Mothers

Please note that this article discusses the topic of pregnancy-related deaths broadly. The [National Indian Health Board](#) recognizes this topic may be sensitive for many readers, and encourages all those impacted by this issue to connect with their support networks.



American Indian/Alaska Native (AI/AN) women are pillars in Tribal communities as life givers, culture bearers, and caretakers of homelands. Each woman has a journey of strength and resilience, and her wisdom grows and is woven through her locks of black and silver hair. Holding the power to bring life into this world is a highly valued and sacred tradition in Indian Country that is surrounded by cultural importance, knowledge, and good medicine. As keepers of traditions and customs in many Tribes, mothers hold distinct roles of nourishing, teaching, and leading their families as matriarchs.

Losing a woman during or after their pregnancy¹ is traumatizing for families and communities, but AI/AN populations face a disproportionate maternal morbidity and mortality burden. AI/AN people make up 2.9 percent of the total United States population², with AI/AN women having the second highest pregnancy-related mortality ratio (28.3 pregnancy-related deaths per 100,000 live births)³ and AI/AN women are 2.3 times more likely to die from a pregnancy-related cause than their non-Hispanic White counterparts⁴. Gathering accurate data also presents a substantial challenge: Racial misclassification and the relatively small sample size of AI/AN women has prevented the issue of maternal mortality in Indian Country from gaining national attention⁵. Protecting AI/AN mothers, their families, and Tribal communities in ways that uphold Tribal values and practices is essential for preventing maternal mortality in Indian Country.

TRIBAL-LED MATERNAL MORTALITY REVIEW COMMITTEES: A POTENTIAL STRATEGY FOR ADDRESSING AI/AN MATERNAL MORTALITY

Over the past two years, the [National Indian Health Board](#) (NIHB) has been working to address this health burden by exploring the feasibility for Tribes to adapt the current [Maternal Mortality Review Committee \(MMRC\)](#) model to their needs through the development of several

tools created by NIHB in tandem with subject matter experts. MMRCs are multidisciplinary committees that perform comprehensive reviews of deaths among women within a year of the end of a pregnancy. The committees include representatives from public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental and behavioral health, patient advocacy groups, and community-based organizations. The [Centers for Disease Control and Prevention](#) (CDC) works with MMRCs to implement review processes that inform recommendations for preventing future deaths⁶. MMRCs have determined two out of every three pregnancy-related deaths are preventable⁷. However, MMRCs only operate at the state level and while there are approximately six state-led MMRCs that have active Tribal representation, there are no Tribal-led MMRCs.

WHY TRIBAL-LED MATERNAL MORTALITY REVIEW COMMITTEES?

The ability to adapt, implement, and maintain their own Tribal-led MMRC upholds Tribal sovereignty and governance. Tribes also have specialized community-driven protective factors to improve maternal health outcomes such as community support, increasing resilience via connection to culture, education, and positive mental health.

Additionally, the establishment of Tribal-led MMRCs will allow Tribes to control their data and respond to maternal deaths as they determine appropriate. Tribes also understand the level of historical trauma and structural racism that is extant throughout the systems and health care facilities that serve AI/AN women.

1 Please note: In this article, we refer to maternal mortality and pregnancy-related deaths as defined by the CDC Pregnancy Mortality Surveillance System, which maternal mortality as, "deaths that occur while a woman is pregnant or within one year of pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes".

2 <https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html>

3 <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#race-ethnicity>

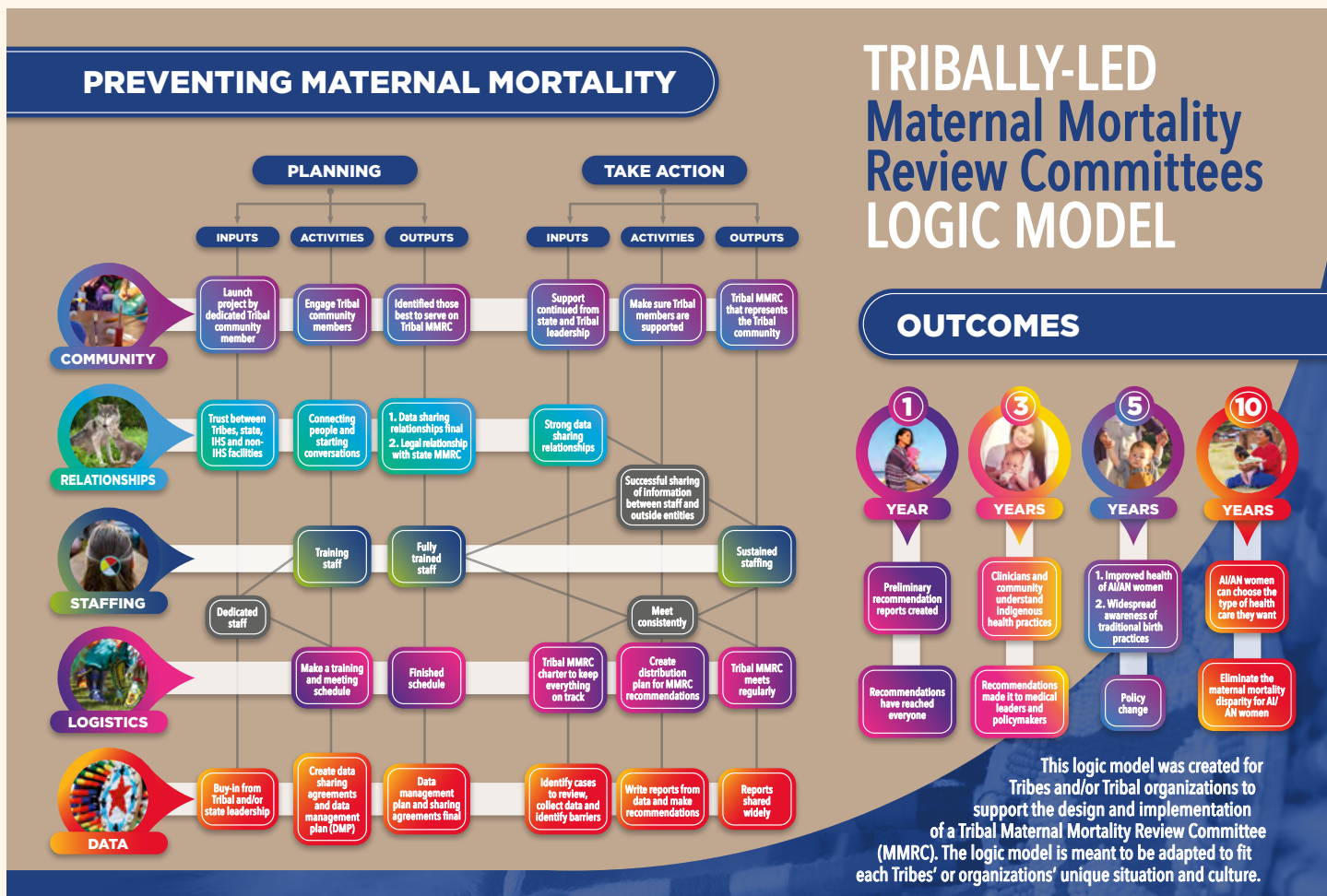
4 <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm>

5 <https://www.americanprogress.org/article/american-indian-alaska-native-maternal-infant-mortality-challenges-opportunities/>

6 <https://reviewtoaction.org/learn/7-things-to-know>

7 <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html>

WHAT IS NIHB DOING TO ESTABLISH TRIBAL-LED MMRCs?



In 2021, NIHB partnered with students from the [Harvard T.H. Chan School of Public Health](#) to develop a logic model specific to Tribal-led MMRCs. This tool provides a roadmap for Tribes and Tribal organizations to explore the inputs and resources needed to support the creation and maintenance of a Tribal-led MMRC. The logic model was developed with the help of two students, five maternal and public health experts, and 19 stakeholder interviews of Tribal members, researchers, services providers, and clinicians. The logic model is intended to provide a flexible foundation for diverse Tribes and consortia interested in developing Tribal-led MMRCs at variable states of readiness and sustainability. To view the logic model, please visit [NIHB's Maternal Mortality Prevention Webpage](#).

In 2022, NIHB has been working to develop and facilitate a self-assessment designed to help Tribes and Tribal organizations understand the feasibility of Tribal-led MMRC development and implementation. This self-assessment is an iterative process that explores Tribes' capacity in the five key components essential for a Tribal-led MMRC that were identified during the Harvard practicum: Community engagement, relationship building, staffing capacity, logistical requirements, and data sharing. In Fall 2021, NIHB conducted a request for applications process

to gather a pilot cohort of Tribes and Tribal organizations to complete the self-assessment. Three awardees for the pilot cohort were selected: [The American Indian Health Commission of Washington State](#), the [Peoria Tribe of Indians of Oklahoma](#), and the [Santee Sioux Tribe of Nebraska](#). These awardees are currently in progress of completing the self-assessment, and more information about a new round of self-assessment awards will be announced later in 2022.

PROTECTING NATIVE MOTHERS: RAISING AWARENESS OF URGENT MATERNAL WARNING SIGNS TO SUPPORT HEALTHY AI/AN PREGNANCY AND POST-PARTUM EXPERIENCES

Almost two-thirds of pregnancy-related deaths are preventable, with mothers often aware when something is wrong with their bodies. One strategy to reduce maternal mortality is to support pregnant and post-partum people in recognizing [urgent maternal warning signs](#), and communicating these signs to family, caregivers, and providers to ensure they receive appropriate, affirming care. People who are or were pregnant can experience issues up to a year after the end of their pregnancy. Signs and symptoms can include dizziness or fainting, extreme swelling, trouble breathing, or thoughts of harming themselves or their baby, among others. Urgent maternal warning signs require immediate care, ▶

which can be negatively impacted by distance to a health care facility and access to culturally competent providers.




CDC's [Hear Her campaign](#) aims to raise awareness of potentially serious pregnancy-related complications and empower women to speak up and connect with their support systems. The campaign also addresses healthcare providers' responsibilities to provide respectful, responsive care and listen to their patients' concerns. There are a variety of helpful materials available for public use, including conversation guides and social media templates. Materials are available in 21 different languages and can be found on [here](#).

This year CDC is developing a new segment of the [Hear Her campaign](#) focused on AI/AN mothers, their families and caregivers, and their healthcare providers. NIHB is working with CDC to ensure Tribal voices and perspectives are reflected in the campaign and recently hosted a session with Tribal public and maternal health professionals,

community members, and non-Tribal partners to provide feedback on potential campaign messages and strategies. The campaign is expected to be released in Summer 2022.

NIHB is committed to exploring Tribally driven perspectives on maternal mortality prevention, and ways to best support AI/AN maternal health while more broadly encompassing physical, mental, and spiritual well-being. In addition to knowing the urgent maternal warning signs, there are many actions mothers, and their friends, family, and communities can take to support themselves or those they love to be healthy and safe, both during and after pregnancy including:

- Getting a COVID-19 vaccine: Available vaccines are safe and effective for pregnant women and studies have shown mothers can pass short-term protection to their babies.
- Stopping commercial tobacco and alcohol use.
- Getting mental health support as needed.
- Connecting with elders and Tribal wisdom keepers to understand the roles, customs, and responsibilities that come with motherhood

Tribal-led MMRCs and the [Hear Her campaign](#) are just two ways of working to help prevent maternal mortality throughout Indian Country. NIHB has established a maternal mortality listserv to ensure those interested in maternal health are included in future events and collaborative activities. With these efforts, NIHB hopes to support overall AI/AN maternal health. Learn more about NIHB's work on maternal health [here](#). For more information the Hear Her campaign, please email HearHer@cdc.gov. 

LISTEN.

**Women know their
bodies best and can tell when
*something is not feeling right.***

HEAR
HEAR HER CONCERNS





ADAPTING AND SURVIVING: Preparing Yourself and Your Tribe for Severe Climate Change

Over the past year, climate change and extreme weather events have continued to be a threat to American Indian/Alaska Native (AI/AN) Tribes and communities. Floods, landslides, wildfires, and storms have begun to increase in severity, and now, there are new extreme climate change events like the [2021 Western North America Heat Wave](#) that left an estimated 1,400 people dead due to temperatures reaching above 115 degrees¹, and also the [Winter Storm Uri](#) — a winter storm followed by a cold snap that left the Midwest with an estimate of 978 fatalities². However, while these new extreme weather events are unprecedented, and are made 150 times more likely to occur by climate change³, Tribes and AI/AN communities have found ways to prepare and protect those who are most at-risk. With this knowledge, the [National Indian Health Board](#) (NIHB) is working with Tribes to prepare a series of fact sheets that will inform Tribes how to prepare for climate events such as rising water, extreme heat, hurricanes, and other inevitable weather events that will occur throughout the course of human-driven climate change.

In 2021 there were a total of 58,733 wildfires across the country that burned more than 7.47 million acres⁴. This past year, amid historic droughts, active wildfires damaged traditional hunting lands and fisheries that were already in a delicate balance due to extreme heat throughout the western region. Tribes were further impacted by poor air quality, which can impair the health of elders, children, and those with lung or cardiovascular diseases like asthma. Now, as wildfires continue to worsen each year, state wildlife departments are looking to Tribes, like the [North Fork Mono of Northern California](#), for ways to manage the impacts

of wildfires⁵. Cultural burning was banned until recently, when state departments realized that blanket [fire suppression](#) is an ineffective colonial practice that makes wildfires increasingly worse over time. As the keepers of knowledge for cultural burning, the North Fork Mono's sovereign rights were recognized so they could continue to practice traditional burning ways on their ancestral lands to bring back health to the land in the west and reduce the extreme land and health impacts of wildfires.

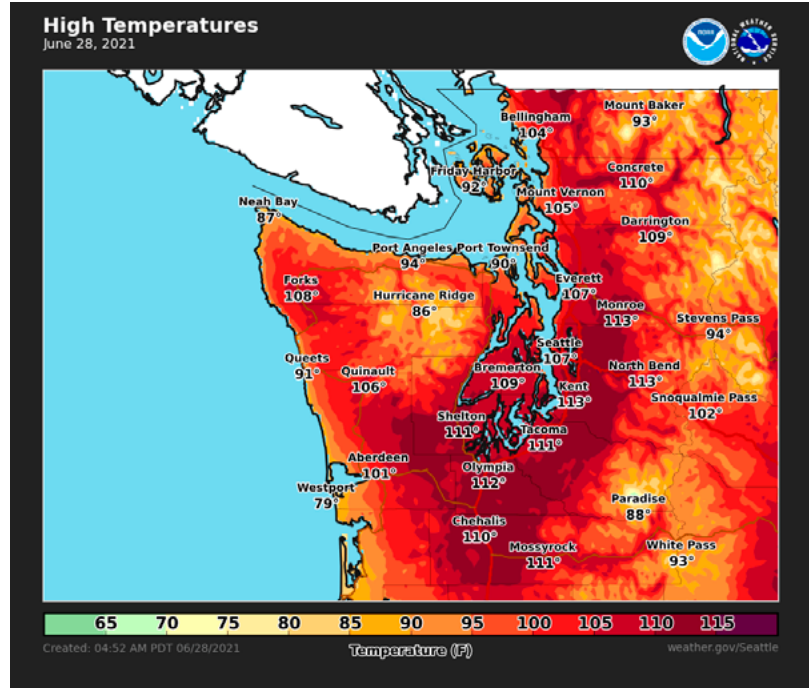


Figure 2: Predicted high temperatures for western Washington on June 28, 2021. United States National Weather Service via Twitter <https://twitter.com/NWSSeattle/status/1409489256792342529>.

1 Global Catastrophe Recap September 2021 (PDF) (Report). Aon Benfield. October 12, 2021. p. 13. Retrieved March 24, 2022.
 2 Aldhous, Peter; Lee, Stephanie; Hirji, Zahra (May 26, 2021). "The Texas Winter Storm And Power Outages Killed Hundreds More People Than The State Says". BuzzFeed News. Retrieved March 24, 2022.
 3 "Rapid attribution analysis of the extraordinary heatwave on the Pacific Coast of the US and Canada June 2021" (PDF). World Weather Attribution. Retrieved March 24, 2022.
 4 <https://disasterphilanthropy.org/disasters/2021-north-american-wildfire-season>

5 <https://www.npr.org/2020/08/24/899422710/to-manage-wildfire-california-looks-to-what-tribes-have-known-all-along>



Hurricanes threaten communities in the Gulf Coast, including the [Coushatta Tribe](#) in Louisiana. The Tribe worked with emergency management professionals to ensure the Tribes thousand or so citizens were able to evacuate from Hurricane Laura's destructive path. The Tribe also worked with state and national disaster preparedness professionals to ensure relocation sites did not expose Tribal evacuees to the COVID-19 pandemic. Hurricane season typically lasts from June to November, and every year, the impacts of climate change has been evident in the warming the waters in the Gulf of Mexico. Warmer waters create ideal conditions for hurricanes to develop more quickly and more strongly, so coastal Tribes will need to continue working to ensure their communities are protected from storms.


In 2021, unprecedented and unpredicted extreme weather events the Pacific Northwest (PNW) heat dome and the Midwest ice freeze occurred. Both events were driven by climate change, encouraging climate scientists to learn what is needed to be prepared for more extreme temperature events like these in the future⁶. However, while the ice freeze and heat dome impacted urban and non-Tribal communities more severely, Tribes used their traditional knowledge of the land and community resiliency to ensure those most impacted were protected. For example, while the PNW lost almost 1 billion sea creatures⁷ due to the combined forces of temperatures reaching over 121 degrees and an extreme low tide, the [Skokomish Indian Tribe](#) ensured elders and those more severely impacted by heat had priority access to air conditioning and water, while encouraging the rest of the Tribe to access the river during the day to stay cool as most homes in the PNW do not have air conditioning.⁸ This use of land knowledge helped the Skokomish stay safe during the worst days of the extreme heat. Likewise, the [Kiowa Tribe](#) in Oklahoma grouped

together during the Midwest ice freeze to check on elders and pass out food and supply boxes to elders and community members while temperatures dropped below zero degrees. When over five million people lost power during the freeze, Kiowa leaders distributed over 45,000 pounds of food to the Tribe and local community members⁹.

These are just three examples of ways that Tribes are adapting traditional knowledge and resiliency to new extreme weather events caused by human-driven climate change. NIHB continues to work with Tribes through the [Climate Ready Tribes Program](#), funded by CDC, to explore ways Tribes can best adapt and understand the public health impacts of climate change that are unique to their Tribal region. This year, the [Lummi Nation](#), the [Sitka Tribe of Alaska](#), and the [Pala Band of Mission Indians](#) are the three Climate Ready Tribes awardees working to educate their communities on climate change. Additionally, the NIHB will be releasing a series of fact sheets for Tribes to learn how to protect themselves during extreme weather events like heat and drought.



TRIBAL CLIMATE & ENVIRONMENTAL HEALTH PROJECT

For more information, please visit the [NIHB Climate Change and Climate Ready Tribes](#). 

⁶ <https://www.ipcc.ch/report/ar6/wg2/>
⁷ <https://www.theatlantic.com/science/archive/2021/12/extreme-heat-baking-sea-animals-alive/620904/>
⁸ Paul, Blair. Interview. By Mattie Curry. 18 November 2021.
⁹ <https://www.newspaper.indianlife.org/story/2021/03/15/news/oklahoma-tribe-volunteers-pass-out-food-boxes-supplies-amid-harsh-winter-weather/1768.html>



NO LONGER IGNORED: Historic Infrastructure Investments in Tribal Clean Water and Sanitation

When Congress passed the bipartisan [Infrastructure Investment and Jobs Act](#) (IIJA) in November 2021, the [National Indian Health Board](#) (NIHB) Chairman and Alaska Area Representative William Smith, Chief of the Valdez Native Tribe of Alaska, declared the IIJA would “infuse much needed funding for necessary sanitation and safe water systems in Tribal communities. These are tremendous long-standing obligations of the federal government which Tribal nations have fought for years to address. Tribal communities have extensive sanitation deficiencies ... which will no longer be ignored.”

Indeed, the IIJA provides historic infrastructure investments of \$3.5 billion over five years, at \$700 million per year, for water and sanitation deficiencies in Tribal communities. This law also provides funds for other infrastructure programs in Tribal communities including Tribal roads, bridges, railroads, high-speed internet, and broadband infrastructure.

The IIJA allows up to \$2.2 billion for economically infeasible projects — projects which would never be addressed without this critical funding.

The IIJA provides \$3.5 billion to [Indian Health Service](#) (IHS) [Sanitation Facilities Program](#).

The IIJA allocates this total amount over five years:

- \$3,377,500,000 for sanitation projects
- \$105,000,000 for salaries, expenses, and administration
- \$3.5 million for the [Department of Health and Human Services](#) Office of the Inspector General for oversight purposes

BACKGROUND

IHS’s [Sanitation Facilities Construction](#) program, established under the [Indian Sanitation Facilities Act of 1959](#) (P.L. 86-121), authorized IHS to provide and maintain essential water supply, sewage, and solid waste disposal for Tribal communities, individuals, and homes. It is intended to bring sanitation infrastructure to a “level one sanitation deficiency” — that is, a sanitation system that complies with all applicable water supply and pollution control laws and only routine and maintenance is necessary. Tribes served by the IHS or that have [Indian Self-Determination Education and Assistance Act](#) contracts, or compacts are eligible for sanitation facilities projects and assistance. The goals, eligibility, project funding, and priorities remain the same regardless of program delivery methods.

Prior to the [Indian Sanitation Facilities Act of 1959](#), the [United States Public Health Service](#) assumed the main responsibility for overseeing the health and sanitation conditions of Tribal communities. The [United States Public Health Service and the Bureau of Indian Affairs](#) (BIA) undertook initiatives to improve the sanitation



infrastructure and conditions of Tribal communities but failed to make substantial and meaningful infrastructure improvements.

The two agencies initiated multiple studies to investigate the sanitation and subsequent health conditions of Tribal communities. The studies focused on areas such as boarding schools, hospitals, headquarters – not rural Tribal communities where the sanitation conditions persisted. In 1957, an act titled ‘to provide for the construction of sewer and water facilities for the [Elko Indian colony](#), Nevada’ was the first piece of legislation to fund sanitation infrastructure for a Tribal nation.

The 2019 Annual Report identified 1,563 sanitation projects, of which 1,088 were economically feasible and 475 were economically infeasible. The total database for those 1,563 sanitation projects estimates \$2.57 billion to fully fund adequate sanitation infrastructure. For certain sanitation projects, funds contributed from other entities or sources, such as the Environmental Protection Agency Set-Aside Wastewater Grants program, are used to cover some portions of the projects. Even with additional resources, the current funding levels for IHS Sanitation Facilities Program of \$196.5 million for Fiscal year (FY) 2021 and \$197.7 million for FY 2022 would not be enough to meet the overall funding deficiencies.



SANITATION DEFICIENCIES PROGRAM

During a Tribal consultation on January 5, 2022, Mark Calkins, Director Division of Sanitation Facilities Construction, presented Fiscal Year (FY) 2021 data in collaboration with Tribal communities and the IHS¹. The findings report, that for the 245,802 homes that need critical sanitation investments a total of \$3,361,445,056 is needed to fully fund sanitation infrastructure. Of the 2,812 new and like-new homes that require sanitation services, a total of \$85,150,431 is needed to fully fund those services. [The 2019 Annual Report to Congress of the United States on Sanitation Deficiency Levels for Indian Homes and Communities](#) reported 6,626 homes have a deficiency level of 4 and 5 which means they lack safe water supply and sewage disposal systems. The Alaska and Navajo IHS Areas experience the highest rates of homes that lack access to safe water supply and or sewage disposal systems.

¹ Calkins, Mark. (2022). Indian Health Service Infrastructure and Jobs Act [PowerPoint slides]. Division of Sanitation Facilities Construction, Indian Health Service. <https://www.ihs.gov/ihscalear/download/?method=inline&fileID=B3270D4B-9454-9677-161FF26B85853D90>

THE INFRASTRUCTURE INVESTMENT AND JOBS ACT

However, the IJA is a real turning point for Tribal communities. The IJA is intended to address the currently known sanitation deficiencies. Moreover, the IJA allows up to \$2.2 billion for economically infeasible projects — projects which would never be addressed without this critical funding.

To date, IHS has held one information session and three virtual Tribal consultation sessions to seek input and recommendations of the IJA sanitation funding should be distributed. On December 9, 2021, IHS hosted a Learning Session to provide a general overview of available funding sources including

the IJA funding. The three virtual Tribal consultations were held on December 14, and 22, 2021, and January 5, 2022.

During the consultation on January 5, IHS proposed a new project allocation methodology. The new methodology proposes, under the guidance of the IJA, an immediate priority to allocate funds where the majority can be used immediately to construct projects which includes those projects economically infeasible. The current project methodology does not prioritize nor fund economically infeasible sanitation projects. Seeking input on the new proposed methodology, IHS will release a ‘Dear Tribal Leader’ letter on the finalized project allocation methodology and funding availability.

This funding will address one major infrastructure item in Tribal communities. However, other infrastructure deficiencies, such as health care facilities, still exist. It is critical for Congress and the Administration to fully fund Indian health care so other necessary services and infrastructure deficiencies are also no longer ignored. 🇺🇸

Mark your Calendars for the Second Tribal Public Health in Indian Country Capacity Scan

Tribal nations have a vested interest and sovereign right to provide valuable public health services to their communities. Especially since the COVID-19 pandemic, most, if not all, Tribal nations are engaged in public health, whether that is through a stand-alone department or program, through integration with clinical services or in partnership with other entities. To understand the evolving public health infrastructure and capacity needs of Tribes, the [National Indian Health Board](#) (NIHB) will launch the second [Public Health in Indian Country Capacity Scan \(PHICCS II\)](#) this June 2022!

PHICCS is the only national survey that captures the capacity of Tribal health and public health systems in delivering public health services. **This scan gives a distinctive voice and visibility to Tribal health and public health systems, who may otherwise be left out.** We know that Tribal systems are unique in how they operate, in who they serve, and in their needs.

WHAT'S NEW FOR PHICCS II?

Over the last several months NIHB has made substantial changes to the PHICCS II questionnaire. These changes are based on feedback from a wide range of individuals, including Tribal health organizations, Tribal partners, and NIHB member organizations.

PHICCS II features the following changes to improve ease-of-use:

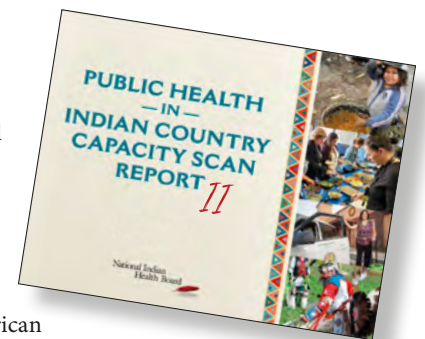
- Reduced the number of questions: PHICCS II has been shortened from 134 to 68 questions
- Improved formatting and flow
- Updated topics to reflect current Tribal public health priorities
- Increased overlap between topics across sections

HOW DO TRIBES AND TRIBAL ORGANIZATIONS BENEFIT FROM PHICCS II?

The PHICCS II report will help demonstrate the connections between the daily operations of individual Tribal health organizations and the collective efforts to improve the health status of American Indian/Alaska Natives (AI/ANs) taking place nationally. Such information will benefit Tribes in several ways, including:

- Assessing Tribal public health systems to identify needs
- Identifying Tribal priorities for development and resource allocation
- Identifying opportunities for training and technical assistance
- Establishing a baseline to measure progress over time
- Supporting advocacy efforts for the betterment of all Tribes. Robust and accurate data will lead to data-informed decision-making
- Increasing the visibility of Tribal entities and the public health services provided
- Owning data and the ability to request data for their programs. NIHB is committed to Tribal data sovereignty

We encourage all Tribes interested in participating in PHICCS II to contact Verne Boerner, Public Health Director, at vboerner@nihb.org. 🇺🇸



Paving the Way for Tribal Public Health Resilience Through Public Health Capacity Building

The last two years of the COVID-19 pandemic have highlighted the chronic underinvestment in Tribal public health by the federal government, and the resiliency and creativity of Tribes to provide essential public health services to their citizens. As Tribes begin to look at the next stages of pandemic recovery and strengthening, Tribal public health departments are increasingly expressing interest in advancing public health capacity.

WHAT IS PUBLIC HEALTH CAPACITY, AND WHY DOES IT MATTER FOR TRIBES?

The term public health capacity describes the ability to perform work related to public health services. By harnessing the benefits of having improved capacity in public health, Tribes can build and adapt their public health services to speak directly to the culture and needs of their communities. The process of developing public health capacity includes strengthening knowledge bases, systems, and leadership and provides opportunities for Tribal public health departments to plan for both short- and long-term public health operations. The act of building capacity is an expression of Tribal sovereignty since it offers opportunities for Tribes to determine how they build their public health systems. Furthermore, an assessment of capacity can help Tribes determine their current needs, existing resources, and priorities for future investment. One recent example of a national-level capacity scan is [the Public Health in Indian Country Capacity Scan \(PHICCS\)](#).

BUILDING TRIBAL PH CAPACITY THROUGH THE SSSC PROGRAM

Tribal communities often face hurdles related to funding, workforce limitations, and disproportionate health complications. Yet despite existing and arising challenges in Tribal public health, Tribes have remained resilient and advanced Tribal public health capacity building, particularly during the COVID-19 pandemic. Several of these efforts are demonstrated by the Tribes that participate in the [Strong Systems, Stronger Communities](#) (SSSC) grant initiative.

SSSC, in partnership with the [Centers for Disease Control and Prevention](#) (CDC), has supported Tribal public health improvement the past four years by providing opportunities for Tribes to fund culturally unique activities to build public health capacity. This grant has offered continued technical assistance and training to over 20 Tribes in addition to many others who participate in peer learning opportunities. This program is unique due to the consideration and prioritization of Tribal culture and traditions in program activities. SSSC also works in partnership with other national organizations of mutual interest to ensure equitable representation and resource availability for Tribes.

EXAMPLES OF PUBLIC HEALTH CAPACITY BUILDING IN INDIAN COUNTRY

Current and past SSSC awardees have made huge strides toward national public health accreditation standards and the overall development of public health capacity for Tribes in the early stages of public health improvement. A reported 95 percent of Tribes that have worked with NIHIB have made progress toward meeting national standards and measures of public health, as outlined in [the Public Health Accreditation Board's \(PHAB's\) Standards and Measures](#). Note that these standards are one way of conceptualizing public health capacity; many Tribes may choose to utilize some, none, or all of the standards and measures as they develop their frameworks for their Tribe's public health capacity.

An additional 79 percent increased their resources related to public health improvement, funding, staffing, and partnerships. For example, one Tribe in the early stages of public health development became a repeat awardee establishing a performance improvement planning team that conducted an accreditation self-assessment along with completing the public health strategic planning process. Another Tribe that has since achieved national public health accreditation, utilized grant funding to address gaps in their performance management and quality improvement systems. During recent post-assessments, Tribes noted being able to use activities completed as a part of grant activities to support the COVID-19 pandemic response and plans to build their achievement to continue progress. Several have also gone on to provide support to other Tribes working on similar projects, building networks of peers invested in Tribal public health capacity.

IMPLICATIONS FOR FUTURE CAPACITY IN PUBLIC HEALTH

In conclusion, public health capacity needs vary from Tribe to Tribe. By supporting Tribes as they identify their specific needs and tailor training and projects to meet them where they are, the [National Indian Health Board](#) (NIHB) has been able to increase knowledge, systems, and partnership to support the improvement of public health capacity in Indian Country. This is reflected in ongoing efforts such as SSSC that provide support to Tribes interested in building their capacity and make way for continuity after the fulfillment of the grant deliverables. As a result, Tribes can use their achievement to address public health challenges through Tribal tailored approaches and use their success to promote the health of their Tribal communities.

For more information, please visit [Public Health Indian Country Capacity Scan \(PHICCS\) Project](#). 



Barriers to Accessing Telehealth

The COVID-19 pandemic permanently shifted health care delivery and how it is conceptualized. The growth of telehealth as a means of health care delivery was a paradigm shifter. It allowed people to receive care without having to physically go to a provider's facility. This permitted people to receive care in an environment in which they are comfortable. It also bridged distance gaps for patients in rural communities. However, many have been left behind, or might be left behind, by the expansion of telehealth. Through a combination of infrastructure and regulatory challenges, Indian Country still faces barriers to fully realizing the potential of telehealth.

March 2020 brought unprecedented challenges to health care providers. The spread of a very contagious respiratory virus created a need to minimize exposure while still ensuring patients could be treated with a transformation in health care delivery. Providers began turning to telehealth as a means of seeing patients and ensuring continuity of care. Prior to the pandemic, telehealth was a relative niche means of health care delivery. According to the [Kaiser Family Foundation](#), 18 percent of Medicare recipients reported their providers had offered telehealth services, a number which expanded to 64 percent within a year of the COVID-19 pandemic's beginning.¹ Telehealth's expansion during the pandemic proved its ability to grow access to care by allowing patients to receive care where they are most comfortable. It also proved effective at bridging distance gaps, helping people to receive care when the closest provider is hours away.


While the expansion of telehealth has been positive, there remain barriers to accessing it. First, while Indian Country continues to advocate for the acceptance of audio only telehealth, telehealth is generally delivered via real time audio/video communication. Accessing real time audio/video communication requires being able to access a fixed broadband connection, which has long been a struggle for Indian Country. This represents a substantial barrier to accessing telehealth and makes it prohibitively difficult for Tribal citizens to do so. While we know Tribes have been successful in addressing this barrier by providing their Tribal citizens with a space to access the broadband technology necessary for a telehealth visit, this does not address one of the most common challenges in rural Tribal communities; access to transportation. If a person does not have access to broadband or reliable transportation, they face being shut out of being able to access telehealth.

¹ Koma, W., Cubanski, J., & Neuman, T. (2021, May 19). Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. Retrieved from Kaiser Family Foundation: <https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/>

Further, there also exist regulatory and statutory barriers to accessing telehealth. The expansion of telehealth has been aided by waivers that are tied to the federal [Public Health Emergency](#) (PHE). These waivers have allowed for an expansion in the modalities and services for which Medicaid and Medicare will reimburse. For example, Medicare will currently reimburse for audio-only telehealth and care provided in the home. However, these flexibilities are currently set to expire 151 days after the end of the PHE. Many states have also taken steps to expand Medicaid reimbursements during the PHE, though this varies by state. Given the perpetual underfunding of the [Indian Health Service](#) (IHS), these reimbursements are essential for ensuring that Indian health providers have the funding necessary to offer these services.

In March 2021, the [National Indian Health Board](#) (NIHB) provided a testimony to the [United States House of Representatives Energy and Commerce Committee Subcommittee on Health](#) during, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care" hearing. To effectuate more robust and comprehensive access to telemedicine across Indian Country, NIHB urges the Committee work to pass the following policy priorities:

- Increase flexibility in Medicare definition of telemedicine services
- Encourage states to increase Medicaid telehealth reimbursement for IHCPs
- Expand access to telehealth in the Indian health system through increased funding and technical fixes
- Permanently extend waivers under Medicare for use of telehealth
- Ensure that Medicare reimburses IHS and Tribal providers for telehealth services at the IHS All-Inclusive Rate or "OMB Rate"

To fully expand telehealth, it is going to be essential for these barriers to be eliminated. NIHB has been engaged on eliminating the regulatory and legislative barriers. 

REPRESENTATIVE DON YOUNG:

“Dean of the House of Representatives” and Friend of Indian Country, Journeys On

The [National Indian Health Board](#) (NIHB) mourns the passing of the “Dean of the House,” Representative Don Young who journeyed on Friday, March 25, 2022, as he was traveling back to Alaska from Washington, DC as he has done so many times for nearly 50 years. His second wife, Anne, was by his side. His first wife, Lu, Gwich'in Athabascan from Fort Yukon, Alaska, had passed on in 2009 after more than 46 years of marriage. A fearless ally of Indian Country, he leaves behind a legacy of friendship and leadership in Indian affairs and Indian health care.

Representative Young was the longest-serving Member of the [House of Representatives](#) in this current Congress and was sworn into the 93rd Congress after winning a special election on March 6, 1973. He was a skillful legislator, fierce advocate, and leader throughout his tenure. Those qualities and skills served him well during his time as Chairman of the House Resources Committee from 1995 to 2001 and Chairman of the House Transportation and Infrastructure Committee from 2001 to 2007. Representative Young also served as Chairman of the Subcommittee on Indian, Insular, and Alaska Native Affairs of the Committee on Natural Resources from 2011 to 2017.

Despite moving to Chairman Emeritus status on the Natural Resources Committee, Representative Young remained active and dedicated to American Indian/Alaska Native (AI/AN) issues. At the time of his passing, he was serving as the Ranking Member of the Subcommittee on Indigenous Peoples of the United States of the Committee on Natural Resources. His work embodied the principles of true government-to-government relations. He engaged with Tribal leaders on a wide range of issues and stood with Tribal nations in fighting for funding and legislation to strengthen Tribal sovereignty, fulfill the trust responsibility, and improve the lives of AI/ANs.

His fearless leadership, immense experience, and tireless efforts extended to and benefitted all Tribal nations. Representative Young used his influence and leadership positions to build a legacy for Indian health care. He sponsored or co-sponsored no less than 44 Indian health care related bills and chaired multiple hearings on Indian health care issues. Most notably, he led the efforts to reauthorize the [Indian Health Care Improvement Act](#) and the [Special Diabetes Program for Indians](#) and to secure advance appropriations for Indian health.

Few Members of Congress understood the challenges facing Tribal communities as well as Don Young. In his early life, he taught a fifth-grade class in a [Bureau of Indian Affairs](#) schools in the remote village of Fort Yukon, Alaska the place he called home until his passing. The conditions were harsh, the challenges great, and the federal government had yet to fulfill its promises to AI/ANs. This perspective was evident when in 2021, he again introduced legislation authorizing advance appropriations and remarked, “Alaska Native and American Indian communities have historically been shortchanged when it comes to receiving high-quality health care to meet their unique needs. The COVID-19 pandemic hit Native Americans especially hard, which makes providing certainty for health care funding even more important.”

These experiences and perspectives led him to a life of public service. NIHB thanks his family for sharing their beloved patriarch with Indian Country. He shared many moments with the NIHB Board of Directors during personal meetings and during the many NIHB conferences at which he welcomed all Tribal nations and AI/ANs to visit him in Washington, DC and Alaska.

In his remarks at the 2021 NIHB National Tribal Public Health Summit, Representative Young reminded all summit participants his door was always open to meet on Tribal issues. He reminded attendees, “I have a little knowledge of how this thing [Congress] works and I’ll be very helpful to all of you.” His parting words at the summit reminded all AI/AN people why he fought so hard and so long for them when he opened his heart in a good way and ended his remarks by simply stating, “I just love you all.” Thank you, dear friend, for your service. You will be greatly missed. 🇺🇸



TRIBAL OUTREACH AND EDUCATION:

Lessons from the Pandemic

The COVID-19 pandemic resulted in a paradigm shift in how to reach people to deliver public health messaging. This transition was also abrupt and required learning lessons as we worked, incorporating those lessons, and moving forward in the best way possible. At the beginning of the pandemic, the [National Indian Health Board](#) (NIHB) had to quickly shift to providing this information virtually and without being present in communities.

American Indian/Alaska Natives (AI/ANs) are no strangers to deadly infectious diseases and have endured a long history of pandemics. Tuberculosis and the Spanish flu of 1918, disproportionately killed and sickened AI/ANs. During the 1918 flu pandemic, more than 80 percent of deaths in Alaska were among Native people; American Indians died at four to five times the rate of other Americans during the H1N1 flu epidemic of 2009.

Before the COVID-19 pandemic, much of NIHB's outreach and education work relied heavily on in-person meetings and site visits but this was not possible during the [Public Health Emergency](#) (PHE). Over the last two years, NIHB has learned a lot about conducting virtual outreach and moving forward in a world where we cannot physically be present. Perhaps the most fundamental lesson is that we can leverage technology to broaden our reach and use it to complement our in-person work.

With the pandemic limiting the ability to be present in communities, NIHB moved to hosting and partaking in virtual trainings, which has allowed the organization to reach Indian Country and ensure they received the information they needed promptly. NIHB provided trainings on the Indian specific provisions for health care that came into existence because of the PHE as well as the Indian collaborated with federal agencies to provide important updates and information on health care coverage and health care services topics. This was especially important as this information quickly evolved throughout the COVID-19 pandemic.

In addition to virtual trainings, NIHB disseminated, analyzed, and gathered information regarding the COVID-19 pandemic, health insurance enrollment, and other pertinent health policy topics. An [Enrollment Assister Toolkit](#), specific explanatory one pagers, and other [outreach materials](#) were made available. To facilitate this, NIHB created a COVID-19 [Tribal Resource Center](#) website.

NIHB also redirected its [Story Banking Campaign](#) from its traditional in-person paper version to a web-based form that remains accessible to any area throughout Indian Country. The Story Banking campaign aims to provide a forum for Tribal health center employees, Enrollment Assisters, Patient Benefit Coordinators, and other Tribal health care facility community members with a means to provide health care insurance related stories. Through these stories, NIHB aims to better understand and convey the best practices and challenges related to health insurance coverage. The online forum has created an easily

accessible and convenient option for Tribal health community members during the PHE.

Because of the vital importance of outreach and education on health insurance and health care services for AI/ANs during the PHE, NIHB relied heavily on training webinars, emailing, telephonic, and social media connectivity. For example, NIHB disseminated updates in the Policy Center virtual newsletter, provided technical assistance to Tribes and Tribal organizations on health insurance related updates and challenges, restructured virtual outreach material emphasizing the importance of signing up for Health Insurance during COVID-19, and much more. The expansion of the modalities through which NIHB reaches Indian Country, has also allowed for the ability to conduct outreach, connecting with people whose communities we may not be able to visit or who may not be able to travel. The expansion of NIHB's ability to conduct widespread outreach has been the most significant lesson of the COVID-19 pandemic and will complement our in-person outreach in the future.

Along with the best practices and lessons learned, NIHB remains committed to researching, compiling, and creating new ways in which Indian Country can access important health care coverage related updates and provisions specific to AI/ANs. Even though the PHE has caused serious repercussions and undoable damage to Indian Country, NIHB aims to continue learning and growing to meet the needs of Tribes and Tribal communities in all its outreach and education endeavors. Sign up for NIHB [emails](#) to stay up to date 📧



CULTURE AS PREVENTION: Protecting Native Youth from Violence



American Indian/Alaska Native (AI/AN) youth are our peoples' future. They will be the holders of our stories, the teachers of our language, and creators of our prosperity. However, AI/AN youth are being exposed to violence at an alarming rate. A 2016 study revealed that more than four in five AI/AN women (84.3 percent) have experienced violence in their lifetime and more than half (56.1 percent) have experienced sexual violence in their lifetime¹. It is believed that the historic maltreatment of AI/ANs and the transmission of these historical injuries through generations contribute to the high prevalence of interpersonal violence against AI/ANs². Research shows adverse behaviors such as domestic or intimate partner violence increase as the number of risk factors increases. These risk factors can be genetic or an aspect of personal behavior, lifestyle, or environmental exposure. To break the cycle of violence among AI/ANs, youth must be exposed to protective factors that both protect against the occurrence of undesirable outcomes and promote the occurrence of desirable outcomes. Increasing protective factors reduces the risk of violence³. Understanding and being able to connect to one's Native culture is a primary protective factor in violence prevention.

- 1 Rosay, 2016
2 Brave Heart, 2003
3 Henson, 2017

In addition to experiencing a greater burden of health disparities compared to other Americans, AI/AN people also experience Adverse Childhood Experiences (ACEs) disproportionately. These health disparities may result from social determinants of health including inadequate education, poverty, and lack of healthcare, but [ACEs](#) are implicated as well. The [National Indian Health Board](#) (NIHB) launched the [ACEs Information Hub](#) of information and resources to increase awareness and knowledge of ACEs and expand Indian Country's capacity to address such adversities. The ACEs Hub offers Tribes and Indian health providers peer-reviewed research, planning resources, and screening approaches.

During the COVID-19 pandemic, AI/AN youth have been particularly vulnerable to disruptions, with many at risk of being left behind in education, economic opportunities, and health and wellbeing during a crucial stage of their life development. Many Tribal individuals, families, and communities have been impacted by childhood experiences causing physical and mental health adversities throughout their lifespan but rely on their culture.

Culture itself can be defined in multiple ways: it is the customs, arts, social institutions, and achievements of a particular group; the way of life for an entire society; or what guides an individual and community. Within AI/AN culture are the elements needed for recovery and wellness. Whether it is dancing at a powwow, learning to basketweave with an elder, or practicing medicine, there is strength in embracing cultural values. Youth involvement in their Tribal community can relieve stress and anxiety, as well as allow them to connect with their culture, promoting cultural engagement. Activities that connect youth and elders provide a space of generational teachings and wisdom that support a sense of belonging for AI/AN youth. Storytelling to pass down traditions and customs, recount history, and pass on knowledge over generations allows for a deeper connection for youth. These examples provide a cultural change in societal norms to promote positivity over violence.

Promoting, creating, and implementing cultural engagement programs for youth in AI/AN communities serves as positive protective factors over violence. A successful prevention strategy will often require evidence-based practices, practice-based evidence, and a culturally-rooted framework. There are several Tribes and Tribal communities that are already

promoting and creating programs for youth across the country. One resource that has a large platform for AI/AN youth is We R Native, a multimedia health resource for Native teens and young adults. This site focuses on promoting life skills and healthy decision-making for Native youth. This service was designed by using behavior change theory and formative research, with extensive input and website content created by Native youth. We R Native includes content on culture, emotional, sexual, and spiritual health, as well as content around violence and abuse.

Cultural and social norms are highly influential in shaping the behavior of an individual. Using culture as a positive reinforcement to protect Native youth against violence has been shown to be successful. For our Native youth to carry on our traditions and values peacefully, we must provide them with the knowledge and tools to do so.

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Impact of the COVID-19 Pandemic on Cancer Screenings in Indian Country

For many decades, cancer disparities have existed in the United States. For American Indian/Alaska Natives (AI/ANs), cancer is a serious health concern.¹ Cervical, breast, and colorectal cancers are among the five most common cancers in AI/AN women and colorectal is among the top five for AI/AN men.¹ According to the [Centers for Disease Control and Prevention](#) (CDC) data from 2012-2016 AI/AN men were more likely to get cancer compared to AI/AN women.² One challenge to addressing these disparities is screening delays, which can lengthen the time to receive a diagnosis and timely treatment.³

Cancer screenings which are tests that look for cancer in people who do not have symptoms, are effective early detection and prevention methods that can reduce overall cancer prevalence and death.⁴ Screening tests for some common cancers such as prostate, colorectal, and cervical cancer can reduce death among AI/AN who have high cancer mortality rates.⁴ However, cancer screenings were interrupted due to the COVID-19 pandemic. Initially, many medical facilities had to cancel or postpone cancer screenings⁴, and at the beginning of the pandemic, many people did not seek routine check-ups and screenings. This along with healthcare facilities prioritizing urgent medical needs led to a decrease in cancer screenings.⁵

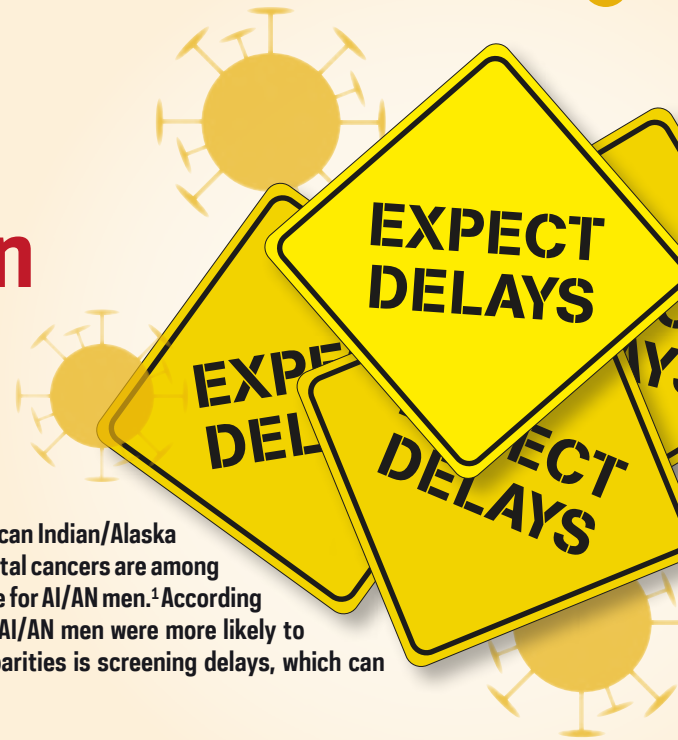
For instance, based on the [National Breast and Cervical Cancer Early Detection Program](#) (NBCCEDP) Cervical Cancer Screening Tests for January 2020–June 2020 compared with the five-year average during 2015–2019, by Racial/Ethnic Group, breast cancer screening decreased by 98 percent among AI/ANs.³ It is suspected this decrease in screening due to the fear of contracting COVID-19 would cause over 90,000 additional cancer-specific deaths for colorectal and breast cancers over 2020–2030, based on the data from cancer-specific mortality in the United States.⁴ However, Tribal organizations responded to connect their people with these necessary procedures.

For example, several organizations helped women in the [Oglala Sioux Tribe](#) to get screened for breast and cervical cancer during the COVID-19 pandemic. The [Great Plains Tribal Leaders Health Board](#), an awardee of the [CDC's National Breast and Cervical Cancer Early Detection Program](#), used a patient navigator through the Walking Forward program. From July 2019 through August 2020, the patient navigator worked with staff at the Women's Clinic

by sending letters to women who were due for a cancer screening test. The patient navigator and clinic staff members also educated women about cancer screening and prevention. Despite the COVID-19 pandemic, from February to August 2020, 225 women were screened.⁶

As the world enters the third year of the pandemic, many people including healthcare employees and staff have received the COVID-19 vaccine and/or booster shots. This has helped many healthcare facilities return to somewhat routine capacity and many are again offering elective cancer screenings and wellness exams. However, as the pandemic continues, how quickly an individual can be screened may vary by community and facility.⁵ Health care systems may need to catch up in some ways with cancer screening. According to the [American Indian Cancer Foundation](#), strategies for screening in the 2020-2022 plan, for instance, reduce structural barriers to breast cancer screening such as clinic hours, financial burden, and transportation, or promote the Indigenous Pink campaign during the month of October.⁷ To minimize the barriers to colorectal cancer screening, healthcare facilities can send a fecal immunochemical test (FIT) kit to Tribal citizens.⁸ It will take time, money, and re-education for the post-COVID world to return to the pre-pandemic cancer screening recommended rates, particularly in those population groups that were impacted the most.⁴

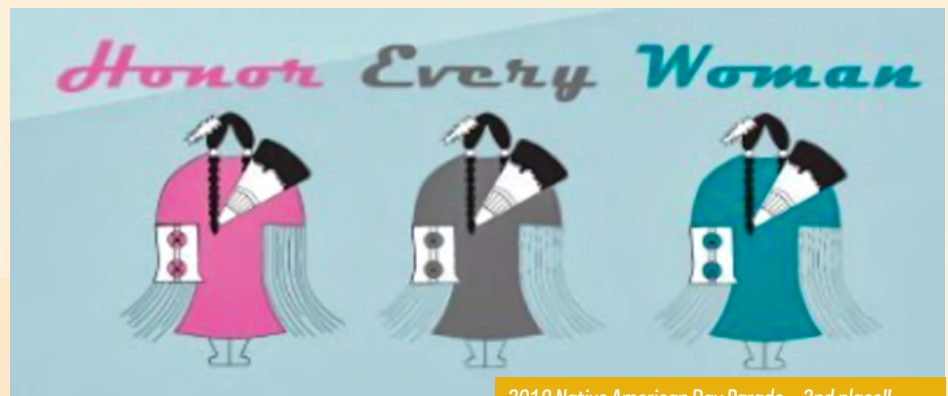
The [National Indian Health Board](#) (NIHB) has designed a tool for Tribal health systems interested in increasing high-quality, population-based breast, cervical, and colorectal cancer screenings titled, [Health Systems Improvement Toolkit: A Guide to Cancer Screenings in Indian Country](#), through support and partnership with the CDC Division of Cancer Prevention and Control. This toolkit builds the capacity of Tribal clinics and programs to increase breast, cervical,



and colorectal cancer screening rates using evidence-based interventions (EBIs).¹ An interactive version of [the toolkit and a guide to cancer screening in the Indian Country](#) is also available on the [NIHB website](#). Additional cancer resources and [plans](#) can be found on the [American Indian Cancer Foundation](#) website.

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2019 Native American Day Parade – 2nd place!!



HEALTHCARE ACQUIRED INFECTIONS: The Silent Risk for American Indian/Alaska Natives

The United States Indian healthcare system provides services to citizens of the 574 federally recognized Tribes in 37 states. According to the [Indian Health Service \(IHS\) Profile Fact Sheet](#), there are 46 Tribally and IHS operated hospitals and close to 510 Tribally and IHS operated outpatient facilities, including health centers, health stations, and clinics that provide care to approximately 2.56 million American Indian/Alaska Natives (AI/ANs) (About IHS/IHS Profile, 2020). In Fiscal Year (FY) 2018 approximately 40,494 AI/ANs were admitted at Tribal hospitals and Tribal outpatient healthcare facilities saw 13,752,397 patients. (About IHS/IHS Profile, 2020).

The [American College of Chest Physicians](#) (CHEST) recently reported on two studies of healthcare associated infections (HAIs) among minority groups. HAI data based on race and ethnicity from the National Inpatient Survey (NIS) and the Medicare Patient Safety were evaluated (Lorenzo, et al., 2020) and showed that AI/ANs are at the highest risk for HAIs. Due to the large population of AI/ANs receiving care and the increased risk, it is important that healthcare professionals and Tribal citizens know what HAIs are, understand the potential risk at healthcare facilities, and the infection control (IC) measures healthcare workers can take to prevent them.

During the COVID-19 pandemic AI/ANs saw infection rates more than 3.5 times the average infection rate, hospitalization rates four times higher than average, and mortality rates higher than white Americans (1). As of January 14, 2022, nearly 8.5 million children have tested positive for COVID-19 since the onset of the pandemic (2). As COVID-19 continued to affect our Tribal communities, The [National Indian Health Board](#) (NIHB) has been dedicated to providing the most up-to-date information including the [COVID-19 Tribal Resource Center](#).

The [U.S. Department of Health and Human Service](#) (HHS) Office of Infectious Disease and HIV/AIDS Policy defines HAIs as “infections people get when receiving healthcare for another condition” (Office of Infectious Disease and HIV/AIDS Policy, 2021). HAIs can occur at any healthcare facility including inpatient hospital or outpatient clinic settings causing illness and possible death; according to the [Centers for Disease Control and Prevention](#) (CDC) HAI data report, hospitals across the United States experienced an increase in hospitalizations and significant healthcare staff shortages due to the COVID-19 pandemic (Healthcare-Associated Infection (HAIs): HAI Data, 2021). Those factors impacted the rate of HAIs resulting in a significant increase in the number of central line-associated bloodstream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs) compared to 2019. In fact, according to the report, there was a 47 percent increase in CLABSIs and a 19 percent increase in CAUTIs among all types of hospitals.

Central lines provide fluids or medications to patients or collect blood for medical tests. They differ from IVs in that they are inserted directly into the vein rather than on the surface of the vein and can remain in place for a longer period thus increasing the risk of introducing bacteria or viruses into the patient’s bloodstream, which can cause CLABSI. There is also an increased risk for CLABSIs if healthcare providers do not follow strict protocol when inserting a central line.

CAUTIs may occur in patients when a urinary catheter is inserted into the bladder. Germs can enter the urinary tract through the urinary catheter and cause infection. Urinary tract infections (UTIs) are the most reported HAIs and nearly 70 percent are caused from urinary catheters, according to the [National Healthcare Safety Network \(NHSN\)](#). This is preventable, and healthcare workers can decrease the risk by taking precautions and following proper techniques when taking care of patients who require a urinary catheter while in the hospital.

Infection control (IC) measures prevent or stop the spread of infections in healthcare settings with the goal of keeping people from getting sick. When healthcare providers consistently practice IC procedures that are known to work, there may be a lower risk for CLABSIs and CAUTIs.

Important IC measures for preventing CLABSIs:

- Handwashing with soap and water or using an alcohol-based hand rub
- Cleaning the area using a skin aseptic
- Drying the area completely before inserting the central line catheter

Important IC measures for preventing CAUTI :

- Placing a urinary catheter only when necessary
- Removing a urinary catheter as soon as possible

HAIs are a potential threat for patient safety and affects one out of every 31 hospital patients, according to [HHS](#). Although there are few studies and limited data on HAIs based on race and ethnicity, it has been demonstrated that AI/ANs are at higher risk for HAIs. ▶

The cause of the increased risk is unknown, and AI/ANs can be at risk whether they receive their care at a hospital in their Tribal community or outside their community. It is important for Tribal healthcare workers and healthcare service providers to recognize the risks leading to HAIs and always use the infection prevention and control (IPC) practices known to prevent HAIs.

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I Am Seen: Reservation Dogs, Native Representation and Mental Health

In August of 2021, everyone with streaming access to the platform [Hulu](#) was able to experience a true first in American television — the first television series with an all-indigenous creative team and the first to be filmed entirely in Oklahoma. [Reservation Dogs](#), described as a comedy, focuses on four American Indian teenagers in rural Oklahoma. The eight-episode first season tackles numerous subjects close to American Indian/Alaska Native (AI/AN) life and mental health. Self-mockery of Native stereotypes, access to health care at [Indian Health Service](#) (IHS) clinics, intergenerational trauma, and the devastating reality of suicide among AI/AN youth all share screen time. These subjects are interwoven with winks, nods, and homages to AI/AN culture presented authentically and respectfully, from beading to an appearance of the Deer Woman, from Aunties and Uncles to a humorous exploration of frybread. Understandably, so many Native viewers have remarked that they see themselves on screen for the first time or, perhaps more importantly for mental health, that they *feel seen*.¹

1 <https://www.imdb.com/title/tt13623580/>

Positive media portrayals of AI/AN life are a welcome relief in Indian Country. The link between negative media portrayals, cultural misrepresentation (or lack of any representation), and negative mental health outcomes has been a central concern of AI/AN nations, communities, and advocates for some time. Caricatures, regalia reduced to a commodity worn as costumes, sports team mascots: the list is long and familiar throughout Indian Country.

Righting these wrongs is at the heart of the [National Indian Health Board's](#) (NIHB) work. In November of 2021, NIHB sent [a letter to the Atlanta Braves](#) concerning the appropriation of sacred AI/AN cultural names and practices used for sports cheers and mascots. The letter cited a 2020 study that showed how the use of Native mascots lowers self-esteem among AI/AN peoples and increases prejudice among non-Native populations.² A similar 2015 study showed that negative media portrayals have a particular impact on Native youth, both in how they feel about themselves and in limiting their pursuit of academic and occupational achievement.³

2 Laurel R. Davis-Delano, Joseph P. Gone & Stephanie A. Fryberg (2020). The psychosocial effects of Native American mascots: a comprehensive review of empirical research findings, *Race Ethnicity and Education*, 23:5, 613-633, DOI: 10.1080/13613324.2020.1772221
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FX RESERVATION DOGS

The answer from mainstream media has sometimes been well-intentioned attempts to show AI/AN life more positively. This has produced mixed results, as seemingly positive portrayals on the surface often betray harmful stereotypes when examined more closely. Disney's attempt to celebrate "princess" *Pocahontas* took romanticized liberties that failed to tell the truth of Powhatan woman Matoaka, notably excluding her capture and exploitation by colonists that ultimately resulted in her death in England before age twenty-one.⁴ Other historical media feature the misguided trope of the "wise Indian" who dispenses his supernatural wisdom in stilted English, something which *Reservation Dogs* addresses directly and effectively with much-needed humor.

Righting wrongs is necessary work, and it is good to see the harms of the past corrected. However, as mental health professionals will freely attest, healthy forward movement in a positive direction is necessary for mental health and wellness, and this is precisely what *Reservation Dogs* does well. Native and indigenous creators are not only reversing the damage that has already been done, but they are also owning their narratives. They are telling their own stories rather than having their stories told by others, no matter how well-intentioned those others may be.⁵


4 <https://www.smithsonianmag.com/history/true-story-pocahontas-180962649/>
5 <https://www.amacad.org/publication/reclaiming-representations-interrupting-cycle-bias-against-native-americans>

Reservation Dogs creator, co-executive producer, writer, and director Sterlin Harjo was born and raised in rural Oklahoma and is a citizen of the [Seminole Nation of Oklahoma](#). The series is co-executive produced by Taika Waititi, who hails from New Zealand and is of Maori descent. While American audiences are likely more familiar with his popular films *Thor: Ragnarok* and the Oscar winning *Jojo Rabbit*, Waititi is the executive producer of several New Zealand films helmed by indigenous filmmakers. By focusing on indigenous writers, directors, and cast members, *Reservation Dogs* presents authentic AI/AN storytelling that resonates with its Native audience.

How are general audiences responding to these Native-owned, indigenous stories? In 2022, *Reservation Dogs* was nominated for “Best Television Show — Musical or Comedy” at the Golden Globe Awards and “Best Comedy Series” at the Critics’ Choice Awards. The series won the Independent Spirit Awards for “Best New Scripted Series” and “Best Ensemble Cast for a New Scripted Series.”⁶ Both *Good Morning America* and *Rolling Stone* magazine named it the

second best TV show of 2021.⁷ As of this publication, it retains a 98 percent favorable critics rating on review aggregate website *Rotten Tomatoes*, based on 57 reviews.⁸ The series has already been renewed for a second season. Clearly, the world is ready for well-told, authentic stories by Native and indigenous storytellers.

Due to the success of productions like *Reservation Dogs*, research opportunities will open to exploring how these new and unprecedented positive media portrayals under Native direction affect the mental health and wellness of AI/ANs across Indian Country. For the sake of AI/AN health, it is an exciting time to see the wrongs of the past corrected with new opportunities for representation. To see and be seen.

*Viewers should note that *Reservation Dogs* is rated TV-MA, which means it may be unsuitable for children younger than 17. Viewer discretion is advised. 

6 https://www.imdb.com/title/tt13623580/awards/?ref_=tt_awd

7 Travers, Peter (December 29, 2021). “10 Best TV Shows of 2021”. *Good Morning America*. <https://www.goodmorningamerica.com/culture/story/10-best-tv-shows-2021-81974402>
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 8 https://www.rottentomatoes.com/tv/reservation_dogs



Tsalagi Public Health Saving Lives and Moving the Needle on Syringe Services During COVID-19

Fear and uncertainty have heightened stress during the COVID-19 pandemic. As a result, some people have increased their use or started using prescription medications, illegal drugs, and alcohol. Substance use puts people at greater risk of contracting COVID-19. This risk may be compounded by factors in the environment: marginal or overcrowded housing, lack of opportunities to maintain personal hygiene due to closure of public restrooms and shelters, and inability to practice physical distancing due to the need to seek substances.

[Tsalagi Public Health's Syringe Services Program Manager, Ginger Parker-Southard](#),

recognizes these disparities impact health outcomes for American Indian/Alaska Natives (AI/ANs) who use alcohol and other substances. Part of her work at Tsalagi Public Health is to advocate for improved healthcare access. “When people with substance use disorders seek medical care in emergency departments with body aches, chills, fever, or nausea, they are often labeled frequent flyers. Then they become at risk for potentially receiving substandard care or even getting rejected because COVID-19 symptoms mimic withdrawal symptoms.” Ginger attributes the stigma associated with drug use as a reason for delayed care. “They sit them in the waiting room for five to seven hours. They are now detoxing, going through withdrawal, and possibly have COVID-19 because the triage nurses have not tested them yet.”



As the pandemic ravaged the country, AI/ANs experienced the highest overdose death rate in 2020, from 28.9 in 2019 to 41.4 per 100,000, approximately 31 percent higher than the White mortality rate. In North Carolina, the drug overdose death rate was 2.3 times higher for AI/ANs than White people (75.4 and 32.7 per 100,000, respectively), according to the state's [Opioid and Substance Use Action Plan Data Dashboard](#). Pandemic response measures such as physical distancing disrupted and, in some cases, suspended support services that people who use drugs relied on. Tsalagi Public Health was unable to provide HIV and hepatitis C testing due to the risks of COVID-19 transmission. [Harm reduction practices](#) that existed before the pandemic, such as never to use alone to reduce overdose, were being changed to encourage people who use drugs to isolate themselves from others to reduce COVID-19 transmission. The lockdown on the Boundary immediately led to a dramatic increase in fatal and non-fatal drug overdoses. These effects of COVID-19 exposed vulnerabilities for those who use drugs.

During the pandemic, the Tsalagi Public Health Syringe Services Program, which began in February 2018, provided participants syringes and other supplies for safer injection of their drugs. “We give out referrals to community resources. We pass out hygiene kits, water, food, hand sanitizer, face masks, and COVID-19 testing kits,” said Parker-Southard.

The program also provides HIV/HCV testing and safe injection education “on how to clean their (injection) sites,” stated Parker-Southard. “We educate our program participants who use drugs to recognize signs of infection and abscess at their injection site. We educate them on how Hep C is spread because it’s not just with the needles. It can be spread with a toothbrush or a razor. We educate clients on how to dispose of needles, clean the needle, test drugs for fentanyl to cut the shot down, and when to abandon self-care practices and seek proper care from a health provider.” She noted they had received approximately 188 pounds (1 lb. = 133 syringes) or close to 570,000 syringes returned to their 27 syringe kiosks. The kiosks are in local community areas, commercial areas, and remote areas like riverbanks, where people congregate to use drugs.

Another important component of the program is the peer support or specialists who share recorded videos and tell their stories about why they started self-medicating. Parker-Southard said, “A huge part of harm reduction is being free to tell your story without judgment or fear of shame or guilt.” When someone is in active use, they expect the people around them to shame and punish their use. Peers can come from a place of non-bias and without judgment and open the conversation for safer practices. Peer support specialists can meet with a family at their home, church, or community setting.

Parker-Southard and her team also provide referrals for drug treatment and medical care, testing, and place-based education on how to administer Narcan, a nasal spray or injection that can stop an opioid overdose from being fatal. “As long as you are empowered with the knowledge to make better, more informed decisions for yourself, that’s what it’s about,” said Parker-Southard. The Syringe Services Program has distributed over 10,000 naloxone kits, and 900 reversals have been reported – meaning over 900 lives have been saved.

In 2020 the [National Indian Health Board](#) (NIHB) launched the [COVID-19 Tribal Resource Center](#) website with Tribally specific Coronavirus-related developments, tools, and information: nihb.org/covid-19/. The [COVID-19 Tribal Resource Center](#) website is part of NIHB’s communication strategy to ensure Tribes are informed and engaged throughout the pandemic and beyond. 🇺🇸

Tribal Sovereignty “Mandates” Tribal Consultation: Public Health-Related Regulations and Respect for Tribal Self-Governance

Tribal nations have been sovereign, independent nations long before colonization, formation of the United States, and broken federal treaties. The hundreds of Tribal communities maintained a nation-to-nation relationship with the United States while reserving original sovereign authority and self-governance over their citizens and territories during all crises including the COVID-19 pandemic.

The COVID-19 pandemic has continued to highlight the importance of self-governance for Tribes and has demonstrated the inherent nature to care for and protect their citizens. The federal government took note of how Tribal nations managed yet another pandemic and their ensuing mitigation tactics. Early on in his administration, President Biden himself wrote of his priority, “to make respect for Tribal sovereignty and self-governance, commitment to fulfilling federal trust and treaty responsibilities to Tribal nations, and regular, meaningful, and robust consultation with Tribal nations cornerstones of Federal Indian Policy.”¹ He further reflected that “[h]istory demonstrates that we best serve Native American people when Tribal governments are empowered to lead their communities, and when federal officials speak with and listen to Tribal leaders in formulating federal policy that affects Tribal nations.”²

Tribal leaders were hopeful when President Biden affirmed his administration’s commitment to Tribal consultation particularly now, as our nation faces crises in health equity, the economy, racial justice, climate change, and so much more – all of which disproportionately harm American Indian/Alaska Natives (AI/ANs). Under the President’s commitment, agencies such as the [Centers for Medicare and Medicaid](#) (CMS) have a duty to consult with Tribal governments when developing policies that impact Tribal nations. CMS has pledged to communicate and consult on an ongoing basis so Tribes have an opportunity to provide *meaningful* and timely input on issues that may have a *substantial direct effect* on them.³ When CMS issued its emergency rule mandating COVID-19 vaccines for certain healthcare workers, it failed to engage with Tribes ahead of publication.

The [National Indian Health Board](#) (NIHB) has been instrumental in assisting in Tribal consultations. NIHB communicates with Tribes and Tribal organizations concerning health issues, disseminates health care information, improves, and expands access for AI/ANs Tribal governments to available programs in the [Department of Health and Human Services](#) (HHS), and coordinates the Tribal consultation activities associated with formulating the [Indian Health Service](#) (IHS) annual budget request.


Genuine Tribal consultation has been conducted successfully by other federal agencies, furthering the disappoint much of Indian Country has endured with the handling of this vaccine mandate. The [Occupational](#)

[Safety and Health Administration](#) (OSHA) upheld its commitment by requiring Tribal consultation during the implementation of its own vaccine mandate, proving that the process works when it is valued and prioritized. The OSHA mandate specified the agency would not engage in enforcement actions at Tribal facilities until after Tribal consultation, a simple yet impactful commitment, one that CMS should have made as well. The vaccine mandate interfered with Tribes’ sovereign rights to carry out their government as they see appropriate for their citizens.

Tribal communities across Indian Country have their own unique traditions, languages, and ways that can best be cared for by their citizens. This has been shown time and time again, but most recently throughout the COVID-19 pandemic. Tribes have implemented safety measures tailored to the sole needs of their communities and have led successful vaccination efforts. For example, the [Blackfeet Nation](#) homelands are in northwest Montana and stretches areas also identified as Glacier National Park. Home to its 17,000 plus citizens, their homelands have abundant natural resources, including forestlands and oil and gas reserves, and is home to many species of fish and wildlife. To “Prevent the Spread on the Rez” the Blackfeet Nation prioritized the safety and needs of Tribal members during the COVID-19 pandemic and closed off its land within the park, even throughout peak tourism season.

Decisions like this and to add more protections such as curfews, mask mandates, and road closures, coupled with outreach and education efforts by Tribal leaders, resulted in better health outcomes and high vaccination rates for AI/AN. This relative success must be taken as a notice to this Administration that Tribes are sovereigns and know how best to govern their citizens, establishing initiatives for Tribes by Tribes, and the importance of the Tribal consultation process.

The federal government has much to learn from Tribal nations, and NIHB are hopeful that this has been a valuable lesson for agencies moving forward. NIHB continuous to play a significant role in focusing attention on Indian health care needs, resulting in progress for Tribes while advocating for the rights of all federally recognized Tribes through the fulfillment of the trust responsibility to deliver health and public health services.

For more information, please visit www.nihb.org. 

1. Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships. Jan. 26, 2021. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/memorandum-on-tribal-consultation-and-strengthening-nation-to-nation-relationships/>.

2. *Id.*

3. Centers for Medicare & Medicaid Services Tribal Consultation Policy, Dec. 10, 2015. <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMS Tribal Consultation Policy 2015.pdf>.

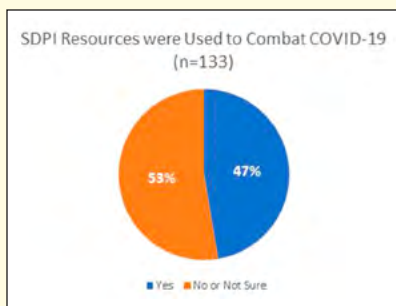
SPECIAL DIABETES PROGRAM FOR INDIANS: 25 Years of Success

SDPI — Saving and Improving Lives

Since 1998, American Indian/Alaska Natives (AI/ANs) have been able to harness one of the most successful public health programs ever implemented in the United States. The [Special Diabetes Program for Indians \(SDPI\)](#), approved by Congress in 1997, has been a turning point for diabetes outcomes in Indian Country. SDPI is administered nationally by [Indian Health Service \(IHS\)](#), but programs are locally driven, culturally informed, and evidence-based. Currently, 301 Tribal, Urban Indian, and IHS clinics offer services in diabetes prevention, management, and treatment to over 780,000 AI/AN people through SDPI.

Now in its twenty-fifth year, SDPI has been incredibly successful. Between 2013 and 2017, diabetes prevalence decreased in AI/AN people from 15.4 percent to 14.6 percent a 5.4 percent decrease. Diabetes care has reduced mortality in AI/AN people by 37 percent between 1999 and 2017, and diabetes-related kidney failure has been reduced by 54 percent between 1996 and 2013. This is the greatest reduction of any racial or ethnic group. Hospitalizations for uncontrolled diabetes, diabetic eye disease, and A1C (blood sugar) levels have decreased since SDPI's inception¹.

Those with diabetes are at higher risk of complications due to the COVID-19 pandemic. However, based on a 2020 survey conducted by the [National Indian Health Board \(NIHB\)](#), nearly half of SDPI programs were able to leverage SDPI resources to combat the COVID-19 pandemic and create protect those in their communities at higher risk. Programs utilized funding to combat food insecurity, provided COVID-19 education and prevention supplies to high-risk patients, and purchased at-home screening tools to help patients avoid high-risk settings.

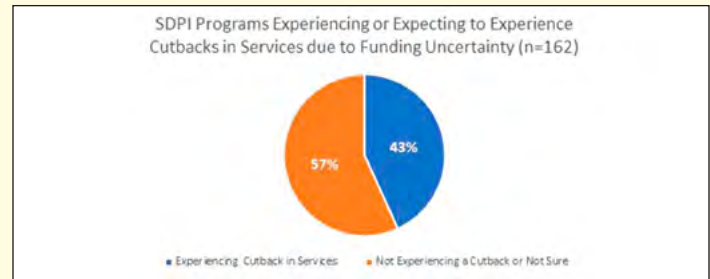


LOOKING TOWARDS THE FUTURE OF SDPI

Despite the incredible success Tribal programs have achieved through SDPI, the program faces significant challenges moving forward. For nearly two decades of its 25-year existence, SDPI has been flat funded at \$150

million annually and has lost significant buying power due to inflation. This funding has been stretched thinner by mandatory sequestrations. While Tribes have been innovative in extending funds to keep programs running, short-term congressional reauthorizations and the COVID-19 pandemic have added additional strains.

These challenges hamper the ability of SDPI programs to provide effective support to communities. Due to the limited funding, current programs have faced difficulties retaining staff, and new Tribes have not been able to join the program. A 2020 NIHB survey found that 43 percent of SDPI programs faced challenges related to cutbacks in services due to funding uncertainty.



“The uncertainty of funding has resulted in the need to prioritize personnel expenses over other program-related expenses... As such, the participation of SDPI staff in events such as the annual Village Health Fairs was placed in potential jeopardy,” one respondent shared. Another respondent stated their program faced challenges, including, *“not being able to hire staff for program activities in a timely manner [and] not being able to maintain staff due to uncertainties.”*

Current SDPI funding expires in September of 2023. Tribal leaders have already begun brainstorming how to best address these challenges and support SDPI programs in performing at the highest level. NIHB and other Tribal organizations have called for more sustainable funding, including permanent reauthorization, a funding increase to \$250 million annually, and adjustments for inflation. Additionally, Tribes are calling for SDPI to be administered through self-determination and self-governance contracts and compacts, which will free up more administrative funds and recognize SDPI as an essential part of the federal trust obligation. The [Tribal Leaders Diabetes Committee \(TLDC\)](#), a Tribal Advisory Committee responsible for advising IHS on SDPI, has also shown their support for efforts to continuously improve the program by promoting consultation with Tribal leaders on distributing funding, requesting support for Tribal priorities, and encouraging IHS to consider improvements to data infrastructure.

CELEBRATING THE NEXT 25 YEARS OF SDPI

Tribes have continued to persevere through many challenges, and SDPI is a historic success that should be celebrated. As SDPI programs prepare for another 25 years of success, Tribal nations have the opportunity to capitalize on the program's accomplishments while adapting SDPI to better serve their communities. Ultimately, SDPI is an incredible tool for combating and eliminating diabetes in our communities and enabling AI/AN people to live their healthiest lives. 🇺🇸

¹ https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf

Impact of Medicaid Expansion on Enrollment: A Comparison

On March 23, 2022, we celebrated the 12-year anniversary of the [Affordable Care Act \(ACA\)](#). This act had many impacts on Indian Country including giving states the option to expand Medicaid to include those adults with incomes up to 138 percent of the federal poverty level (FPL). Without expansion, a person can only qualify for Medicaid at 100 percent of the FPL and below. States first implemented Medicaid expansion on January 1, 2014. Currently, 39 states including DC have adopted Medicaid Expansion and 12 states have not.¹ Table A summarizes the Medicaid expansion in the United States.

1 See <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> for a visual map of states who have adopted Medicaid Expansion.

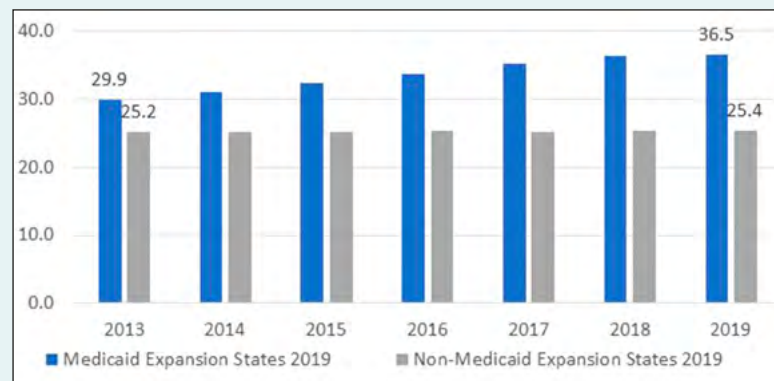
Table A: States with Medicaid Expansion	Number
As of January 1, 2014	25
4/1/2014 to 11/1/2018	9
11/1/2019 to 7/1/2021	5
States without Medicaid Expansion	12
Total States including DC	51

One of the main effects of Medicaid expansion has been gains in enrollment. In 2014, there were approximately 1.28 million American Indian/Alaska Natives (AI/ANs) in the United States whose income was 100 percent or lower than the FPL according to the American Community Survey.² For example, the FPL in 2014 for a family of four was \$23,850.³ Therefore, in a non-expansion state, a family of four who earned \$25,000 in 2014 would not qualify for Medicaid by income alone since their income is more than the FPL. With Medicaid expansion, a family of four who earned less than \$32,913 (138 percent of \$23,850) would qualify for Medicaid. ACS estimates an additional 500,000 AI/ANs would qualify for Medicaid if all states expanded in 2014.

The American Community Survey data is currently available through 2019.⁴ For the purposes of this analysis, the 34 states that activated expansion before January 1, 2019, are included as the “Medicaid expansion states”⁵ and the 17 states who have not expanded or expanded after January 1, 2019 are included as “non-Medicaid expansion states”⁶. To avoid confusion, the label year 2019 has been added to indicate this was the status as of January 1, 2019. Chart A shows the proportion of AI/AN enrolled in Medicaid from 2013 to 2019 for the two groups. Note that

nine of the 34 expansion states implemented Medicaid expansion after January 1, 2014, including them in the Medicaid expansion states group underestimates the impact of Medicaid expansion since the effect of expansion wasn’t in that first year. The chart starts in 2013 to give us one year of data prior to Medicaid expansion. Note that 29.9 percent of AI/ANs were enrolled in Medicaid in the Medicaid expansion states 2019 and 25.2 percent in the non-Medicaid expansion states. Medicaid enrollment remains flat in the non-expansion state group, with an increase of .7 percent from 25.2 to 25.4 from 2013 to 2019. However, in the Medicaid expansion state 2019 group, we see that the percentage of AI/ANs who are enrolled in Medicaid grows from 29.9 percent to 36.5 percent, representing a 22 percent increase. The growth in the proportion of AI/ANs enrolled in Medicaid is 32 times higher for the expansion 2019 states to the non-expansion 2019 states.

CHART A: PERCENT OF AI/AN ENROLLED IN MEDICAID 2013 TO 2019



Another way to look at the enrollment data is with the numbers of AI/ANs enrolled. But before we do that, let us look at what happens to the change in AI/AN population. Table B shows the AI/AN population from 2013 to 2019 between the two expansion groups and for the United States as a whole. Overall, AI/AN population grew by 10.2 percent with the Medicaid expansion states group seeing a larger increase in AI/

2 All population estimates and Medicaid enrollment statistics are from the American Community Survey (2014, 5-year estimates), United States Census Bureau.

3 Note, this is for the 48 contiguous states. The incomes are higher for Alaska. See: <https://aspe.hhs.gov/2014-poverty-guidelines>

4 2020 ACS 5-year estimates will become available March 31, 2022.

5 The 34 states are: AK, AZ, AR, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, VA, WA, and WV.

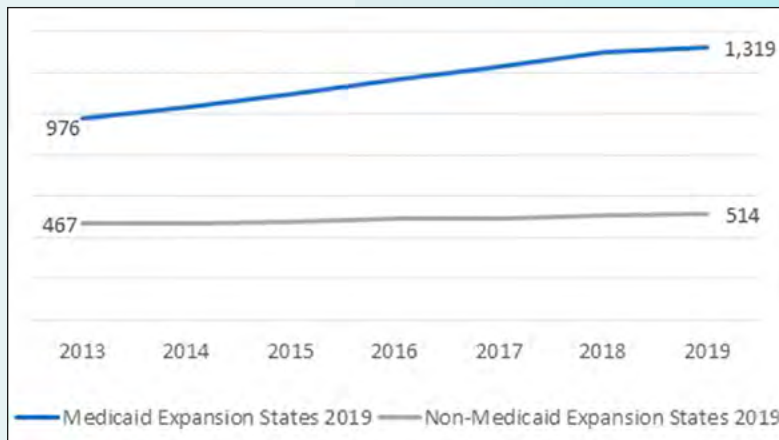
6 The 17 states are: AL, FL, GA, ID, KS, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, and WY.

AN population of 10.7 percent compared to 9.3 percent in the non-expansion states group.

Table B: AI/AN Population	2013	2019	% change
Medicaid Expansion States 2019	3,263,027	3,610,993	10.7
Non-Medicaid Expansion States 2019	1,854,076	2,027,381	9.3
Total Population	5,117,103	5,638,374	10.2

Chart B shows Medicaid enrollment in thousands from 2013 to 2019. In 2013, AI/AN Medicaid enrollment in the expansion state group was 976,000 and grew by 35 percent to 1.32 million. The growth in Medicaid enrollment is 3.3 times larger than the population growth. The AI/AN Medicaid enrollment in the non-expansion state group was 467,000 in 2013 and grew to 514,000 in 2019. This represents a growth of 10.1 percent, which is 1.1 times higher than the AI/AN population growth for that group over that time period. The graph also shows the difference in enrollment growth by the slope of the expansion state group (blue line) to the non-expansion state group's flat nature.

CHART B: AI/AN MEDICAID ENROLLMENT FROM 2013 TO 2019 (in thousands)



The charts show that Medicaid expansion has had a positive effect on Medicaid enrollment for AI/ANs. With the additional five states who have expanded Medicaid since January 1, 2019, the growth in AI/AN Medicaid enrollment will continue.

The [National Indian Health Board's \(NIHB\) Tribal Health Reform Resource Center](#) website provides pertinent information on the [ACA](#) including [Medicaid Expansion](#). ❄️

Tribal Health Advocates See Momentum in Smokefree Policies

The words “Water is Life” may seem self-explanatory to any reader, but Indian Country understands the statement’s special, sacred meaning, as Indigenous water protectors have gained international recognition in recent years. What may be less understood but no less important are the words “Air is Life.” This is the rallying cry for Indigenous activists who advocate for clean air in Tribal communities.

Smoke from commercial tobacco products dirties the air and harms life. This is true for firsthand smoke, which is breathed into the smoker’s lungs, secondhand smoke, which is inhaled by people besides the smoker, and even thirdhand smoke, which is residue left on surfaces near the smoker. Thirdhand smoke can accumulate in areas where large numbers of people smoke regularly, such as gaming room floors, bars, and parlors.

Many Tribes operate gaming facilities to generate revenue for their governments providing a crucial revenue stream to fund government operations and social services for Tribal members. However, many facilities (similar to non-Tribal facilities) may allow commercial tobacco use, exposing customers, visitors, and employees at these facilities. One study showed that a four-hour visit to a casino floor where smoking was prevalent correlated to a *tenfold* increase in tobacco chemicals in the body¹. Further research has shown employees at gaming facilities where smoking is allowed have much higher exposure to secondhand smoke, which increases rates of heart and lung diseases². Additionally, research into consumer preference found that prohibiting smoking did not decrease the number of patrons at Tribal casinos, and over three-quarters (79 percent) of patrons preferred a smokefree environment.³

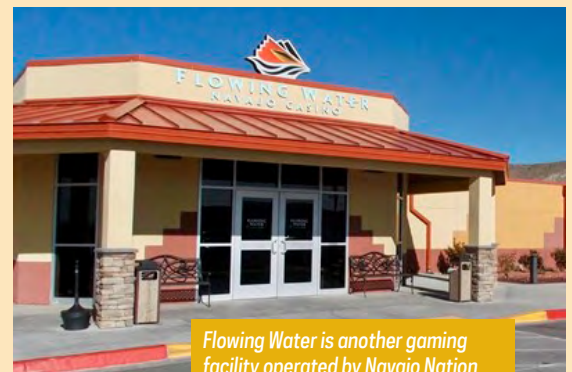
When gaming facilities — along with so much else — had to close in 2020 due to the COVID-19 pandemic, many Tribes used the closure time to renovate and deep clean their facilities, which can see hundreds or even thousands of people each day. In these cases, cleaning crews were able to remove long standing residue from commercial tobacco product smoke. According to the [American Nonsmokers’ Rights Foundation](#), at least 157 Tribally operated gaming facilities (out of a total of 525) converted to smokefree status during the COVID-19 pandemic⁴. However, not all of these facilities may remain smokefree — some Tribes only wanted to prevent smoking due to COVID-19’s impact on lung health and intend to revert to allowing smoking after the pandemic ended.

[The Air Is Life Coalition](#) — a group of Indigenous public health practitioners, subject matter experts, and community members — successfully advocated for the [Navajo Nation](#) to enact the Air is Life Act of 2021, which President Nez signed into law on November 6, 2021. The new law requires all public facilities and events in the Nation to be free of

commercial tobacco use, or “smokefree.” This includes powwows, rodeos, and other events as well as gaming facilities. The law also requires signs posted in public areas where people used to smoke. This requirement is permanent and will remain after the end of the pandemic. The coalition will remain in place to help implement the new requirements on Navajo Nation. There may also be staff training and community education work to be done to make sure the law is effective. Members of the coalition hope that other Tribes will build on the momentum to ensure Tribal facilities and spaces become smokefree and uphold the words “Air Is Life.” 🌿



Fire Rock Casino on Navajo Nation, which reopened in March 2021 as a temporarily smoke free facility, will now be permanently smokefree.



Flowing Water is another gaming facility operated by Navajo Nation that is now permanently smoke free.

1 Repace, J. “Secondhand Smoke In Pennsylvania Casinos: A Study Of Nonsmokers’ Exposure, Dose, And Risk”. Am J Public Health 99(8), 2009.

2 US Surgeon General. “The Health Consequences of Involuntary Exposure to Tobacco Smoke.” 2006 https://www.cdc.gov/tobacco/data_statistics/sgr/2006/index.htm

3 “Smoking in Casinos: Did We Have It Wrong?” Presented at the National Indian Gaming Association (NIGA) 2021 Indian Gaming Tradeshow & Convention by MichaelnMeczka, MMRC; Terry Savage, Lake Superior Band of Chippewa; Andrew Klebanow, C3 Gaming; and Clinton Isham, ANR Foundation.

<https://smokefreecasinos.org/wp-content/uploads/pdf/2021-NIGA-Gaming-Survey-Facts.pdf>

4 <https://www.gamingdirectory.com/smokefree/properties/>

Following Navajo Nation’s enactment of the Air is Life Act of 2021, the National Indian Health Board adopted Resolution 22-06, which will require that all of the organization’s events be held in smokefree facilities.

The Devastating Rise of Fentanyl in Indian Country

One of the more harrowing health disparities facing American Indian/Alaska Natives (AI/ANs) is opioid-related overdose deaths. Between 2000 and 2016, the overdose death rate among AI/ANs increased six-fold and currently exceeds the national rate.¹ To better understand opioid overdose deaths in Indian Country the [National Indian Health Board](#) (NIHB) has provided a brief overview of the epidemic with a particular focus on the most recent threat, fentanyl.

1 Centers for Disease Control and Prevention. (2021, June 15). Opioid Overdose Prevention in Tribal Communities. <https://www.cdc.gov/injury/budget/opioidoverdosepolicy/TribalCommunities.html>

WHAT ARE THE PHASES OF THE OPIOID EPIDEMIC?

The opioid epidemic in Indian Country involves several forms of opioids that have occurred in three distinct waves. The first began in the 1990s and primarily involved prescription opioids and overdose deaths attributed to overprescribing and allegations of reckless manufacture and distribution from drug companies. These allegations have resulted in important court cases, the most recent of which is a tentative [\\$590 million settlement](#) between Tribes and Johnson & Johnson, along with three distributors. The second wave began in 2010, as heroin became more prevalent. Many attribute the rise in heroin use, in part, to dependencies established during the first wave. As Tribes responded to prescription drug abuse, opioid prescription protocols tightened, making prescription opioids more difficult to obtain — legally or illicitly. Heroin filled an availability gap for those who had become dependent. In 2013, the third wave began. This deadly wave of synthetic opioids has been marked by significant increases in AI/AN opioid-related overdose deaths, and the common denominator is increasingly fentanyl.²

WHAT IS FENTANYL USED FOR?

It is important to note that not all fentanyl use is illicit or necessarily dangerous. Fentanyl does exist in a pharmaceutical form approved for pain management, particularly for chronic pain, post-surgery management, and advanced stages of cancer. However, it is carefully administered because it is a synthetic opioid that is approximately 50 times more potent than heroin and 100 times more potent than morphine. For Indian Country, it is illicit, non-pharmaceutical fentanyl that causes the most overdose deaths.³ It is also important to distinguish between those who are fentanyl-seeking — meaning they purposely look for fentanyl for its narcotic effects — and those who are seeking *other* drugs that have been mixed with fentanyl. Overdose often occurs when someone is seeking a different drug, unaware that it contains potentially lethal doses of fentanyl mixed in.

Why would other drugs as diverse as methamphetamines, heroin, cocaine, benzodiazepines, or MDMA (Ecstasy or Molly) contain fentanyl? Fentanyl is comparatively inexpensive to produce and extremely potent in small amounts. Drug dealers know that if they intentionally mix — or “cut” — a drug with fentanyl, they will increase its addictive properties and the likelihood of the person using drugs coming back for more. They can also include less of the more expensive drug in exchange for the smaller amount of fentanyl while still providing the sought-after narcotic effects.

2 Centers for Disease Control and Prevention. (2021, March 17). Understanding the Epidemic. <https://www.cdc.gov/drugoverdose/epidemic/index.html#:~:text=The%20first%20wave%20began%20with,overdose%20deaths%20involving%20heroin4>

3 United States Drug Enforcement Agency. (2022). Facts About Fentanyl. <https://www.dea.gov/resources/facts-about-fentanyl>


WHAT IS THE PROBLEM?

The challenge, of course, is that illicit drugs are not regulated. A pill may contain a lethal dose of fentanyl, and the person obtaining the drug is none the wiser. While body type, individual metabolism, and personal tolerance all factor into the likelihood of overdose, the [United States Drug Enforcement Administration](#) (DEA) has demonstrated that only two milligrams of fentanyl can be lethal and have encountered counterfeit pills that contain up to 5.1 milligrams per tablet. One recent test showed that 42 percent of all illicit pills tested for fentanyl had potentially lethal doses. Since Drug Trafficking Organizations (DTOs) typically traffic fentanyl by the kilogram, it is alarming to know that just one kilogram of fentanyl can kill up to 500,000 people. More disturbingly, a lethal dose of fentanyl comprises what, to the naked eye, looks like only a few grains of sand.⁴

WHERE DOES FENTANYL ORIGINATE?

It is generally understood that the fentanyl affecting Indian Country is not manufactured on Tribal lands. Instead, it comes from other cities, especially border towns, and is purchased from well-established DTOs by independent dealers. The number one fentanyl supplier to the United States, Canada, and Mexico is China. These Chinese exports consist of pure fentanyl, its variants, and counterfeit prescriptions laced with fentanyl that are sold as powders, nasal sprays, and pressed pills. Pressed pills are particularly dangerous, as they look like prescription drugs and can easily be consumed with no awareness that they contain fentanyl. It is especially dangerous for anyone who purchases illicit drugs online, as the drugs frequently originate from sources known to deal in fentanyl.⁵

WHAT CAN BE DONE?

Prescription opioids and heroin continue to threaten the lives of AI/ANs. This third and even more deadly wave of the opioid epidemic and ongoing threats from fentanyl requires a decisive response from Indian Country. NIHB continues to advocate for full, direct, and non-competitive funding with minimal administrative burden for Tribes to effectively address the opioid epidemic, with the full awareness that Tribal needs vary across regions and service areas. NIHB maintains a [Tribal Opioid Response Resource Toolkit](#) and is actively planning further opportunities for Tribal professionals and advocates to share strategies for harm reduction, opioid overdose prevention, and comprehensive approaches to prevention, treatment, and recovery services for opioid misuse and Opioid Use Disorder (OUD). 

4 United States Drug Enforcement Agency. (2022). Facts About Fentanyl. <https://www.dea.gov/resources/facts-about-fentanyl>

5 Department of the Interior. (2019, March 20). Drugs in Indian Country. <https://www.doi.gov/ocl/drugs-indian-country>

Federal Tribal Advisory Committees — A Revolutionary Tool for Advocacy

Indian Country needs your voice and leadership to help shape federal Indian health policy. Federal Tribal Advisory Committees (TACs) can be a revolutionary tool for advocacy, but only if the committees are Tribally led and there is complete and diverse participation from all regions. Without diverse and robust Tribal participation, the voices of many Tribes will go unrepresented in the formation of federal Indian health policy.

TACs were established to enhance the government-to-government relationship, honor federal trust responsibilities and obligations to Tribes and American Indian/Alaska Natives (AI/ANs) and increase understanding between federally recognized Tribes and federal agencies. TACs play a critical role in advancing policy priorities and recommendations for Indian health across all agencies. These committees should allow for regular and meaningful collaboration and consultation with Tribal leaders on policies that have Tribal implications and substantial direct effects on Tribal communities.

More Tribal participation is needed to ensure Tribal priorities are represented across all agencies. TACs are vital in enhancing the relationships between the federal government and Tribal nations. However, many agencies struggle to keep Tribal leaders on the TACs and fail to fill vacant seats. For example, six of the twelve area seats on the [Indian Health Service \(IHS\) Information Systems Advisory Committee \(ISAC\)](#) are vacant. TACs should be a vehicle for acquiring a broad range of Tribal views; however, due to chronic vacancies, many regions go unrepresented. TACs provide a unique opportunity for Tribal leaders and their representatives to speak directly with federal officials about how federal policies impact their respective communities and share the experiences of Tribal members and the effects that federal programs are having. Federal officials must hear their stories, and these committees are critical to facilitating these discussions.

Tribal leaders do not need specialized technical knowledge to serve on a TAC. The [National Indian Health Board \(NIHB\)](#) and various regional health boards provide technical support to Tribal leaders serving on TACs. NIHB staff routinely serve as Technical Advisors to Tribal leaders serving on TACs. NIHB attends all TAC meetings in this capacity and provides TAC members briefing materials, policy and budgetary analysis, talking points, and notes on priority issues. NIHB also works to ensure Tribal leaders are prepared to represent the needs of AI/AN people, regardless of their level of technical expertise.

Over the last year, in efforts to strengthen the government-to-government relationship, President Biden's administration expanded the role of TACs across the federal government. Our responsibility is to take advantage of this expanded access to elevate Tribal health priorities across the federal government. We must do our part to ensure that all TAC meetings are meaningful and represent a wide array of perspectives from

Indian Country. To develop comprehensive health policy for the benefit of Indian Country, Direct Service, and Self-governance, Tribal leaders must all be at the table to advocate for their communities. NIHB stands ready to provide technical assistance to any Tribal leader who wishes to serve on a TAC.

Please see the chart for a brief overview of TACs that need your voice. To learn more about the Federal Tribal Advisory Committees, request technical assistance, or stay updated on TAC news, please contact A.C. Locklear, NIHB Federal Relations Lead, at alocklear@nihb.org or call 202- 996-2882. For more information, please visit NIHB's COVID-19 Tribal Resource Center — [Tribal Advisory Committees](#).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TRIBAL ADVISORY COMMITTEES

COMMITTEE	PURPOSE
Administration for Children and Families (ACF) Tribal Advisory Committee	The ACF TAC's primary purpose is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of ACF programs. https://www.acf.hhs.gov/initiatives-priorities/tribal
Centers for Disease Control and Prevention (CDC) Tribal Advisory Committee	The TAC advises CDC/ATSDR on policy issues and broad strategies that may significantly affect American Indian/Alaska Native (AI/AN) communities. The TAC will assist CDC/ATSDR in fulfilling its mission to promote health and quality of life by preventing and controlling disease, injury, and disability through established and ongoing relationships and consultation sessions. https://www.cdc.gov/tribal/consultation-support/tac/index.html

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TRIBAL ADVISORY COMMITTEES ■ CONTINUED

COMMITTEE	PURPOSE
Centers for Medicare and Medicare Services (CMS) Tribal Technical Advisory Committee (TTAG)	The TTAG provides advice and input to CMS on policy and program issues impacting American Indians and Alaska Natives (AI/ANs) served by CMS programs. Although not a substitute for formal consultation with Tribal leaders, TTAG enhances the government-to-government relationship and improves increased understanding between CMS and Tribes. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Tribal-Technical-Advisory-Group
Secretary's Tribal Advisory Committee (STAC)	The STAC's primary purpose is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. https://www.hhs.gov/about/agencies/iea/tribal-affairs/about-stac/index.html
Health Resources and Services Administration (HRSA) Tribal Advisory Council	The HRSA TAC will be a vehicle for acquiring a broad range of Tribal views, determining the impact of HRSA programs on the American Indian/Alaska Native (AI/AN) health systems and population, developing innovative approaches to deliver health care, and assisting with effective tribal consultation. https://www.hrsa.gov/about/organization/bureaus/ohe/populations/aian.html
National Institutes of Health (NIH) Tribal Health Research Office (THRO) Tribal Advisory Committee	The TAC is advisory to the NIH and provides a forum for meetings between elected Tribal officials (or their designated representatives) and NIH officials to exchange views, share information, and seek advice concerning intergovernmental responsibilities related to the implementation and administration of NIH programs. https://dpcpsi.nih.gov/thro/tac
Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Technical Advisory Committee (TTAC)	The SAMHSA TTAC will provide a complementary venue wherein Tribal representatives and SAMHSA staff will exchange information about public health issues in Indian Country, identify urgent mental health and substance abuse needs in AI/AN communities, and discuss collaborative approaches to addressing these issues and needs. https://www.samhsa.gov/about-us/advisory-councils/tribal-technical-advisory-committee-ttac/council-roster

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TRIBAL ADVISORY COMMITTEES ■ CONTINUED

COMMITTEE	PURPOSE
Veterans' Affairs Tribal Advisory Committee	The Committee serves in an advisory capacity and advises the Secretary on ways the Department can improve the programs and services of the Department to better serve Native American Veterans. Committee members make recommendations to the Secretary regarding such activities. https://www.va.gov/tribalgovernment/

INDIAN HEALTH SERVICES (IHS) ADVISORY COMMITTEES, BOARDS, AND WORKGROUPS

COMMITTEE	PURPOSE
Community Health Aide Program Tribal Advisory Group (CHAP TAG)	The workgroup is charged with providing subject matter expertise, program information, innovative solutions, and advice to the Indian Health Service (IHS) to establish a National Community Health Aide Program. https://www.ihs.gov/chap/chaptag
Direct Service Tribes Advisory Committee (DSTAC)	The Direct Service Tribes Advisory Committee (DSTAC) was established to provide leadership that advises the Indian Health Service (IHS) Director on the development of health policy and participates in IHS decision-making that affects the delivery of health care. DSTAC also offers advocacy and policy guidance by regularly providing recommendations to the agency. https://www.ihs.gov/odsct/dstac/
Director's Workgroup on Improving Purchased/ Referred Care (PRC Workgroup)	The purpose of the Director's Workgroup on Improving PRC (Workgroup) is to provide recommendations to the Indian Health Service (IHS) Director on strategies to improve and reform the Agency's PRC program. The Workgroup reviews input received to improve the PRC program; evaluates the existing formula for distributing PRC funds; and recommends improvements in the way PRC operations are conducted within IHS and the Indian health system. https://www.ihs.gov/prc/director-s-workgroup-on-improving-prc/
Facilities Appropriations Advisory Board (FAAB)	The Facilities Appropriation Advisory Board (FAAB) is established as a standing committee of Tribal and Indian Health Service (IHS) representatives. The primary purpose of the FAAB is to make recommendations to the Director, IHS on matters involving all Office of Environmental Health and Engineering (OEHE) programs. https://www.ihs.gov/ihtm/circulars/2015/facilities-appropriations-advisory-board-charter/

INDIAN HEALTH SERVICES (IHS) ADVISORY COMMITTEES, BOARDS, AND WORKGROUPS • CONTINUED

COMMITTEE	PURPOSE
Information Systems Advisory Committee (ISAC)	<p>The Information Systems Advisory Committee (ISAC) was established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems. The ISAC will assist in insuring that information systems are available, accessible, useful, cost effective, and user friendly for local level providers, while continuing to create standardized aggregate data that supports advocacy for Indian health programs at the national level.</p> <p>https://www.ihs.gov/isac/</p>
National Tribal Advisory Committee on Behavioral Health (NTAC)	<p>The National Tribal Advisory Committee (NTAC) on Behavioral Health acts as an advisory body to the Division of Behavioral Health and to the Director of the Indian Health Service, with the aim of providing guidance and recommendations on programmatic issues that affect the delivery of behavioral health care for American Indian/Alaska Natives.</p> <p>https://www.ihs.gov/dbh/consultationandconfer/ntac/</p>
Tribal Leaders' Diabetes Committee (TLDC)	<p>The TLDC was established in 1998 and makes recommendations to the IHS Director on broad-based policy and advocacy priorities for diabetes and related chronic conditions, as well as recommends a process for the distribution of Special Diabetes Programs for Indians funds.</p> <p>https://www.ihs.gov/sdpi/tldc/</p>
Tribal Self-Governance Advisory Committee (TSGAC)	<p>The TSGAC provides a forum for Tribal and Federal officials to discuss issues related to Tribal administration of Federal programs and services, exchange ideas, and develop solutions intended to improve Self-Governance and enhance the Tribal-Federal partnership. The TSGAC advises the IHS Director and the Director of the Office of Tribal Self-Governance on issues and concerns pertaining to Tribal Self-Governance and the implementation of the Self-Governance within the IHS. The TSGAC represents Self-Governance Tribes by acting on their behalf to clarify issues that affect all compacting tribes specific to issues affecting the delivery of health care of American Indian/Alaska Natives.</p> <p>https://www.tribalselfgov.org/advisory-committees/tsgac/</p>





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