All Eyes on White House as Indian Country Prepares for Possible Medicaid Block Grants

The White House Office of Management and Budget (OMB) is currently reviewing proposed guidance from the Centers for Medicare & Medicaid Services (CMS) that could invite states to use Section 1115 waivers to administer Medicaid funding through a block grant. Should states move forward with block grants or Medicaid per capita allocations, the impact to the Indian health system could be huge. As such, it is critical that Tribes understand what Medicaid block grants would be, their potential impact, and what they can do about it!

Congress amended the Social Security Act in 1976 to authorize Medicaid reimbursement for services provided in Indian Health Service (IHS) and Tribally operated health care facilities. Congress explained that Medicaid payments were viewed as a much-needed supplement to a health care program which was insufficient to provide quality health care to American Indians and Alaska Natives. At the same time, Congress ensured that the Medicaid payments for services provided in IHS/Tribal facilities to Medicaid eligible Indians would be reimbursed 100% by the federal government because it was a federal obligation.

Congress established the Indian Health Service (IHS) in partial fulfillment of its Treaty and Trust obligations for health care to Tribal Nations and American Indian and Alaska Native (AI/AN) Peoples. Yet since its founding, the federal government has never funded IHS at the level of need, contributing to the lower health status and higher rates of health disparities among AI/ANs nationwide. The IHS Tribal Budget Formulation Workgroup has indicated that in order for IHS to reach full funding at the level of need, yearly appropriations would have to reach over $37 billion; in contrast, fiscal year (FY) 2019 appropriations for IHS are at only about $5.8 billion.

Without sufficient funding, IHS continues to face significant challenges with recruitment and retention of quality providers; with maintenance and upgrades to hospitals and clinics; with health information technology (IT) modernization; and with the ability to offer comprehensive treatment-based and preventive health services.

The only surefire solution to these challenges is for Congress to fully fund IHS and transition the agency to mandatory (or off-budget) appropriations. While mandatory funding for IHS remains the long-term goal, there are preliminary steps that can lead to greater stability for the Indian health system, and reduce the threat of funding lapses due to government shutdowns. Namely, authorizing advance appropriations for IHS and other Indian programs would move the needle significantly forward towards
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The National Indian Health Board (NIHB) represents Tribal governments – both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS).

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

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

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

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

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

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

A SHARED GOAL – QUALITY HEALTH CARE
The future of health care for American Indians and Alaska Natives is intertwined with policy decisions at the federal level and changes in mainstream health care management. NIHB brings Tribal governments timely information to help them effectively make sound health care policy decisions. NIHB provides a vehicle to keep the flow of health care information in front of policy makers and Tribal governments manifesting progress in health care and strengthening Tribal sovereignty.
FROM THE CHAIRPERSON

DEAR INDIAN COUNTRY FRIENDS AND ADVOCATES,

Welcome to the Fall 2019 edition of the National Indian Health Board's (NIHB) Health Reporter! As always, we are excited to continue the work “to advocate as the united voice of federally recognized American Indian and Alaska Native Tribes, 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.” We are pleased to see many of you in Temecula, California this September for the 2019 National Tribal Health Conference! We also offer a big THANK YOU to our partners in the California Area who have helped make this event possible – especially the California Rural Indian Health Board.

As my first year as the Chairperson of NIHB comes to a close, I have been humbled and honored to advocate for better health care for Indian Country and increased investments in Tribal public health infrastructure and systems. I will continue to look to you for assistance and guidance as we, together, fight to improve the health of our people. Our health is our sovereignty.

This year continues to bring challenges for the advancement of Indian health. As we all know, Indian health programs continue to experience undue burden and disruption as a result of the 35-day federal government shutdown earlier this year. This hardship reaffirmed the need for advance appropriations for the Indian Health Service. Additionally, proposed reforms to Medicaid continue to pose a direct threat to that program’s ability to support the Indian health system and could potentially harm the thousands of American Indians and Alaska Natives who rely on the program. At the same time, Tribes and the Indian Health Service are working to develop and implement a plan to update the Indian health system’s Health Information Technology to strengthen the delivery of quality health services to Tribes across the country.

But there are also new opportunities that inspire us to keep advancing this work: this year, Congress will need to enact long-term reauthorization of the Special Diabetes Program for Indians (SDPI) – one of the most successful public health programs ever implemented. In addition, the expansion of the Community Health Aide Program to Tribes outside of Alaska is creating exciting new opportunities for Tribes to utilize midlevel, culturally competent providers. The National Indian Health Board strongly supports this expansion, and we are continuing our work to ensure other programs, like Community Health Representatives, are not negatively impacted.

In this edition of the Health Reporter you will learn about important efforts NIHB is undertaking towards addressing advance appropriations for IHS, including Tribal needs in legislation aimed at curtailing surprise billing across the country, public health efforts including cancer screening in Tribal communities, collaboration between the Indian Health Service and the Veterans Administration, dental health, and the SDPI. Indian Country has been able to tackle each of the challenges by coming together and speaking with one voice. It is critical for our Tribal communities to advocate for increased resources for health care and public health infrastructure. NIHB continues to remain engaged with policymakers in Congress and the Administration to ensure the trust responsibility is met and the health of our people is addressed.

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

Victoria Kitcheyan
Chairperson
The national expansion of the Community Health Aide Program (CHAP) provides another successful workforce model for Tribal communities seeking to enhance their health care systems by increasing their access to midlevel health providers. The National Indian Health Board continues to support the Tribes as they rise to the challenge of meeting the health care needs for their people. This article demonstrates the strengths of the CHAP, gives an update on where the CHAP policy stands, and shows the importance of culturally-competent services.

The Community Health Aide Program (CHAP) is an excellent example of Tribal innovation and ingenuity in the face of unmet health needs. In the 1960s, Alaska Natives were experiencing a tuberculosis epidemic, high infant mortality, and high rates of injury in rural Alaska. Limited access to health care providers, compounded by challenges posed by remoteness of the villages, transportation, and weather concerns made it very difficult for Alaska Natives to get the quality health care they needed. The Tribes in Alaska drove the creation of the Community Health Aide Program in response. CHAP trains local residents to provide basic health care, assuring that health services are available in the local community from culturally competent providers. For more than 50 years, CHAP has proven an effective method for diminishing the health disparities of Alaska Natives. These midlevel providers, who often come from the villages they serve, work most effectively in facility and village clinic settings to offer routine and preventative medical and dental health care, as well as behavioral health services within the scope of their training and certification from the federal government.

It is due to this success that Congress gave the authority to the Indian Health Service (IHS) to expand CHAP to Tribes outside Alaska. IHS, in consultation with Tribes, began expanding the program through the formation of a draft interim policy governing how CHAP would be structured in Areas outside of Alaska. As of this writing, IHS is still incorporating comments submitted during consultation. The draft interim policy discusses building out a CHAP infrastructure at the Area level, which could include an Area Certification Board to evaluate and certify CHAP providers, and an Academic Review Committee, which would periodically evaluate the training curricula for CHAP trainees.

While the final interim policy is being created, many Tribes are working toward integrating CHAP into their existing health care delivery models.

**AN EXPANSION OF CHAP IS NOT AN ELIMINATION OF COMMUNITY HEALTH REPRESENTATIVES (CHR)**

The National Indian Health Board has heard directly from Tribal leaders that their support for the national expansion of the CHAP should not impact continuation of their Community Health Representative (CHR) programs. The concerted effort to preserve the role of the CHRs in Tribal communities stems from concerns over previous budget recommendations put forward by President Trump that attempted to eliminate funding for CHR programs. Despite this recommendation, Congress listened to the Tribes and restored level funding to the CHR program in Fiscal Year (FY) 2019, at $63 million. President Trump recommended that FY 2020 funds for the CHR program be used to transition CHR programs to CHAP. Hearing concerns from many Tribes, NIHB requested separate and dedicated funding for both the CHAP and CHR programs in its response to IHS’ Dear Tribal Leader Letter requesting feedback on the CHAP interim policy. Both programs provide vital health care services to their communities and are successful because they provide culturally competent care to patients.

**THE EXPANSION OF COMMUNITY HEALTH SERVICES STRENGTHENS THE LEGACY OF SELF-DETERMINATION**

The Community Health Aide Program became an important first step towards putting Alaska Native health care in the hands of Alaska Native people and now that the program is being extended nationwide, all Tribal communities will have access to the same opportunity. Although CHAP was created in part to mitigate the tuberculosis epidemic in rural Alaska, community health aides expanded their scope quickly, responding to emergencies and providing care for expectant mothers. And although CHAP has historically shared similar goals to the Community Health Representative (CHR) program, the programs remain fundamentally different. While CHAP’s midlevel providers directly in the community, CHR programs are more likely to assist with navigating the health system and removing barriers to accessing care, such as providing in-home health screenings. The successful integration of the CHAP and/or CHR program(s) into a Tribal community’s health system is yet another step towards Tribes affirming their political sovereignty and ensuring that the federal government upholds its treaty and trust relationship.

Some Tribes began developing programs to train local residents to meet their needs for a health workforce as early as the 1950s. Congress had authorized money to support CHAPs in Alaska and CHRs by 1968—the first time that money had been either requested or appropriated specifically to meet this type of need in Indian Country—the same year President Lyndon B. Johnson proposed ending the harmful termination-era policies for Indian Country, marking the beginning of the current policy of

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**CHAP AND CHR:**

**TWO SUCCESSFUL PROGRAMS IN THE INDIAN HEALTH SYSTEM**

**Community Health Aide Program (CHAP)**

Three types of mid-level practitioners: community health aides, behavioral health aides, and dental health aides—who are clinically trained and work in their own communities, which expands the reach of the Indian health system.

**Community Health Representatives (CHR)**

Community members who provide health promotion, disease prevention, patient education, transportation, and more services to AI/ANs.
self-determination which subsequent generations continue to affirm.

Prior to the establishment of the Indian Health Service at the U.S. Department of Health and Human Services, the Division of Indian Health at the U.S. Department of Health, Education, and Welfare selected a proposed model to serve as the basis for their 1968 funding request of CHAP/CHRs. The project Congress selected was initially a proposal submitted by President John Wooden Legs, of the Northern Cheyenne and funded through the Economic Opportunity Act of 1964. Funding through this mechanism for a CHR program introduced one of the first opportunities for the Tribes to demonstrate Indian Self-Determination to the federal government. President Wooden Legs’ efforts successfully funded a maternal and child health worker under the Tribe’s direct supervision, rather than that of the federal government, the U.S. Public Health Service. The path towards the expansion of Tribal services and programs has a rich history and demonstrates the resilience of the Tribal Nations that have invested years in their fight toward true Tribal sovereignty. NIHIB continues supporting them in this fight for the upcoming appropriations cycle and looks forward to their strong future. 

Ensuring “Meaningful” Tribal Consultation

In recent decades, legislation and policy statements have explicitly called for increased support of Tribal sovereignty and enhanced government-to-government communication between the United States and Tribes. When President Nixon, in a 1970 Special Message, called for a balanced relationship between governments and clarifying “that Indians can become independent of Federal control without being cut off from Federal concern and Federal support,” he articulated a dynamic that became the origin of current consultation between Tribal governments and federal agencies.

More than 20 years later in 1994, President Clinton issued Executive Order 13175, requiring federal departments and agencies to consult with Tribal governments whenever proposed policies or actions would substantially impact Tribes. The Obama Administration further affirmed Tribal sovereignty and the unique trust relationship, emphasizing the importance of agencies “engaging in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications.”

Tribal consultation is fundamental for improving the quality of decision-making within the federal government, improving outcomes for Tribal communities, and protecting Tribal interests. When it comes to health, Tribes have the greatest understanding of what will best empower their people. Culturally competent care and services play an integral role in eliminating health disparities among American Indian/Alaska Natives, and fortunately, Tribal consultation serves as a way for Tribes to have a say in the programs and services affecting them.

However, Tribes have faced challenges in ensuring that agencies meaningfully consult and collaborate with them.

EDUCATION

More often than not, federal officials do not understand Tribal sovereignty or the United States’ trust responsibility. It is important that Tribal leaders and representatives emphasize that 1) Tribes are sovereign nations and 2) the federal government as a whole, not just agencies, has a special government-to-government relationship with Tribes that is expressly recognized in the U.S. Constitution, treaties, statutes, and executive orders. Meaningful consultation requires at least a basic understanding of the trust responsibility and its history.

TIMING

After-the-fact consultation is neither meaningful nor effective, and it prevents Tribes from collaborating with agencies before decisions are made. Although agencies – not Tribes – have a legal obligation to consult, Tribal leaders and representatives should try to establish and maintain working relationships with relevant agencies. Having an established relationship will allow Tribes to be engaged early on in the Tribal consultation process.

PROCEDURAL FOCUS

Tribes often feel as though their concerns and input are not being heard or incorporated into the agencies’ policies. A number of factors have raised this concern among Tribal leaders, including the feeling that consultation is often treated as a procedural step done only to move forward with implementing policy. By looking at the intent of Executive Order 13175, it is clear that agencies have a duty to focus on the substantive issues and concerns that Tribes bring to consultation. Further, the trust responsibility is a legally enforceable fiduciary obligation of the United States to protect Tribal treaty rights, assets, lands, and resources; adequate protection of Tribes cannot be done without first engaging in truly meaningful consultation.

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Every year, the National Indian Health Board (NIHB) engages with Tribes and Tribal leaders to set forth a policy agenda that focuses on key health priorities and topical areas that will require targeted efforts and concerted energy to advance throughout the year. The result of this annual process is a guiding document for NIHB to continue our advocacy efforts, to effectuate the delivery of quality services.

On Location: Behavioral Health in Indian Country

SUBSTANCE ABUSE & SUICIDE PREVENTION PROGRAM (SASPP) & DOMESTIC VIOLENCE PREVENTION PROGRAM (DVPP) GRANTEE HIGHLIGHTS

The Substance Abuse and Suicide Prevention Program (SASPP), formerly the Methamphetamine and Suicide Prevention Initiative (MSPI), and the Domestic Violence Prevention Program (DVPP) are national programs focusing on substance misuse/suicide prevention and violence prevention/treatment services for Indian Country, respectively. Both initiatives promote the use and development of evidence-based and practice-based culturally-appropriate approaches to prevention. The Indian Health Service currently funds 175 SASPP programs and 83 DVPP programs across Indian Country.

During late summer and early fall 2018, the National Indian Health Board (NIHB) with the assistance of videographer Cherylee Francis, went on location in six Tribal communities to capture stories from SASPP and DVPP programs, resulting in six individual films and one compilation film showcasing the impacts of the grantee projects in Tribal Communities. The six sites included:

- Pueblo of Acoma (Albuquerque Area)
- Quileute Tribe (Portland Area)
- Chippewa Cree Tribe/Rocky Boy Health Board MSPI (Billings Area)
- Aroostook Band of Micmacs (Nashville Area)
- Choctaw Nation (Oklahoma Area)
- Paiute Indian Tribe of Utah (Phoenix Area)

From youth programs to canoe journeys and flute playing as paths to prevention each film highlights the innovations and successes of the SASPP and DVPP projects. The films will be made publically available on the NIHB website, used in NIHB outreach and education on the program, and shared with Tribal communities and other partners in Indian Country. We hope that others will be inspired by and learn from the grantees innovative approach to this work!

WHAT DOES THE HEALTH IT MODERNIZATION PROCESS LOOK LIKE?

1/1/1 SITE VISITS
20 site visits in Indian Country to collect information on the Electronic Health Record. Analysis performed will help identify the impact of Health IT on clinical care and performance.

AOA & STRATEGY
Directly assess and evaluate approaches to modernization. A roadmap will be developed for a set of selected alternatives.

DATA CALL
Send questionnaire to sites using the IHS Electronic Health Record. Results will be summarized and shared with Health IT Modernization Project team and Tribes.

COMMUNITY OF PRACTICE
Establish and facilitate a forum for personal and professional development around the effective use of the IHS Electronic Health Record.

LEGACY ASSESSMENT
Assess and evaluate current state of the IHS Electronic Health Record. Also, provide a summary of potential opportunities, implications, and requirements for Health Modernization as a result of evaluation.
Progress at the Policy Level: Improving the Health IT System in Indian Country

The explosion of Health IT capabilities in recent years, primarily driven by federal regulation, has caused the Indian Health Service’s (IHS’s) Health Information Technology (Health IT) to outgrow the agency’s capacity to maintain and support necessary enhancements. The National Indian Health Board (NIHB) Board of Directors has requested that the Trump Administration improve the Health IT system at the IHS.

NIHB has heard from Tribes that the greatest challenge of Health IT Modernization has been the lack of dedicated and sustainable funding to adequately support Health IT infrastructure, including full deployment and support for EHRs. Resources, including workforce and training, have been inadequate to sustain clinical quality data and business applications necessary to provide safe quality health services.

The IHS Tribal Budget Formulation Workgroup has strongly recommended that for Fiscal Year (FY) 2020, the IHS add an IT spending line in the budget that would specifically designate funds for Health IT requirements and resources. Establishing a Health IT line item would help to ensure that costs for Hospitals and Clinics (H&C) remain focused on the patient’s quality of care received and their access to direct patient care.

NIHB looks forward to working with Tribes as they continue their advocacy efforts to secure a strong Health IT system for American Indian and 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 with them and is reflective of their innovative communities that require sustainability throughout their diverse healthcare settings.
Once Again, Ensuring Timely Appropriations for the Indian Health Service Remains Questionable

Usually by the time August recess starts, congressional appropriators are close to concluding work on funding packages for the next Fiscal Year (FY). But as of August 30, 2019 the Senate has yet to begin formal work on any FY 2020 appropriations package. With current year’s funding set to expire by September 30, Congress has only three legislative weeks to complete all twelve appropriations bills upon returning from recess on Monday, September 9. This restricted timeframe for completing work on spending legislation increases the possibility of yet another continuing resolution to avoid a government shutdown.

HOW WE GOT HERE

Congress did not complete its work on FY 2019 appropriations until four and a half months into it. When the Consolidated Appropriations Act of 2019 became law with the President’s signature on February 15 of this year, it ended the longest government shutdown in American history. The act flat-funded every federal agency that had endured the government shutdown through September 30, 2019, including the Indian Health Service (IHS), which had experienced a record 35 days without funding.

One of the consequences of the 35-day government shutdown was a months-long delay to the budgetary process for FY 2020. For instance, the President’s Budget Request to Congress – which is usually released in February of each year – wasn’t released in full until mid-March, further postponing work on yearly appropriations. Usually, the House and Senate agree to what’s known as a “Budget Resolution” before commencing work on a subsequent year’s funding bills. The Budget Resolution sets the parameters for spending negotiations for both chambers, and also outlines the top-line funding levels for defense and non-defense programs that are then divvied up across the twelve yearly discretionary appropriations bills.

Because Congress didn’t agree to a Budget Resolution at the beginning of this year, the House of Representatives decided to use a “deeming resolution” to guide their work on FY 2020 appropriations. The deeming resolution established estimates for each of the twelve appropriations bills. Under this mechanism, the House completed and passed ten out of twelve funding packages for FY 2020, including the Interior Appropriations bill funding IHS.

The Senate did not take this approach. While Senate Appropriations Committee Chairman Richard Shelby (R-AL) indicated that the Senate may also elect to use a deeming resolution for FY 2020 spending bills, this approach was ultimately discarded in favor of waiting for a formal Budget Deal. Unfortunately, that Budget Deal, HR 3877 – the Bipartisan Budget Act of 2019 – wasn’t signed into law until the end of July, right before Congress departed for August recess.

PATH FORWARD

The House passed its FY 2020 bill for Interior, Environment, and Related Agencies, which also funds IHS, back in May 2019. Under the House-passed bill, the IHS budget would receive an overall increase of $537 million over current funding levels, to a total budget of $6.3 billion. Budget line items such as IHS Hospitals and Clinics would be increased to $2.42 billion overall. Other line item increases included, but were not limited to, $125.3 million for Mental Health; $304.2 million for Health Care Facilities Construction; and $90.6 million for Indian Health Professions. Many other line items such as Urban Indian Health, Alcohol and Substance Abuse, and Health Education also saw increases.

However, because the House was using ballpark estimates, it is unlikely that these numbers will be maintained in the Senate. Under the top-line funding levels formally established by the Bipartisan Budget Act of 2019, the House-passed appropriations bills would have to be
Addressing Indian Country’s Cancer Burden through Improvements in Cancer Screening

American Indian/Alaska Native (AI/AN) populations face a significant cancer burden. Although cancer incidence and mortality rates vary by Tribe, region, and type of cancer, AI/AN populations have seen little advancement in terms of cancer control during the last two decades.

While cancer deaths are decreasing in white populations, cancer deaths are rising in AI/AN communities. Specifically, white populations typically live longer than AI/ANs after being diagnosed with cancer and AI/ANs are also less likely to participate in and have access to preventive cancer-related services such as cervical Pap smears and mammograms. Narrowing the focus to specific cancer types paints an even more poignant picture of the overall cancer burden. Breast cancer is the most frequently diagnosed cancer and the leading cause of death among AI/AN women. For AI/AN women, the cervical cancer mortality rate is almost twice the rate in White women. Colorectal cancer is another treatable cancer that, while overall mortality rates have gone down, is still 39% higher than white populations.

The cancer burden in Tribal communities is further exacerbated by rural isolation, higher rates of poverty, food insecurity, and general lack of access to appropriate health care.

To address this cancer burden, the National Indian Health Board (NIHB) is committed to improving health and promoting health equity within Tribal communities through better access to high quality cancer screenings. Cancer screening is particularly important for breast, cervical, and colorectal cancers due to the link between early detection and effective treatment. This is because routine patient cancer screenings, such as mammograms, Pap tests, and colonoscopies, are especially effective as these screenings can frequently prevent or detect these cancers before a person develops any symptoms.

Through support and partnership with the Centers for Disease Control and Prevention (CDC), NIHB is pleased to release a new tool, Health Systems Improvement Toolkit: A Guide To Cancer Screenings in Indian Country. This toolkit has been developed with the support of Tribal health systems to share best practices around implementing the evidence-based interventions (EBIs) and strategies found in The Guide to Community Preventive Services (The Community Guide). NIHB’s action guide is designed specifically for Tribal health systems interested in increasing high-quality, population-based breast, cervical, and colorectal cancer screenings. Not only does it contain in-depth guidance on implementing cancer screening-related EBIs, it also contains key tools and resources that Tribal clinics and programs can tailor invidually for their patient populations. This tool can be accessed at www.NIHBCancerscreening.nptoolkit.org or by visiting NIHB’s website at www.nihb.org.

As we work to increase cancer screenings in Indian Country, it’s important to identify barriers such as lack of reliable access to healthcare, cultural differences, and other social determinants of health. Through this holistic approach and with dedicated support and efforts from the national level on down to a local level, we can work together to end the cancer burden in Indian Country.

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2. The cervical cancer mortality rate for AI/AN women in Indian Health Service (IHS) Contract Health Service Delivery Area (CHSDA) counties is almost twice the rate in White women (4.2 per 100,000, compared to 2.0 per 100,000).

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Chairman Shelby (R-AL) has expressed interest in combining the Defense, Energy and Water, and Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) bills into a “minibus” in order to streamline potential for timely passage, and which, if any, may be subject to another continuing resolution. With an impending deadline of September 30 to complete all twelve spending bills, it seems highly likely that some or all funding bills will be subject to a funding extension at current levels. Indeed, the only certainty is that Congress must pass a full appropriations package or a series of continuing resolutions that account for all twelve spending bills in order to avoid a second government shutdown this calendar year alone. That is likely a tall order given the available time frame.

In addition, it remains unclear which funding bills will receive timely passage, and which, if any, may be subject to another continuing resolution. With an impending deadline of September 30 to complete all twelve spending bills, it seems highly likely that some or all funding bills will be subject to a funding extension at current levels. Indeed, the only certainty is that Congress must pass a full appropriations package or a series of continuing resolutions that account for all twelve spending bills in order to avoid a second government shutdown this calendar year alone. That is likely a tall order given the available time frame.

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Dental Therapy Movement Approaches Tipping Point in 2019

This year, more states than ever before considered legislation authorizing dental therapy! As more state lawmakers became familiar with the successes that dental therapists have created in Alaska Native communities and Tribal communities in the Pacific Northwest, support for the innovative workforce model has grown substantially. As Tribal dental therapists continue to serve their communities, focusing on preventative and restorative care, supporters can point to more and more demonstrated success as they advocate in states across the country.

Just this year, lawmakers in FIVE states passed dental therapy bills into law. In some of those states, like Idaho, this was the first year a dental therapy bill had been introduced! In other states, like New Mexico, persistent Tribal advocacy pushed dental therapy across the finish line after multiple legislative sessions.

The five states that passed dental therapy this year have different demographics, sizes, and political dispositions. Idaho, New Mexico, Montana, Connecticut, and Nevada show that dental therapy is a solution that works in rural, urban, Tribal, and still more communities. Advocates in other states are already planning for the coming years to expand dental therapy even further.

It is clear that dental therapy nationwide is now a question of when, not if.

Idaho On March 25, Governor Brad Little signed a bill allowing dental therapists to work in Tribal health facilities. The governor’s signature was the culmination of months of work from the Idaho Tribes. Following a site visit to see the Alaska dental therapists in action, Tribal leaders and health directors from Coeur d’Alene, Shoshone Bannock, and Nez Perce began advocating for their right to employ dental therapists in their own clinics and dental programs.

The legislation enacted into law applies only to Tribes in the state. However, it follows evidence-based standards developed by the Commission on Dental Accreditation (CODA), so Idaho Tribes will be able to use the same flexible model that Alaska Tribes have used since 2004. One Tribe even has a student already studying in Alaska to become a dental therapist!

New Mexico After nine years of sustained effort, Tribes succeeded in securing passage of dental therapy legislation in New Mexico! Governor Lujan Grisham signed H.B. 308 into law on March 28. The new law allows dental therapists to practice in specific practice settings statewide, including health facilities run by the Indian Health Service or by a Tribe. Dental therapists can also now practice in Federally Qualified Health Centers and look-alikes, long-term care facilities, or a nonprofit dental organization. The law also provides for an annual report to the New Mexico Legislature on various oral health issues and a biennial report on dental therapy education programs in the state.

A political compromise included in the final text of the legislation requires that dental therapists first obtain a dental hygienist license. As Tribes have seen in other states with this requirement, dental therapists with a hygiene license are in school for two to four years longer than the standards for dental therapy education require, adding a cost and time burden onto the provider. In turn, that provider then has more of an incentive to work in a for-profit setting away from where providers are needed most. Tribes are at a competitive disadvantage as employers when a hygiene requirement is added to the mix. So Tribes fought for and won a carve-out:

improving the dependability of funding and the continuity of health services.

In the spring of 2019, the National Indian Health Board reported that three pieces of legislation had been introduced to provide IHS with advance appropriations. S. 229 and H.R. 1128 – the Indian Programs Advance Appropriations Act – were introduced by Senator Tom Udall (D-NM) and Congresswoman Betty McCollum (D-MN), respectively, and would provide advance appropriations for both the IHS and the Bureau of Indian Affairs. H.R. 1135 – Indian Health Service Advance Appropriations Act – introduced by Congressman Don Young (R-AK), would provide advance appropriations for IHS only.

An important distinction between S.229/HR 1128 and HR 1135 are the different IHS accounts that would be authorized to receive advance appropriations. Under S.229/HR 1128, IHS Services and Contract Support Costs would be authorized to receive advance appropriations; contrastingly, under HR 1135, IHS Services and IHS facilities would receive authorization. Because of these differences, it is important that Tribes and Tribal organizations connect with their members of Congress to provide feedback on both legislative approaches.

CURRENT LANDSCAPE

Before leaving for August recess, Congress passed HR 3877 – the Bipartisan Budget Act of 2019. Better known as the “Budget Deal,” this legislation established top-line spending numbers for defense and non-defense programs for both FY 2020 and FY 2021. It also established the parameters for providing advance appropriations to existing accounts such as the Veterans Health Administration, and outlined the process for enacting new authorizations.

Under House Rules, the Chairman of the House Budget Committee would have to approve any new authorizations for advance appropriations. For the Senate, it would require approval from the Chairman of the Senate Budget Committee or an affirmative vote by at least 60 Senators (three-fifths majority). Importantly, HR 3877 includes a “sunset” clause on these parameters, such that they would become null and void if the House and Senate agree to a new concurrent resolution by April 15, 2020, that makes any changes to funding levels for FY 2021.

Because the Budget Deal sets top-line funding levels for the next two years, the earliest year
Continued from page 1 –

1128 and HR 1135, has indicated its desire to hold a hearing on advance appropriations this year. While details are still forthcoming, a potential hearing would most likely focus on the current proposed legislation with opportunities to discuss the broader impacts of government shutdowns and continuing resolutions on the long-term stability of IHS and Indian programs. NIHB will share more details as they become available, including a scheduled date and witness testimony from Tribal leaders and representatives.

**Next Steps**

NIHB has been advocating for a congressional hearing on advance appropriations ever since the Government Accountability Office (GAO) issued its report outlining a path forward for advance appropriations for IHS in September 2018. The House Natural Resources Subcommittee for Indigenous Peoples of the United States, which has jurisdiction over HR 1128 and HR 1135, has indicated its desire of a state license, and legislation recognizing the sufficiency of that certification sailed through the Montana State House of Representatives. The Senate was a bit trickier, with compromise legislation limiting the scope of CHAP’s dental providers passing narrowly. But when the CHAP implementation bill was signed into law on May 9, Montana Tribes gained a mechanism to employ CHAP dental providers. Multiple Tribes are already planning to do so in the near future.

**Montana**

Tribes in Big Sky Country took a unique approach to dental therapy under the Indian Health Care Improvement Act (IHCIA). That law forms the backbone of the Indian Health Service’s ability to provide quality health care to American Indians and Alaska Natives. The law allowed the Indian Health Service to expand the Community Health Aide Program (CHAP) from Alaska to Tribes throughout the country based off of that program’s success in providing medical care, behavioral health, and dental health services to remote Alaska Native communities. Unfortunately, IHCIA also included a political requirement that Tribes outside Alaska get permission from their states to use dental therapists under CHAP.

Montana Tribes asked the legislature to consider a bill that allows CHAP providers – including dental therapists — to work for Montana Tribes without a state license. CHAP providers receive federal certification in lieu of a state license, and legislation recognizing the sufficiency of that certification sailed through the Montana State House of Representatives. The Senate was a bit trickier, with compromise legislation limiting the scope of CHAP’s dental providers passing narrowly. But when the CHAP implementation bill was signed into law on May 9, Montana Tribes gained a mechanism to employ CHAP dental providers. Multiple Tribes are already planning to do so in the near future.

**Nevada**

Nevada’s Tribes have achieved unprecedented success in the state legislature: the Tribal campaign to authorize dental therapy successfully advocated to the Nevada Legislature and enacted a dental therapy law in a single legislative session! The new law does require all dental therapists licensed by the state to have a hygiene requirement, but also explicitly includes Tribal facilities as applicable practice settings. The campaign to pass the law was largely driven by the state’s Tribes, and S.B. 366 overcame significant political opposition.

But this new law is just the first step. The Tribes have already begun advocating to strengthen the law by incorporating evidence based standards for licensure and for reciprocity for Nevada to recognize dental therapy licenses from other states. In the meantime, the Tribes in Nevada are working with the University of Nevada Las Vegas as a potential site for the education program for dental therapists who will eventually work for the Tribes.

**Connecticut**

Finally, Connecticut is now the 13th state with a pathway for Tribes to employ dental therapists. The state’s new law, signed on June 28, provides a pathway to license dental therapists in the state of Connecticut. However, the new law as currently written includes two provisions that may lessen the workforce model’s effectiveness in the places it is needed most. First, the legislature included a requirement that all dental therapists practicing in the state also obtain a dental hygienist license. Second, the legislature required that a dentist employing dental therapists supervise every procedure they conduct for their first 1,000 hours, or nearly six months of full time employment. Other states have found success in 400 or 500 hour requirements to ensure competence without overly burdening the supervising dentists.

While no state’s dental therapy law is identical, Tribes have seen considerable success in 2019 in advocating for their right to employ these focused oral health providers. This momentum is sure to carry into 2020 and years following, until the tools needed to address oral health outcomes are available to every Tribe.

**Involved**

that new advance appropriations authority can be implemented for programs such as IHS will likely be FY 2022. In the interim, the National Indian Health Board (NIHB) continues to engage in outreach and education with members of Congress on the need for advance appropriations for Indian programs, and continues to build congressional support for S.229/HR 1128 and HR 1135.
Preventing and Treating Diabetes with Indigenous Knowledge

Since 1997, Tribes implementing the Special Diabetes Program for Indians (SDPI) have seen remarkable improvements in the health of their communities. Nationwide, since SDPI has been implemented, American Indian and Alaska Native (AI/AN) communities have seen incredible success in combating diabetes and related complications despite having the highest prevalence of the disease. From 1996 to 2013 rates of kidney failure in AI/AN decreased by 54% - the largest declines for any demographic nationwide. Diabetic eye disease rates also decreased by 50% during the SDPI era. Additionally, diabetes rates have not increased among either AI/AN youth or adults in many years.

There are many factors that make SDPI so successful; one of the factors identified by Tribal leaders is that by design, the SDPI grant program allows individual grantees to adapt their program to incorporate their culture and traditional knowledge. Each grantee can implement a culturally appropriate intervention to best serve what their community needs, whether that is encouraging knowledge and preparation of traditional food, using traditional medical providers, or incorporating cultural activities that promote healthy behaviors, including those that promote both physical and mental well-being.

At the 2019 Indian Health Service (IHS) Diabetes in Indian Country Conference, many SDPI programs shared the unique ways they approach diabetes prevention and treatment while adapting the program to support their own community.

YUKON KUSKOKWIM HEALTH CORPORATION (YKHC): THE RECIPE FOR SUCCESS

Yukon-Kuskokwim Health Corporation (YKHC), the largest diabetes prevention program in Alaska, serves 58 federally-recognized Tribes and operates 41 Village Clinics in the Yukon-Kuskokwim Delta. The goal of the YKHC diabetes prevention program is to prevent diabetes and other co-morbidities through education, clinical access, and case management. YKHC’s values honor the culture of the Tribes they serve, naming Optimism, Compassion, Pursuit of Excellence, Personal Growth, Importance of Family, Trust, and Elder Knowledge as core values for their work.

Many of YKHC’s SDPI activities focus on promoting traditional values and are holistic, encouraging physical, emotional, spiritual and mental well-being.

YKHC’s newest venture builds on their existing healthy food programs, and honors the subsistence lifestyle that is practiced by many Alaska Native communities. YKHC SDPI is creating a set of video recipes that incorporate traditional Alaskan ingredients while integrating fresh produce (which are supplied by another YKHC venture), or canned vegetables, and other healthier additions. YKHC staff shared that communities sometimes use traditional foods to create less healthy treats—such as mixing berries with Crisco and sugar for a delicious dessert. The goal of sharing recipes is to offer healthier options for eating the traditional foods that can sometimes be substituted for the higher calorie options. To date, YKHC has created videos with instructions for making berry water as a sweet and healthy treat, as well as healthy versions of meals such as moose roast, salmon chowder, and fern soup.

CHINLE COMPREHENSIVE HEALTH CARE FACILITY: HOLISTIC HEALTH: TREATING THE MIND, BODY, AND SPIRIT

The Chinle Comprehensive Health Care Facility, which serves 38,000 people on the Navajo Nation, developed innovative and culturally grounded programs that address the holistic needs of their community members with diabetes.

Chinle’s Integrated Behavioral Health (IBH) Program is one of the innovative examples of how their program incorporates culture and a holistic approach to health in how they manage diabetes. The IBH program offers art therapy, talk therapy, and meditation and mindfulness sessions. Upon a diabetes diagnosis, all patients are screened for depression, and encouraged to join the community groups. Patients can engage in traditional art methods such as weaving and rug making, as well as journaling, creating poems and stories, sketches, sculptures, and wood carving. One patient shared “…art is healing. Making art helped me overcome depression, find a release from the disease, and discover and nurture a sense of well-being”. Chinle’s ONM department, through implementation of the Navajo Wellness Model, promotes K’é (relationship) and T’áá hwo’ójít’ éego (self-reliance), by incorporating culture and holistic approach to health for those managing diabetes. ONM’s traditional healers offer storytelling, cultural games, sweat lodge ceremonies, prayer stories, and the opportunity to engage in traditional oral stories. ONM traditional healers teach traditional healing beliefs and practices as a discipline for promoting wellness and health and assists clinical staff in providing culturally appropriate care for patient and families.

One of Chinle’s most successful clinical activities is the diabetes health coach model. Chinle uses a Diabetes health coach model as an integral component in the primary care team. Chinle trained and integrated paraprofessionals from the Navajo community that are fluent in Dine language into the primary care clinics.

Chinle continues to assess and respond to community needs. For instance, challenges facing community members also include transportation due to poor road conditions and access to care. In responding to community members needs and in alignment with traditional belief of a medicine man bringing health to the home, Chinle offers mobile health clinic services. The Mobile Health Clinic, offers primary care services such as wellness visits
with a provider, to bring primary care and wrap around services directly to the communities members who need help with managing their diabetes and healthcare needs.

Overall, Navajo traditions and beliefs are deeply integrated in the services provided by the Chinle Service Unit. Orientation requires all staff to complete four modules to get a better understanding of the culturally tailored strategic plan called Tapestry of Wellness and three additional modules to help staff understand Navajo culture using the Navajo Wellness Model and to improve staff relationships and effective communication with Navajo patients.

Additionally, Chine recognizes the role of language in culture and in shaping experiences. Patients are able to talk in their Native language with their provider whether the provider is a community member themselves, or through an interpreter. Screening and counseling are conducted in a way that is both culturally based and effective for the communities they serve. For instance, screening for depression is often conducted by asking “what did you used to enjoy before you felt this way?” and discussing topics that are familiar to patients such as weaving, or working with plants and animals. When patients are diagnosed with diabetes, the focus is on discussing the symptoms rather than the diagnosis, and assistance in managing these symptoms is conducted only with permission from the patient. A patient is never bluntly told they have diabetes, and language helps greatly improve staff relationships and effective communication with Navajo patients.

The National Indian Health Board is dedicated to supporting the growth of the next generation of Tribal Health leaders and advocates. The NIHB Youth Health Policy Fellowship is a year-long endeavor where Fellows are given the tools, resources, and mentorship to become health advocates for their communities. The Fellows work alongside Tribal leaders, policy specialists, and public health experts to develop their policy skills.

The NIHB Youth Health Policy Fellows learn about a variety of topics over three in-person meetings and five web-based trainings. The knowledge and skills the Fellows develop over the year include:

- Learning about the Indian health policy and the nation-to-nation relationship between Tribal governments and the Federal government
- Development of policy analysis skills
- Creating policy papers with recommendations for change
- Educating their Congressional and Tribal leaders on important health policy issues
- Networking with Tribal, Congressional, and Federal Agency leaders
- Growing their team building, indigenous leadership, and consensus-building skills
- Impacting the development of NIHB’s evidence-driven health programs and policies

This year’s NIHB Youth Health Policy Fellows are a group of talented and positive young women from all over Indian Country. They are driven and dedicated to learning about health policy and how they can impact health outcomes in their communities. They each have their own experiences and set of skills that will help them to become vital resources to their Tribal communities and to Indian Country.

### 2018-2019 NIHB Youth Health Policy Fellows:

- **Danielle Antelope** - Eastern Shoshone Tribe
  - Blackfeet Community College
  - Daniells spent the year working on policy solutions for addressing the opioid crisis on the Blackfeet Reservation

- **Nachya George** - Yakama Nation
  - Eastern Washington University
  - Nachya is from the Yakama Nation and her fellowship project was centered on the integration of physical and behavioral health

- **Onalncee Colegrove** - Hopo Valley Tribe
  - Dartmouth College
  - Onalncee’s project covered the opioid crisis in Hopo Valley and their clinic’s holistic approach

- **Jolie Murray** - Beaver Village, Koyukon
  - Alaska Fairbanks University
  - Jolie’s worked throughout the year on a policy project that examined rural housing issues and their health impacts in Alaska

- **Mandy Dazen** - White Mountain Apache
  - Fort Lewis College
  - The focus of Mandy’s policy research was on diabetes and its impact in the White Mountain Apache community

- **Mariah Sharpe** - Colorado River Indian Tribes, Mohave and Chemehuevi
  - Paradise Valley Community College
  - Mariah used her experience in the youth fellowship to encourage diabetes awareness in the Colorado River Indian Tribal Community

- **Betsy Waller** - Chickasaw Nation
  - Choctaw Nation University of Oklahoma
  - Betsy concentrated her policy project on alternative solutions to diabetes prevention in the Chickasaw and Choctaw communities

- **Tia Yazzie** - Navajo Nation
  - Dartmouth College
  - Tia used her year in the fellowship to learn more about using policy to impact the issue of missing and murdered indigenous women

### Renew SDPI to Continue to Promote These Successful Programs

SDPI programs are ingrained in the community, and adapt the best practices in diabetes management to work in conjunction with indigenous knowledge. This structure allows diabetes prevention and treatment to serve in a way that is community based and effective.

SDPI has demonstrated success for Tribes in reducing diabetes and related conditions. The program must be renewed by Congress by September 30, 2019 or the ability of these Tribes and the other 299 SDPI programs to continue the fight against diabetes will be in jeopardy.
Using Data to Strengthen Outreach and Education

The National Indian Health Board (NIHB) engages thousands of Indian health program staff annually to share information on how community members can enroll in and retain health care coverage, including Medicare, Medicaid and private insurance (including insurance purchased on the health insurance exchanges). This work is critical because more health care coverage, means more third party revenue coming into the Indian health system which helps supplement the chronic underfunding by the federal government.

In order to ensure that we are maximizing our outreach and education opportunities, we need to use data to monitor and evaluate outreach efforts to show gains in health care coverage. As a result, data tracking and statistics can show the connection between outreach and health care coverage enrollment among American Indians and Alaska Natives (AI/ANs).

NIHB conducts its outreach and education through a number of different trainings, conference presentations and one-on-one interactions. In this manner, NIHB shares its expertise on the full range of topics that arise around enrollment in health care coverage. These events and opportunities are for both new and experienced Indian health program staff and cover the basics of insurance eligibility and enrollment processes, providing an opportunity to share experiences; good and bad. In addition, progress is shared on addressing longstanding issues like internet / broadband access, staff training, the critical role of third party revenue, and state/county staff awareness of Indian provisions and protections that impact enrollment.

Outreach and education materials are distributed at each event and input is received on the effectiveness of these materials. This input is used to revise the materials and over time the brochures have improved with customized information for different areas of the country, including materials in certain Tribal languages. Topics covered range from income categories to frequently answered questions, including how to respond to Tribal members’ questions about treaty obligations; and the role of Medicaid and Medicare in Indian health.

During these trainings in Indian Country, NIHB also takes time to visit IHS and Tribal health programs to hear how things are going, what best practices are working and what results Tribes are seeing in improved health status and improved health care infrastructure. We have found that these positive stories provide great encouragement to other Tribes who are still expanding their efforts in this area.

However, NIHB understands there is no one way to perform outreach and education and even our improved materials need constant review and revision. Changes in the law, regulations or even proposed changes need a response to ensure the work of enrollment continues in order to maximize IHS and Tribal clinic revenue. Funding for outreach and education has declined in recent years and in some cases, enrollment declines have followed as a result. The increased use of data on enrollment is one area where information can be used to help direct resources to areas of greatest opportunity.

One promising area is the use of Census Surveys or Administrative insurance enrollment data to target outreach and education efforts.

**MEDICAID**

**United States:** 2010 to 2017 Medicaid Coverage for AI/ANs, total (8 million in 2017) and for those with Access to IHS (910,000 in 2017)

Medicaid coverage increased by 31.5% from 2010 to 2017 with 450,000 more AI/ANs covered. This indicates that overall gains were large and suggests the outreach and education efforts were successful, especially in light of the substantial resources from IHS dedicated to increasing enrollment from 2013-2016. Unfortunately, recent declines in enrollment have been reported for both AI/ANs and the general population from 2016 to 2017, most likely attributable to reduced resources for outreach and education.

**UNINSURED AI/AN CHILDREN**

One example of where enrollment data demonstrates a need for a more targeted approach is that of children under the age of 19. No one would think we’d neglect this population and yet 50% of all Medicaid enrollees are children. However, it seems the take-up rates for children, particularly those who are IHS patients is low. In fact most of the remaining uninsured AI/AN children are patients of IHS (as defined by US Census as having access to IHS).

Recent survey data points out two disturbing trends. First the number of uninsured AI/AN children is increasing, from 158,000 in 2016 to 170,000 in 2017. Second, the number of children uninsured is disproportionately children with access to IHS. The evidence: only 27% of AI/AN Children (487,000) have access to IHS, but 64% of the uninsured children (over 109,000 uninsured) have access to IHS. This data suggests a targeted approach for I/T/U programs to focus on enrolling children.

**UNINSURED AI/ANs**

AI/ANs with access to IHS are far more likely to be uninsured. What is true for uninsured children is also true for all AI/ANs. In fact 48% of the remaining uninsured have access to IHS despite making up just 28% of all AI/ANs.

In summary, it is now possible to utilize state level data to examine gaps in coverage for AI/ANs by various categories including uninsured status, and variables including age, veterans status, and whether or not the AI/AN has access to IHS. This information can be put to good use to target education and outreach activities.

**AI/AN Veterans’ Medicaid Coverage**

Under a Medicaid block grant program, states would receive a predetermined lump sum in the form of a grant from the federal government. Under a per capita cap program, states would receive a capped amount per Medicaid enrollee from the federal government. Caps would be estimated from previous costs, although the federal government would only be responsible for funding up to the cap; individual states would have to pay the excess costs, if any. Tribes are concerned that any changes to Medicaid through block grants or per capita programs will result in Medicaid cuts for American Indians and Alaska Natives who already struggle with limited access to health care. It could also jeopardize the entire Indian health care system by significantly reducing third party resources. In addition, changing Medicaid to a per capita or block grant system would essentially shift the trust responsibility from the federal government to the states.

The guidance under review at OMB would provide guidelines for how states can submit 1115 demonstration waivers that would allow them to transform their Medicaid program into a block grant or per capita allocation. This means that it is up to the state to propose such a transformation and CMS will have ultimate authority on whether such a proposal gets approved. Therefore it is imperative that Tribes stay informed on their states’ actions and hold the state to Tribal consultation before submitting such a waiver to CMS.

Medicaid block grants are not a new idea. In 2017 Congress explored the possibility of changing Medicaid to a block grant system when it was drafting legislation around repealing and replacing the Patient Protection and Affordable Care Act (ACA). At the time, NIHB and Tribes advocated for Congress to honor its federal responsibility for Indian health care, rather than passing that obligation on to the states. While Congress eventually did not move forward with Medicaid reform, it is important that Tribes continue to remain engaged on the discussion and advocate to their states and CMS about the impact that Medicaid block grants could have on their health system.

It is also important to note that despite the willingness of CMS to entertain Medicaid block grant proposals, it is unclear if CMS has the legal authority to approve any such proposal. Earlier this year, House Democrats wrote to Health and Human Services Secretary, Alex Azar, expressing their concerns about the legal and policy implications of a block grant system. Experts argue that CMS lacks the authority to change Medicaid’s funding formula without congressional approval. In addition, a coalition of twenty-seven national health care organizations and patient advocates wrote a letter to CMS Administrator Seema Verma opposing the agency’s Medicaid block grant guidance.

While the rest of the country and Tribes await the pending guidance, NIHB continues to advocate to senior officials that Medicaid for Indian Country be protected and maintained. After all, as Congress declared in the Indian Health Care Improvement Act, “it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians ... to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” Full federal funding for Medicaid services received through the Indian health system plays a critical role in fulfilling this policy.

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4 25 U.S.C. § 1602(1)
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