Indian Healthcare in President Trump’s First 100 Days in Office

The first one hundred days of a presidency is an opportunity for the president to set the tone for his Administration and implement promises made on the campaign trail. One of the promises made by President Trump includes the repeal and replacement of the Patient Protection and Affordable Care Act (ACA).

While it is up to Congress to create and pass legislation, there are still a number of ways a President can affect current legislation, such as, changing how a law is implemented and enforced. This can be done through Executive Orders, Presidential Memoranda, the regulatory process, and sub-regulatory processes. This article provides an overview of President Trump’s first 100 days in office and the actions his Administration has taken that impact the healthcare delivery for American Indians and Alaska Natives (AI/ANs).

In February, President Trump’s nominee, Tom Price, MD, was confirmed as the Secretary of the U.S. Department of Health and Human Services (HHS). Secretary Price previously served as a U.S. Representative for Georgia’s 6th Congressional District and in this role he led efforts to repeal the ACA. He also proposed legislation that would roll back federal insurance standards and provide states more authority. In March, President Trump’s nominee to head the Centers for Medicare and Medicaid Services (CMS),

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The Time is Now for Special Diabetes Program for Indians Renewal

The Special Diabetes Program for Indians (SDPI) impacts the lives of well over 782,000 American Indians and Alaska Natives each year through funding 301 diabetes treatment and prevention programs across the nation. The current SDPI reauthorization will expire on September 30, 2017 unless Congress acts. NIHB is on the front lines of this legislative battle — but we need your help!

No one can deny that SDPI has been an incredible success – in fact, it is one of the most successful public health programs ever created. The results since the program’s beginning in 1997, demonstrate remarkable outcomes from SDPI programs including a reduction from 9.0% to 8.1% in average A1C levels, reduced LDL cholesterol levels, and weight loss of program

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THE NATIONAL INDIAN HEALTH BOARD

Established by the Tribes to advocate as the United Voice of Federally Recognized American Indian and Alaska Native Tribes, NIHB seeks to reinforce tribal sovereignty, strengthen tribal health systems, secure resources, and build capacity to achieve the highest level of health and well-being for our people.

The National Indian Health Board (NIHB) advocates on behalf of all federally-recognized Tribal governments – both those that operate their own health care delivery systems and those receiving health care directly from the Indian Health Service (IHS).

Located on Capitol Hill in Washington, D.C., NIHB provides a variety of services to Tribes, area Indian 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, and project management. NIHB is a 501(c)3 charitable organization.
FROM THE CHAIRPERSON

VINTON HAWLEY

DEAR INDIAN COUNTRY FRIENDS AND ADVOCATES,

Welcome to the Spring 2017 edition of the National Indian Health Board’s (NIHB) Health Reporter! As always, we are excited to advocate for the rights of all federally recognized American Indian and Alaska Native Tribes through the fulfillment of the trust responsibility to deliver health and public health services. We are excited to see many of you in beautiful Anchorage, Alaska this June for our 8th Annual Tribal Public Health Summit! We also offer a big THANK YOU to our partners in Alaska who have made this event possible — especially the Alaska Native Health Board.

In January 2017, I was honored to be elected as the new Chairman of NIHB. I am humbled to follow in the footsteps of the previous Chairman, Lester Secatero, and am excited to continue the tireless work of so many before me to advocate for better health care, stronger investment into Tribal public health infrastructures and health systems in Indian Country. I am looking to you for assistance and encouragement as we, together, fight to improve the health of our people. Together we can achieve anything if we are unified and speaking with one voice.

This year has brought change: we have a new Administration and Congress in Washington, DC. Both Executive and Legislative branches have vowed to curtail the federal government and repeal and replace the Patient Protection and Affordable Care Act (ACA). Fortunately, some of the most critical provisions to Indian Country in the ACA (such as the Indian Health Care Improvement Act) will most likely remain intact. But other proposed legislation that reforms the Medicaid system and the way that the health insurance marketplace operates could spell trouble for Indian Country. Other challenges include ensuring that the Special Diabetes Program for Indians funding (SDPI) — the most successful disease prevention and health promotion program in Indian Country — continues beyond September. None of these objectives are guaranteed. NIHB will continue to speak up for the Tribes every day on these critical matters.

We must remind Congress and the Administration of the importance of the federal trust responsibility for health and the need to work in close partnership with Tribes.

NIHB also continues to grow in the field of public health. And we will continue reminding Congress and the Administration that the Trust responsibility extends to the Tribal public health system and that investment in the nations’ infrastructure must include investment in the public health infrastructure of Indian Country.

In celebration of National Public Health Week, NIHB held a briefing on Capitol Hill detailing some of the key public health challenges in Indian Country. We were excited to have participation from over 30 Congressional staff.

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

Vinton Hawley
Chairperson
Seema Verma was confirmed. Administrator Verma was previously the President/CEO and founder of SVC, Inc., a national health policy consulting firm working extensively on Medicaid, insurance, and public health with Governor’s offices, State Medicaid agencies, State Health Departments, and State Departments of Insurance. Ms. Verma was the architect of the Healthy Indiana Plan (HIP), the Nation’s first consumer-directed Medicaid program under Governor Mitch Daniels of Indiana.

On March 8th, Secretary Price met with Tribal leaders during the first Secretary’s Tribal Advisory Committee (STAC) meeting of the new Administration. During that meeting, Secretary Price committed to upholding the nation-to-nation relationship between Tribes and the United States and honoring Tribal consultation. He outlined his priorities which include addressing: childhood obesity, the opioid epidemic, and behavioral health issues. Secretary Price even suggested holding future STAC meetings in Indian Country. Secretary Price again met with Tribal Leaders on March 30, 2017 where he reiterated his support for funding Tribal health programs. He noted that he would work hard to ensure that quality health care exists in Indian Country and that he would like to work with Tribes in partnership.

President Trump released a significant number of Executive Orders and Presidential Memoranda in the first one hundred days of his presidency. The first Executive Order that was released on President Trump’s first day in office was Executive Order 13765, to Minimize the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal. The Executive Order directs all relevant heads of Federal departments and agencies to ensure that the ACA is being efficiently implemented, minimize its economic and regulatory burdens, and prepare to provide states with more flexibility to create a more open health care market. In addition, CMS published an ACA Market Stabilization final rule on April 18, 2017 amending standards to the federally-facilitated marketplace (FFM). The final rule imposes new limitations on special enrollment periods. However American Indians and Alaska Natives (AI/AN) are currently exempt from the new requirements. AI/ANs are also exempt from the final rule requiring submission of additional pre-enrollment supporting documentation to verify eligibility.

Also on the first day of his presidency, President Trump issued a Regulatory Freeze Memorandum for the Heads of Executive Departments and Agencies, which ordered a freeze on all pending regulations and a postponement for regulations that had not taken effect yet. The regulatory freeze is common for new administrations to ensure that the President’s appointees have the opportunity to review any new or pending regulations to ensure consistency with the policies and priorities of the new Administration. In addition, President Trump issued Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs. The purpose of Executive Order 13771 was to reduce the number of federal regulations by requiring that for every new regulation issued, at least two prior regulations would be identified for elimination. However, the Office of Management and Budget (OMB) has since clarified that the Order only applies to “significant regulatory action that imposes costs.”

President Trump also issued a Presidential Memorandum imposing an immediate freeze on the hiring of Federal civilian employees to be applied across the executive branch. As part of this freeze, no vacant positions could be filled and no new positions could be created. The Director of the Office of Personnel Management (OPM) granted a few exemptions for HHS positions. NIHB sent a letter to the Trump administration requesting an exemption for IHS positions and the NIHB Board of Directors passed a resolution requesting an exemption for IHS employees from the hiring freeze. HHS did exempt certain IHS positions in February and the overall hiring freeze was lifted on April 12th. However, the Director of the Office of Management and Budget, Mick Mulvaney has issued a memorandum calling for a Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce.

A related concern that Tribes have expressed is Executive Order 13781 which calls for a Comprehensive Plan for Reorganizing the Executive Branch. While the order is designed to improve the efficiency, effectiveness, and accountability of the executive branch, the Executive Order proposes the elimination of entire departments or even agencies. The public can go to Whitehouse.gov to submit their recommendations by June 13th. Recently, HHS issued an internal memorandum creating workgroups comprised of officials from each agency under HHS to develop recommendations for reforming the agency. NIHB is working with Tribes to request Tribal input and consultation into the recommendations provided by those workgroups. HHS must submit their proposal to the Office of Management and Budget by June 13!

NIHB is consistently monitoring presidential and federal agency actions and working hard to keep Indian Country informed. We are taking necessary actions to gather feedback and voice Tribal perspectives. For more information or to get involved in the NIHB Medicare, Medicaid Policy Committee (MMPC), please contact the NIHB Federal Relations Department by emailing the Director of Federal Relations Devin Delrow at ddelrow@nihb.org.
Congress is considering major changes to the Patient Protection and Affordable Care Act (ACA) that will revolutionize the American health care system. The legislation – known as the American Health Care Act (AHCA) – passed the U.S. House of Representatives on May 4, 2017 and is being considered by the full Senate at the time of this publication. The legislative language contained in this resulting bill calls for significant changes to the health insurance markets, health insurance subsidies, penalties and the Medicaid program. The AHCA proposes Medicaid per capita caps, shortens enrollment periods into health insurance, and implementation of a series of age-based tax credits for securing coverage; a great departure from models seen under the ACA.

In response to the AHCA proposal, the National Indian Health Board (NIHB) and National Congress of American Indians (NCAI) issued a joint letter to Majority Speaker of the House, Paul Ryan, outlining several priorities for Tribal communities. These include:
• Preserve Medicaid Expansion for all Americans and especially for individuals receiving Medicaid through an Indian Health Service (IHS) or Tribally operated health facility
• Clarify that AI/ANs should not be subject to state-imposed work requirements under the Medicaid program
• Continue the cost sharing protections for American Indians and Alaska Natives (AI/ANs) contained in section 1402(d) of the Affordable Care Act
• State-imposed work requirements under the Medicaid program
• Monthly AI/AN enrollments will be permitted to continue under this final rule as established through the ACA. However, there was no Tribal consultation prior to the development of this rule. Per Executive Order 13175, the federal government must consult with Tribes prior to the promulgation of any rule that will have a significant impact on Tribes. Making changes to health insurance coverage that is critical to supplementing the chronically underfunded Indian Health Service certainly has a significant impact on Tribes. NIHB released official comments to the then Acting Administrator Patrick Conway expressing such concerns and calling for future Tribal consultation.

SECRETARY PRICE AND ADMINISTRATOR VERMA GOVERNORS’ LETTER:
HHS Secretary Tom Price and CMS Administrator Seema Verma released a letter to state governors on March 14, 2017. This letter outlined several priorities of the new Administration with regards to Medicaid. It discusses “a new era for federal and state Medicaid partnership” focused on giving “states more freedom to design programs” and encouraging “innovative solutions” with regards to their Medicaid populations. Innovative programs could have a variety of designs, depending on the state, but as outlined in the letter innovative programs would ideally target mitigating state and federal costs and incorporate approaches to increase employment and community engagement of adult beneficiaries.

Secretary Price and Administrator Verma indicated that they will be entertaining state applications to change the way their Medicaid programs work through the submission of what is called a “waiver.” Concernedly, Secretary Price and Administrator Verma expressed their desire to “fast track” these applications. As a result, Tribes are concerned that they will be left out of changes made to state Medicaid programs and that there will be no Tribal consultation.

It is important that states continue to engage in meaningful consultation with Tribes. Tribes should proactively reach out to state Medicaid programs to share Tribal Medicaid priorities. Through CMS’s Tribal Consultation Policy, Tribes can request Tribal consultation at any time with a state on an action that would significantly impact Tribes. Tribes should stay vigilant on proposed waivers and make sure states are consulting with them prior to the submission of any new proposal.

It is part of NIHB’s mission to educate the Administration and Congress about the trust responsibilities the federal government holds with federally recognized Tribes to provide health, education, and other services. NIHB encourages Indian Country to stay vigilant, monitor the pending changes to health care delivery, and continue to educate those who would seek to reform Tribal health care.
Dental Therapy Makes Important Legislative Gains in States

The National Indian Health Board continues to support and advocate on behalf of expanded oral health access in Indian Country as part of the Tribal Oral Health Initiative. One of the most promising solutions is the Dental Therapy (DT) model, which has operated in Alaska Native communities since 2004. DTs are midlevel providers trained and certified to perform the most common dental procedures, focusing on preventative and restorative methods. Under the supervision of a dentist, dental therapists often operate in rural communities and can meet much of patient need. Due to language inserted into the Affordable Care Act, Tribes outside of Alaska wishing to implement dental therapy using federal funds must get their state’s permission to do so.

NIHB works with Tribal and state advocacy groups as they engage with state lawmakers to pass authorizing legislation. Often, the most challenging step is getting legislation introduced for consideration. As lawmakers become more familiar with the solutions dental therapy offers, momentum builds and culminates in the state passing a new law regarding dental therapy. Below is a summary of progress made at the state level to pass DT legislation.

Washington State
The major victory on DT this year came from Washington state and the tireless work of Tribal advocates in the state. Thanks to the efforts of oral health supporters in Olympia, such as State Senator John McCoy (Tulalip), Washington State has a new law on the books authorizing Tribes to implement dental therapy using IHS funds. Since its first introduction into the Washington State Legislature, the bill had broad support in both parties. The law is the first in the nation specific to Tribes. Washington’s 29 Tribes now have the legal authority to implement dental therapy through the Indian health system if they choose, and several Tribes are hoping to begin implementation soon.

Washington State is also home to Swinomish Tribe, which is the first Tribe to implement dental therapy using their own licensing standards.

Arizona
Unique among the states, Arizona has a Sunrise Committee to evaluate potential new programs before authorizing legislation is introduced. Due to the strong lobbying presence of the Arizona Dental Association, which opposes changes to the current oral healthcare delivery model, the dental therapy legislation in Arizona did not make it past this step to be introduced in the state legislature. Due to the dental shortage across much of rural Arizona, advocates in Arizona, working with many Tribes in the state, will continue their efforts in years to come.

Kansas
Advocates in Kansas also sponsored a bill authorizing dental therapy across the state, but the bill has not passed through the Health and Human Services Committee, making passage this session unlikely. One of the strongest champions for dental therapy in the state legislature is Rep. Ponka-We Victors, a member of the Ponca Tribe and Tohono O’odham Nation. Rep. Victors is the only Tribal member in the Kansas state legislature. Tribes in Kansas have endorsed the efforts to bring dental therapy to their communities.

Michigan
Michigan lawmakers introduced a DT bill last session. Senate Bill 1013, sponsored by Republican Senator Mike Shirkey, did not receive a hearing before the Senate Committee on Health Policy.

New Mexico
In New Mexico dental therapy advocates made significant progress in their efforts, seeing a bill authorizing dental therapy statewide pass the House of Representatives with broad and bipartisan support. Unfortunately, time ran out of the legislative session before the state Senate could consider the bill. Due in part to the strong coalition backing dental therapy and the New Mexico Dental Association’s neutrality on the proposed legislation, advocates are very optimistic the bill will pass through both chambers next session. Health Action New Mexico, the coalition in favor of dental therapy, has a history of engagement with Tribes in New Mexico and has the support of the All Pueblo Governors Council, among others.
North Dakota
North Dakota’s legislature meets every two years. When legislation authorizing dental therapy across the state was first introduced, the state House of Representatives voted it down. This year, the bill did not pass a vote in the state Senate. While advocates are disappointed, they are not discouraged, and they plan to reintroduce the bill in 2019. In the meantime, they will continue having conversations about how dental therapy can address the severe provider shortage in North Dakota.

Oregon
In 2015, the Northwest Portland Area Indian Health Board asked the Oregon Health Authority (OHA) to consider Tribal dental therapy pilot projects. In 2016, OHA approved pilot projects on reservations for the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians as well as the Coquille Indian Tribe. These pilot projects are currently underway and several other Tribal and Urban sites are exploring the use of DTs through the same authority, and the data they provide will be invaluable to advocates moving forward.

You can learn more about NIHB’s Oral Health Initiative including fact sheets and additional resources at www.nihb.org/oralhealthinitiative
The Lake County Tribal Health Consortium (LCTHC) is comprised of six federally recognized Tribes located in Lake County, California: Big Valley Rancheria Band of Pomo Indians, Elem Indian Colony, Habematolel Pomo of Upper Lake, Middletown Rancheria of Pomo Indians, Robinson Rancheria Band of Pomo Indians, and Scotts Valley Band of Pomo Indians.

The mission of the Lake County Tribal Health Consortium is the provision of necessary and culturally appropriate health services to all Native Americans and is an integral part of the Lake County Tribes’ reunification efforts to rebuild their culture and to bring all Tribal members home.

LCTHC has been a grantee of the Special Diabetes Program for Indians since 1998, the first year that Tribes received funding to combat the diabetes epidemic in Indian Country. Today, LCTHC SDPI Diabetes Education Program serves approximately 2,000 Natives and employs lifestyle coaches, a registered diettian, family health coach, fitness trainers, and a diabetes educator.

Their Diabetes Prevention Program (DPP) has resulted in lost weight, increased physical activity and decreased consumption of unhealthy foods in program participants, thus reducing the risk factors for diabetes. The program is a Center for Disease Control and Prevention registered Diabetes Prevention Program and with that registration, will be eligible to begin billing Medicare for these services in 2018.

In 2012, the program received the Frankie Award from the National Diabetes Education Program for addressing health disparities and developing a program that meets the needs of the Native Community in Lake County.

Three years ago, holding community advocacy as its best practice for the SDPI grant, Diabetes Education and Program manager Gemalli Austin, DrPH, RD, created the first Diabetes Action Council (Hinth’el Diabetes Action Council, HDAC). With mentorship from Vicki Shively, Northern Valley Community Health and support from the Indian Health Service California Area Diabetes Consultant Helen Maldonado, the HDAC has been a source of strength for the community-directed SDPI.

Researchers have concluded that California could save $1.7 billion in five years by investing $10 per person per year in diabetes prevention programs that have already proven successful (California Obesity Prevention Plan, 2010).

SDPI SPOTLIGHT
The Lake County Tribal Health Consortium
grant. The HDAC includes representatives from the six local Tribes and two community representatives at-large who direct the implementation of a strategic plan to prevent and treat diabetes. The HDAC also has a youth council within to ensure that plans and activities are inclusive of the younger Tribal members and conscious of future generations.

PRACTICING HEALTHY HABITS
The Lake County Tribal Health consortium SDPI program has been offering many services to the Native American community over the years such as health education, vision screenings, lifestyle coaching and the evidence-based Diabetes Prevention Program, however, their most cherished recent creation is the community garden. Referred to as “Kwa Xho,” or earth food in the Pomo language, it has become a “paradise” for everyone of all ages. With a mission that promotes good health, the Kwa Xho serves as the focal point for healthy eating. While embracing the benefits of Kwa Xho, Gemalli expresses the constant challenge of helping to reverse the traces of unhealthy living left behind from historical trauma. Boarding schools, the loss of land, and the abundant distribution of food commodities all contributed to a loss of a way of a healthy life. Diabetes soon followed.

Growing and maintaining a garden was traditionally a way of life that families depended on to survive. In a recent Community Needs and Readiness Assessment Survey conducted by a LCHC team, over 78% of the 614 participants indicated food insecurity in the past 12 months. The survey also discovered that 70.7% of AI/AN respondents eat out at least once a week with local casinos and fast food being their top two destinations. Respondents also indicated the top two ways to learn more about nutrition and health eating was through food demonstrations/cooking classes and learning how to grow healthy food.

Kwa Xho is located at the health clinic and is nurtured by many elders and youth. The youth council within the HDAC council work with the elders on a weekly basis. Also, each week, participating elders from all of the six Tribes receive a bag of produce that comes from the garden, becoming a tradition they look forward to. Each year at the end of May, hundreds of people gather for the annual Community Garden Blessing, planting seeds and plants to kick off the season. Throughout the season, community members who participate in maintaining the garden receive points for every visit. After accumulating a fair amount they can use them to “shop” and buy items such as gardening tools.

The LCTHC’s Diabetes Education Program partnered with the California Tribal Epidemiology Center and Program Evaluator, Cathy Ferron, to evaluate the garden program and found that there was an increase in vegetable intake, especially during the garden season. Garden participants are also aware of the need to be screened for diabetes and 80% of them have been screened and 42% have been told by a doctor that they have diabetes. One goal is to increase diabetic patient participation in the garden.

KEEPING HOPE ALIVE
As the SDPI is set to expire in September 2017, there is a risk of loss of funding or a lapse in funding if Congress does not act soon. Program Manager Austin expresses her concern with funding and shares what she expects to happen if their budget is affected for the upcoming year. She believes they may lose staff, program supplies and Ms. Quitiquit expresses that the ability to provide education would be highly affected. Continuing SDPI in this community means restoring the healthy lifestyle back into Lake County Tribes for the elders and new generations to come. SDPI proves itself to be an instrumental component in efforts to rebuild their culture and be free of diabetes.

More information:
Special Diabetes Program for Indians (IHS) – www.ihs.gov/sdpi/
Diabetes in Indian Country (NIHB) – www.nihb.org/sdipi/
Tribal Zika Response and Planning; Prepare for Mosquito Season

The National Indian Health Board (NIHB), in partnership with the Centers for Disease Control and Prevention (CDC), is engaged in activities to combat the risks of the Zika Virus in Indian Country. The implications that come with possible birth defects from infection are too great of a public health concern to be limited to those most at risk; combating the Zika virus is a community health endeavor.

TRIBAL ZIKA PREPAREDNESS AND RESPONSE FROM THE NATIONAL INDIAN HEALTH BOARD

This past February, NIHB hosted two Tribal Summits on Zika Virus Response and Planning, one in Scottsdale, Arizona from February 2-3, and the other in Orlando, Florida from February 22-23. Participants interacted with experts on the history of the Zika virus, transmission avenues, resources for prevention, and building partnerships for emergency preparedness.

The summit produced valuable participant feedback, such as the need to increase collaboration. This includes partnerships between Tribal stakeholders like emergency preparedness teams, medical providers, community health representatives, and public health. Programs that can provide outreach to pregnant women, such as WIC, were seen as novel approaches to reaching vulnerable populations. Additionally, not all Tribes have health departments and epidemiologists, a concern that emphasizes the need for cross-jurisdictional relationship building. Those communities with emergency response operations in place are encouraged to practice response scenarios with outside jurisdictions whenever the opportunity arises.

WHAT YOU SHOULD KNOW ABOUT THE ZIKA VIRUS

1. Zika primarily spreads through infected mosquitoes.
2. Zika has been locally transmitted in the United States through sex with an infected person. Women who have traveled to an area with risk of Zika should consider using condoms or not having sex for at least 8 weeks, while men should consider the same for 6 months.2
3. The best way to prevent Zika is to prevent Mosquito bites. There is not yet any treatment for the Zika virus.
4. Zika is linked to birth defects. Zika infection during pregnancy can cause a serious birth defect called microcephaly that is a sign of incomplete brain development. Doctors have also found other problems in pregnancies and among fetuses and infants infected with Zika virus before birth.
5. Pregnant women should not travel to areas with the risk of Zika.
6. Returning travelers infected with Zika can spread the virus through mosquito bites. During the first week of infection, Zika virus can be found in a person’s blood and can pass from an infected person to a mosquito through mosquito bites. An infected mosquito can then spread the virus to other people. Travelers are encouraged to continue wearing repellent for up to 4 weeks after returning home.

ZIKA PREVENTION

The species that carry Zika have adapted to living around humans and are primarily container breeders – laying eggs in places like old tires, buckets, bromeliad plants, and puddles near homes.

Use insect repellents approved by the Environmental Protection Agency (EPA) and includes DEET, picaridin, IR3535, oil of lemon eucalyptus, or 2-undecanone, wear protective clothing (such as long sleeves and long pants and/or clothing treated with the insecticide permethrin), and remove standing water, which is where mosquitoes live and lay their eggs. When possible, air-conditioning (in lieu of opening windows) or screens should be used to keep mosquitoes out of the home.

Since the Zika virus may be spread through sexual contact, the use of condoms during sex is recommended.3 This includes not having sex with a potentially infected partner and the correct use of male and female condoms and dental dams from start to finish every time you have sex with a partner who may be infected.

QUESTIONS TO EXPLORE IN YOUR COMMUNITY

Many states provide free Zika prevention kits and some states cover the cost of diagnostic testing for Zika through Medicaid. Here are some questions to explore for Tribal communities ready to engage in prevention efforts:

- Does your state offer free Zika prevention kits for pregnant women?
- Does your community receive Public Health Emergency Preparedness funds from state and local public health systems?

For more information and resources:

Center for Disease Control and Prevention

Be sure to follow #ZapZika on social media for a compilation of the latest updates and announcements.

3. Ibid
Naloxone Can Provide a Lifeline for Many But Access in Indian Country is Limited

As a form of tertiary prevention, Naloxone is a vital tool for first responders, police officers, and civilians to possess and know how to use. Primarily administered via intravenous injection, Naloxone works by blocking or reversing the symptoms of an overdose, such as slowed breathing, loss of consciousness and extreme drowsiness. In laymen’s terms, it draws the individual out of the overdose. Estimates by the Centers for Disease Control and Prevention state that nearly 27,000 overdose-related fatalities were prevented by Naloxone injections between 1996 and 2014.

For American Indian and Alaska Native (AI/AN) communities — who experienced a four-fold increase in opioid related overdoses from 2001 to 2013 — access to Naloxone is vitally important. Tribal communities face significant disparities in opioid addiction and overdose rates, including a much lower age of onset of drug use in youth, higher rates of substance misuse and addiction overall, and low access to behavioral health services such as drug rehabilitation. These conditions both stem from, and are influenced by, the historical, social, economic, and infrastructural challenges unique to Tribal communities.

Nevertheless, opportunities exist to reduce the harm associated with drug use, and equip Tribal communities with the necessary resources to address behavioral health priorities. For instance, in 2016, the White House Council on Drug Control Policy partnered with the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) to arm 300 BIA officers across 90 IHS clinics with Naloxone. In addition, many Tribes across Indian Country have expanded their substance misuse clinics and allocated funds towards purchasing Naloxone kits and educating their communities on its benefits. Many have partnered with syringe exchange service providers and with Tribal and state law enforcement to improve coordination of services. In 2015, fourteen states including California, Montana, North Dakota, Minnesota, Wisconsin and Utah also passed laws permitting the sale of over-the-counter Naloxone at major drug stores.

Despite the progress, limitations in access still exist. For instance, at roughly $20 per dose, financing Naloxone can be very costly. Tribal jurisdictional issues related to Public Law-280 also present challenges for Tribes and their ability to coordinate with non-Tribal first responders and police officers. In addition, the lack of nationwide Good Samaritan Laws — which protect individuals from criminal liability should they report an overdose — discourage communication, reduce community trust, and restrict access to care.

As the shift towards more inclusive, empathy-driven drug policies continues nationwide, many Tribes have been on the vanguard of both the opioid epidemic and the most effective policies and programs to address it. Continued advocacy for drug policy reform is needed at the Tribal, state and federal levels. Whether through sustaining funding for existing substance misuse prevention and treatment services, lobbying for funding and programmatic expansion, or bolstering coordination across various stakeholders — the fight to end the opioid epidemic remains within reach.

For decades, the war on drugs was fought through interdiction on drug sales, incarceration of drug dealers and users, and widespread anti-drug campaigns that arguably did little to assist chronic drug users in need of public health, mental health, and medical services. Although the tide has not completely shifted, more and more medical professionals are employing a public health approach that values prevention, resource allocations to those most in need, and an emphasis on treating drug use as a mental health issue rather than a criminal issue. This change in perspective has produced new programs, medicines and public policies. An example of this shift is greater access to, and support for, the overdose-reversing drug Naloxone.
TRIBAL SOVEREIGNTY: A MEANS TO ADVANCE HEALTH EQUITY

The attainment of the highest level of health for all people, health equity, is a matter of social justice. Achieving health equity in Indian Country requires widespread commitment to not only address existing inequalities and injustices, but to also prevent new inequalities from occurring. Therefore, ensuring that all AI/ANs achieve the highest level of health possible will require broad spectrum action that goes beyond addressing individual determinants of health and disease management, to include action to address social, economic, and environmental disadvantages that impact communities and Tribal Nations.

When considering how to advance health equity in Tribal communities, several unique opportunities emerge which draw support from traditional values, the federal trust responsibility, and Tribal sovereignty. Within Tribal communities, traditional values frequently include the concept of equity, even if that term is not used explicitly. Additionally, many Tribal communities place more focus on the collective group rather than the individual, in contrast to the individualism frequently celebrated in American/Western mainstream culture. The federal trust responsibility also provides unique opportunities in that AI/AN in federally recognized Tribes are born with a legal right to health care, denoting the opportunity for universal health care access in Tribal communities. Finally, Tribal sovereignty provides scope for targeted, innovative strategies that acknowledge each Tribe’s unique governance history and circumstance instead of considering AI/AN as one homogenous population.

As sovereign nations, Tribes have the authority to govern themselves and establish public health law and policy in their pursuit towards health equity. Tribes have enacted laws, policies and ordinances in the areas of environmental health, violence and injury prevention, agriculture and food safety, and emergency preparedness (to name but a few) to reduce health disparities and advance health equity. For example, the Nottawaseppi Huron Band of the Potawatomi Indians enacted a tobacco code "to ensure that all Tribal members, family, friends, employees and Tribal guests, and the next seven generations are not exposed to commercial tobacco use.” It specifically reserves the right to ceremonial and/or traditional tobacco use, which honors traditional values. The code requires the removal of all tobacco advertisements and does not allow Tribal employees to wear clothing that bears tobacco company logos at school or community events during work hours. The code also prohibits smoking in all Tribal buildings, except for gaming facilities.

Public health, with a multi-disciplinary approach focused on the social determinants of health, is a true opportunity to advance the well-being of AI/AN communities. A Tribe’s commitment to advancing health equity not only has the potential to lead to healthier Native communities by decreasing disparities for generations to come, it offers Tribes the opportunity to advance their sovereignty and uphold the federal government’s trust responsibility.


EQUITY VS EQUALITY
Equity involves trying to understand and give people what they need to enjoy full, healthy lives. Equality aims to ensure that everyone gets the same things in order to enjoy full, healthy lives. Like equity, equality aims to promote fairness and justice, but it can only work if everyone starts from the same place and needs the same things.

NIHB Health Equity Summit in Denver, Colorado, ‘Leading the Work of Health Equity’, March 1-2, 2017
participants around Indian Country. From 1996-2013 End-Stage Renal Disease (ESRD) in AI/ANs has decreased by 54% – the steepest decline of any ethnic group. That data tracks closely with the inception of SDPI so the link between the end of ESRD and SDPI is clear. ESRD is one of the biggest drivers of Medicare costs at almost 90,000 per patient per year. SDPI is saving lives and saving dollars.

Despite the remarkable successes of the program, we still rely on Congress to renew this program from year to year. Recently, the program has been reauthorized in one or two year reauthorization periods at $150 million a year – with no funding increase since 2004. When factoring in new Tribes that now receive the funding, population growth, and medical inflation, this flat funding for the past thirteen years actually represents a significant decrease. This leaves SDPI programs with difficult choices, potentially limiting the effect this remarkable program can have. We hope that Congressional leaders make the renewal of these programs a legislative priority in the coming months. Failure to enact SDPI quickly will result in the loss of staff for many SDPI programs living in rural areas and will cause disruptions to patient care.

With all this at stake, it is critical that Congress act swiftly to reauthorize this important program so that we can continue to save lives, federal dollars and secure programmatic staff. The NIHB and Tribes will continue advocating for long-term reauthorization of at least $200 million per year for SDPI.

NIHB and Tribes are encouraged by the strong support for SDPI in Congress. In September 2016, a letter addressed to Congressional leadership in support of SDPI gathered signatures from 356 (out of 435) House Members and 75 (out of 100) Senators.

SDPI is usually renewed as part of the “Medicare Extenders” legislation. In 2015, the annual legislation which typically contained Medicare Extenders was permanently reauthorized. There may be opportunity now for several different mechanisms for renewing funding for this important program. In March 2017, Senator Udall (D-NM) introduced the Special Diabetes Program for Indians Reauthorization Act of 2017 (S. 747). This piece of legislation would reauthorize SDPI for $150 million per year through 2024, with annual increases based on medical inflation. A companion bill was introduced in the House of Representatives in May 2017 by Congresswoman Norma Torres (D-CA) (H.R. 2545). Alternatively, SDPI may be added yet again with other public health improvement programs known as the Medicare Extenders and attached to the Children’s Health Insurance Program (CHIP) reauthorization.

BUT WE NEED YOUR HELP.
Given the uncertainty of the legislative path to reauthorization, it is now more important...
than ever for SDPI grantees to share success stories of how SDPI is impacting Tribal communities with NIHB and their Members of Congress. Have you or a loved one participated in your Tribe’s local SDPI program? If so, send NIHB your story and photos using the online form located at www.nihb.org/sdpi.

Tribes are also encouraged to provide education on the importance of this program by inviting lawmakers to visit SDPI grant sites and meet with practitioners and participants. In past renewal efforts, these site visits have been extremely effective in garnering support from lawmakers. Now is the time to SHOW your member of Congress how your SDPI program is saving lives and transforming communities. Just follow these four easy steps:

Schedule a time to meet with your Member of Congress
Host your member at your SDPI site
Organize the community to participate
Witness the change when your Member returns to Washington, DC

NIHB has a toolkit available with step-by-step instructions on how to host a site visit with Members of Congress located at www.nihb.org/sdpi/host.php.

You can also send SDPI Postcards to your Members of Congress. Contact NIHB staff to request post cards to pass out at your community meetings and events.

To learn more about how you can assist in advocating for the renewal of the Special Diabetes Program for Indians, please visit www.nihb.org/sdpi or contact NIHB Congressional Relations Manager, Michelle Castagne, at mcastagne@nihb.org or 202-507-4083.

Upcoming Events

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<td>Tribal Leaders Diabetes Committee Meeting</td>
<td>June 5-6, 2017</td>
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<tr>
<td>NIHBI Tribal Public Health Summit</td>
<td>June 6-8, 2017</td>
<td>Anchorage, AK</td>
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<td>National Congress of American Indians Mid-Year</td>
<td>June 12-15, 2017</td>
<td>Uncasville, CT</td>
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<td>2017 National UNITY Conference</td>
<td>July 6-10, 2017</td>
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<td>NIHBI Medicare, Medicaid, Policy Committee Meeting</td>
<td>July 11, 2017</td>
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<td>CMS Tribal Technical Advisory Group</td>
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<td>Tribal Self Governance Advisory Committee Meeting</td>
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<td>Direct Service Tribes National Meeting</td>
<td>August 2-3, 2017</td>
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<td>National American Indian/ Alaska Native Annual Behavioral Health Conference</td>
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<td>CDC Tribal Advisory Committee Meeting</td>
<td>August 8-9, 2017</td>
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<td>2nd Annual Native American Nutrition Conference</td>
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<td>NIHB National Tribal Health Conference</td>
<td>September 25-28, 2017</td>
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<td>American Indian Health Research Conference</td>
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<td>Alaska Federation of Natives Annual Convention</td>
<td>October 19-21, 2017</td>
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Please join us
NATIONAL TRIBAL HEALTH CONFERENCE
September 25-28, 2017
Hyatt Regency • Bellevue, Washington