



National Indian Health Board

Health Reporter

Fall 2022

FEDERAL BUDGET PROCESS – Part I of IV: An Overview

INTRODUCTION

The [National Indian Health Board's](#) (NIHB) federal budget process four-part series is intended to bring key features of the process into focus to know *who* is in charge of federal spending decision-making, *what* is at stake, *when* the action is taking place, and *where* it is in the process. Over the years, the federal government has formed a fiduciary duty to Tribal nations whereby it recognizes a trust obligation as it relates healthcare for Tribal nations.

Enactment and Explanatory Statements

The federal budget process is cyclical, with a perpetual three-year implementation. Without enacted spending legislation, the federal government shuts down. When referring to enactment of spending legislation, it is often referring to enactment of regular appropriations. Congress also enacts supplemental appropriations to provide additional budget authority during a given fiscal year. Congress typically ends up enacting Continuing Resolutions (CRs) to provide interim funding in the absence of full-year regular appropriations. Some mandatory and “direct spending” becomes available upon certain conditions and does not require an additional action. Committee Reports and Explanatory Statements accompany regular appropriations laws, describing specific account detail, and any directives. These reports are powerful tools to analyze regular appropriations spending over time.

Budget Execution

Once funds are enacted, the [Office of Management and Budget](#) (OMB) will “apportion” or divide, amounts made available. In the event of a CR, exceptions to apportionment can provide funding for a longer duration, as is the case for certain the [Indian Health Service](#) (IHS) Tribal Health



Programs (THPs). Federal budgets are formulated using data collected during the budget execution phase as the processes and procedures of budget execution inform the quality of data that goes into the formulation of the President’s Budget Request.

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Executive Branch Formulation

After the President's Budget Request is submitted to Congress, the Executive Branch begins its formulation of the President's Budget for the next cycle. In the spring, OMB issues planning guidance to executive agencies for the fiscal year that begins approximately 18 months later. Throughout the summer, executive agencies develop their initial budget requests, and in September, submit initial budget requests to OMB. Throughout the fall, OMB reviews each budget request against the President's priorities. In November or December, OMB informs executive agencies of any required changes, known as OMB "Passback." Executive agencies may appeal decisions to the OMB Director and in some cases directly to the President. The President must submit a Budget Request to Congress by the first Monday in February, which signals the beginning of the Congressional budget formulation process. Across several Presidencies, Budget Requests have typically been late.

Legislative Branch Formulation

The President's Budget Request to Congress outlines how the Executive Branch proposes to achieve its administrative implementation and serves as a relative starting point as Congress considers its budget, spending, and revenue legislation. During Congressional budget formulation, action occurs on multiple fronts simultaneously. Both the House and Senate must pass a budget resolution or similar authority setting top-line revenue and spending targets. After setting top-line spending amounts,

Appropriations Committees set caps on spending for each of the 12 regular appropriations bills. Before top-line spending is set, each chamber's Appropriations Committee begins to receive input from members of Congress and the general public. At the outset, the House and Senate budget resolutions and appropriations bills often differ in their amounts, uses, and instructions. Ultimately, each chamber of Congress must enact identical legislation or risk a government shutdown.

Back Around to Enactment

When spending legislation is enacted, the process cycles back to the beginning of this overview. It is important to note where the process is at, at any given time, may have multiple answers, depending on which funded year being inquired. At any point, one may be in audit and reporting for the previous year, in budget execution for the current year, Congressional formulation for the next, and Executive Branch Formulation for two years out. NIHB plans to animate this series into an Indian Appropriations 101 training and hold webinars to continuously refresh Tribal leaders of the complexities of the federal appropriations process as it relates to health care funding for Tribal nations.

For more information or assistance with mitigating the Federal Appropriations process, please contact Tyler Scribner, *Budget and Appropriations Counsel* at the National Indian Health Board at 202-507-4070.

FEDERAL BUDGET PROCESS – Part II of IV: Talk the Talk

AUTHORIZATION VS. APPROPRIATION

Part I of this series focused on how the executive and legislative branches of government work to establish appropriations. Part II and III will focus on types of funding in preparation for Part IV, which will animate the process and identify points of intervention for Tribal nations to impact the outcome. Activity is building to the most critical aspect of the process which is Tribal nation engagement. NIHB routinely partners with the [National Congress of American Indians](#) (NCAI) the [Nation Council of Urban Indian Health](#) (NCUIH), and directly with Tribal nations to advocate for Tribal health funding. Admittedly, this content can be complex, so NIHB stands ready to assist Tribal nations when requested.

An *authorization* is any statutory provision that defines the authority of the government to act, which includes establishing policies, restrictions, and deals with organization and administrative matters. Authorizations may include a subsequent Congressional act to provide appropriations. An example of an authorization is the permanent reauthorization of the [Indian Health Care Improvement Act](#) (IHCA) which authorizes specific IHS activities, sets out the national policy for health services delivery to Tribal nations, and sets goals to reduce, "The prevalence and incidence of preventable illness among, and unnecessary and premature deaths of, Indians."¹ Further, "A major national goal of the [U.S.] is to provide the resources, processes, and structure that will enable Indian Tribes and Tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population..."²

An *appropriation* is a statutory provision that provides budget authority which allows federal agencies to incur obligations and make payments from the Treasury for specific purposes and usually during a specified

period. Appropriations include mandatory and discretionary spending. An example of a *discretionary appropriation* is the *Senate Appropriations Subcommittee on Interior, Environment and Related Agencies'* proposal to provide fiscal year (FY) 2023 appropriations for IHS and FY 2024 advance appropriations for Services and IHS Facilities accounts in its FY 2023 regular appropriations bill. An example of a *mandatory appropriation* is the direct spending for the [Special Diabetes Program for Indians](#) (SDPI)³.

Mandatory vs. Discretionary

Federal budgets distinguish between two types of spending: *Mandatory spending*, for which the level of funding is controlled outside of the annual appropriations and *discretionary spending*, which is controlled through the annual appropriations process outlined in Part I of this series. The President's Budget and Congressional Budget Resolutions include information on both mandatory and discretionary spending.

Types of Mandatory Funding

Mandatory spending, also known as direct spending, is sometimes referred to as entitlement spending and is not controlled through the

¹ 25 U.S.C. § 1601.
² 25 U.S.C. § 1601(2).

³ 25 U.S. Code 254c-3(c)(2)(D).



annual appropriations process; instead, it is based on eligibility and benefit criteria established in law. A key distinction is that Congressional jurisdiction for this spending is under the various authorizing committees of the House and Senate; not Appropriations Committees. While much of the mandatory spending is provided as direct appropriations, some require an appropriating action as part of the annual (regular) appropriations process as *appropriated entitlements* which carry the same requirements for payment with standing to sue if those obligations are not met. The appropriated amounts are codified in statute and require an additional appropriating action to establish budget authority. *Contract authority* provides agencies the authority to obligate funds but does not allow for outlay to occur. This means that agencies can enter binding contracts but are not provided the funds to satisfy those obligations until Congress takes additional appropriating action.

Next, Part III of this series will describe discretionary funding and various types of appropriations to solve significant challenges facing Indian Country surrounding federal government shutdowns and devastating impacts on health service delivery to Tribal communities.

For more information or assistance with mitigating the Federal Appropriations process, please contact Tyler Scribner, *Budget and Appropriations Counsel* at the National Indian Health Board at 202-507-4070.

FEDERAL BUDGET PROCESS – Part III of IV: Talk the Talk

DISCRETIONARY TO FUNDING TYPES TO PROTECT TRIBAL FUNDING

Part III of this series continues to explain the types of funding to begin to identify solutions to federal government shutdowns and the impact on Indian Country budgets, in particular IHS funding.

Types of Discretionary Funding

Discretionary spending is provided by appropriations acts as part of the annual (regular) appropriations process. While discretionary spending is typically provided as “current year” funding, the authority to obligate funds may be done for a one-year, multi-year, or no-year period; typically for allowable costs incurred for a designated fiscal year.

There are three other types of alternate funding periods: “advance appropriations,” “forward funding,” and “advance funding.”

Advance appropriations are merely advance agreements to provide funds at a later date. Since no funds are made available until the period for which they are agreed to, they are a budget-neutral solution to the outsized impacts of funding disruptions on the Indian health care system. Congress retains control of these agreements and can respond to real-world changes because it can be rescinded or modified prior to obligation by subsequent agreement.

Forward funding is additional budget authority that is made available late in the fiscal year and carries over into at least one following fiscal year. The primary focus is to facilitate obligations during the summer months for activities that begin in the fall, such as the school year. Since the funding is provided in the current year for activities that “begin” in the fall, forward funding does not score as budget-neutral and increases the total budget authority for a given year with respect to federal budget scorekeeping.

Advance funding is provided late in a particular funding year, but any use of advance funding authority is charged to the follow fiscal year’s appropriation. This authority is generally used for accounts that fund mandatory payments to individuals. Advance funding is typically only available in the final weeks of the fiscal year and are intended for situations where changes in eligible beneficiaries may substantially affect payments or payments may be difficult to predict more than a year in

advance. Ultimately, this funding period is intended to limit or eliminate the potential for a funding shortfall for mandatory obligations.

Regular Appropriations

Regular appropriations refer to the 12 regular appropriations acts considered as part of the annual appropriations process. Congress may roll all 12 regular appropriations bills into a single bill, often referred to as an “Omnibus.” If Congress combines less than 12 but more than one regular appropriations bill into a single bill, it is often referred to as a “Minibus.” A “stand-alone” bill refers to one of the 12 regular appropriations bills.

Supplemental Appropriations

Supplemental appropriations provide additional budget authority above any amount provided as part of regular or mandatory appropriations. Supplemental appropriations are typically provided when the enacted amounts are insufficient or when Congress seeks to finance activities not otherwise provided for by appropriations acts.

Continuing Resolutions

Continuing Resolutions (CRs) fund the federal government for part of the year at the prior year’s enacted amounts, with certain exceptions. “Anomalies” change the duration, amount, or purpose of funds under a CR. For example, anomalies make sense where a program experiences regular and predictable changes in the rate of obligations during the period, for the safety of human life and federal property, for annualizing a new program, or adequately funding a facility and operations newly completed during the prior funding period.

Parts I, II, and III of this Federal Budget Series are intended as primers to culminate into a call for action and a how to. **Part IV – *Why Engagement is Important*** pulls it all together. NIHB intends to be facilitative and supportive to Tribal nations to increase its chances of securing an even greater realization of the trust and treaty obligations for health. ▶

► Federal Budget Process = continued

NIHB does so through Tribal technical assistance, coordinating Tribal caucuses with its partners at the National Congress of American Indians (NCAI) and the Nation Council of Urban Indian Health (NCUIH), assistance in preparing testimony, and supporting NIHB Board Members and other Tribal leaders in testifying, all help advance the commitment to fulfill the trust and treaty obligations.

For more information or assistance with understanding the finer points of the Federal Appropriations process, please contact Tyler Scribner, *Budget and Appropriations Counsel* at the National Indian Health Board at 202-507-4070.

FEDERAL BUDGET PROCESS – Part IV of IV: Why Engagement is Important

STRENGTH IN NUMBERS

With respect to federal spending, Indian Country is strongest when more voices join the fight. There is no standard form that funds are provided by Congress, or how they must be administered by the executive. This means Tribal voices, Tribal experience, and Tribal expertise are vital to federal partners promoting Tribal sovereignty in a good way.

Set the Stage

The President's Budget Request is just that – a request. However, the executive has considerable leeway to design, staff, and implement the authority of the federal government. Once funds are received, the Executive Branch often has discretion in how to design notices of funding opportunities and, ultimately, who receives those funds. Administrative law is an often-underestimated tool that can write federal law with the stroke of a pen. Even after regulations are promulgated, interpretive rulemaking allows agencies to forgo notice-and-comment procedures, establishing national law with a single action. Engage agencies and administrative officials to establish good administrative law and implement procedures that inform good budget requests to Congress.

You Have to Be in It, to Win It

To have funding requests in play in a particular appropriations bill, one must work to establish a total cap on spending that would provide the resources to grant the request. Engage with the Budget Committees of each Congressional chamber to establish total caps on discretionary and mandatory spending that reflect the goals. Authorizing Committees submit reports called "Views and Estimates" to the Budget Committee on changes they hope to enact that will affect the federal budget. If the spending request requires authorization or reauthorization, tell the authorizing committees in Congress to include the changes in its Views and Estimates report.

Once grand total spending caps are set through a budget resolution or similar authority, Appropriations Committees set caps on each of the 12 regular appropriations bills. Engage with Appropriations Committees to establish caps on spending for appropriations bills that would provide the resources to grant the request. Each individual member of Congress may submit "Member requests" to Appropriations Committees for supported spending. The recent return of "earmarks" known currently as Congressionally Directed Spending, are an opportunity to call on members of Congress to provide Tribal nations special project funding. Note that Member requests and Congressionally Directed Spending are two different things – support Tribal spending broadly, tell the representative not earmarks.

Approach from All Angles


During the federal budget and appropriations process, a back-and-forth internal discussion is taking place. When engaging with the Executive Branch, engage budget offices to recommend budget directives, and program offices to recommend budget submissions. When engaging with Congress, recognize committees are receiving input from colleagues and the general public. As part of any Congressional hearing, a two-way communication is taking place on the budget. Engage witnesses, including federal agencies, to testify for strong Tribal spending; and engage committee members to ask questions that force witnesses to reply on issues of Tribal interest. Throughout the process, approach the budget and appropriations formulation process from all angles to increase the discourse and traction on specific interests.

Your Voice Makes the Difference

Whether a federal budget expert or not, Tribal voices makes an impactful difference. Often, the data and justification are in place for federal action, but what is lacking is the political will to act.

Tribal leader stories about Native communities, programs, nations, and the people are unique and impactful. It is the exact sort of information Congress is often missing in the discussion. Never underestimate the power of your perspective, and the power of Indian Country in the nation-to-nation relationship. Recall the credo from the late Billy Frank, "Tell your story." Tribal leaders have the honor, and some say *sacred duty* on behalf of their ancestors, to speak for the communities, and to realize their place on the timeline to prepare for future generations.

The treaties were the protection Tribal ancestors provided for today's generation. It is an opportunity to pay it forward through collective active voice. The Tribal voice matters and it makes a difference. NIHB hopes you will join in the movement.

For more information or assistance with budget and appropriations process and advocating for Tribal Health, please contact Tyler Scribner, *Budget and Appropriations Counsel* at the National Indian Health Board at 202-507-4070. 

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THE NATIONAL INDIAN HEALTH BOARD

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

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

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

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

PROJECT MANAGEMENT

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

RAISING AWARENESS

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

NIHB advocates for the rights of all federally recognized American Indian/Alaska Native (AI/AN) Tribes through the fulfillment of the trust responsibility to deliver health and public health services. Since 1972, NIHB has advised the United States Congress, IHS federal agencies, and private foundations on health care issues of AI/ANs.

NIHB staff maintains communication with Area Health Boards, national Indian organizations, Tribes along with AI/AN people. NIHB gives voice to AI/AN health policy concerns through participation in national organizations ranging from the Association of State Medicaid directors to the IHS Leadership Council.

A SHARED GOAL— QUALITY HEALTH CARE

The future of health care for AI/ANs is intertwined with policy decisions at the federal level and changes in mainstream health care management. NIHB brings Tribal governments timely information to help them effectively make sound health care policy decisions. NIHB provides a vehicle to keep the flow of health care information in front of policy makers and Tribal governments manifesting progress in health care and strengthening Tribal sovereignty.

ADVANCE APPROPRIATIONS: Congress and the Biden Administration Make Historic Commitment to Indian Health Care

“Government shutdowns represent the inability of government to work as a team. Politics should not be the rule of the day but cooperation and collaboration to run the country, including sovereign nations through treaties.”



Ensuring stable and predictable funding for the [Indian Health Service \(IHS\)](#), advance appropriations is a longstanding Tribal request and recommendation that the [National Indian Health Board \(NIHB\)](#), the [National Congress of American Indians \(NCAI\)](#), and other partner Native organizations have diligently advocated for years. Most recently, NIHB and NCAI have joined efforts to collect primary data through a [survey](#) from Tribes on the impacts of IHS from government shutdowns and Continuing Resolutions (CR).

An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. For example, if advance appropriations were secured in the fiscal year (FY) 2023 spending bills there will be an appropriation for FY 2024 regardless of a government shutdown or CR occurrence. This means when the budget is being proposed for FY 2024, IHS would already have an appropriation for that fiscal year because of the advance appropriation funded from the FY 2023 spending bills and therefore a more stable, predictable funding stream for IHS. Please see Parts I through VI of the Health Reporter to see a detailed Budget and Appropriations Analysis and how NIHB intends to support Tribal nations to get advance appropriations across the finish line.

Endorsing support for advance appropriations for IHS, the Biden Administration is aware of the adverse impacts of discretionary funding and has included advance appropriation in the [FY 2023 President's Budget](#). Passing the appropriation bills this July, the House did not include advance appropriations despite overwhelming Tribal advocacy. On the other hand, making an historic investment to the health of Indian Country, the Senate did include advance appropriations in their appropriation bills providing \$5.577 billion for FY 2024. However, securement of advance appropriations is not yet final.

Tribes need advance appropriations for IHS funding now. Allies in Congress are asking for your stories to help get their colleagues on board. Members of Congress frequently ask, “Why do Tribes need Advance Appropriations?” and “How do funding disruptions harm Tribal nations and their people?”

From initial survey responses, Tribal leaders and Tribal health directors have noted federal governmental shutdowns result in loss of patient contact hours, loss of third-party billing opportunity and revenue, and loss of hours of operations of health services.

Here is a preview and sampling of responses of the devastation of federal government shutdowns and why advance appropriations is critically needed:

“There were cuts to Tribal Council and Director Salaries of 8.5 percent. Caused huge employee moral issue with people who are termed essential. Promoted racism within the organization. Cut hours and laid off some government staff.”

“Patients’ expectations are that we continue to provide a high level of service and at times we are not able to meet them.”

Overwhelmingly, multiple Tribes have experienced interruptions in providing mental health services, substance abuse treatment, and adverse impacts on recruiting and retaining professional medical staff. Fortunately, or unfortunately, some Tribes did not experience furloughing or layoffs because they were able to use revenue to cover the wages. Others made the tough decision to furlough or layoff medical staff.

“Being critically underfunded affects the services we can provide especially in very remote areas, also not having advanced appropriations makes it hard to plan, and also having to supplement from our third-party funds takes away from the additional services we are able to provide to due people due to no access due because of our location.”

Testifying in support of advance appropriations, a Tribe noted, “People who actually visit villages will better understand [their] living conditions and see how remote [they] are. Transportation is mainly by aircraft; others, if the weather is allowable, travel by boat and during the winter by snowmobiles”.

You can share your stories highlighting direct adverse impacts of unstable IHS funding and be entered to win a Pendleton. You can choose to have your answers and Tribe’s name remain anonymous. Your Tribal response may be the key to getting us across the finish line so please take the time to complete the narrative and, “Tell your story.”

For questions, please contact Aaron Payment, EdD, Director of Government Relations at apayment@nihb.org.

To learn more and take the survey, scan this QR code:



50 Years of Building Tribal Leader Capacity Through Excellence in Technical Assistance

The [National Indian Health Board](#) (NIHB) provides many services to Tribes, Tribal leaders, Tribal representatives, and Tribal organizations. Most notably, NIHB builds Tribal leaders' capacity to advocate for American Indian/Alaska Native (AI/AN) health advancement. NIHB builds capacity by providing Tribal leaders and representatives with world-class technical assistance or advisement. NIHB supports Tribal leaders by providing briefing materials, policy and budgetary analysis, talking points, and notes on priority issues. Tribal leaders are often called to represent the priorities of Indian Country in several ways, such as providing Congressional testimony, participating in Tribal consultation, or serving on a Federal Tribal Advisory Committee (TAC). NIHB works to ensure that Tribal leaders are prepared to represent the needs of AI/AN people, regardless of their level of technical expertise.

NIHB offers phenomenal technical advisement and has significantly increased the capacity of many to advocate on behalf of all AI/AN people. When appointed to serve as Tribal Advisors, often Tribal leaders worry about having the technical expertise to represent the priorities of all AI/AN people. NIHB CEO Stacy Bohlen, Sault Ste. Marie Tribe of Chippewa Indians, makes sure to inform them of how NIHB could support them in the role by providing technical expertise in several policy areas. NIHB consistently provides world-class technical advisement that represents the priorities of Indian Country.

NIHB provides resources to Tribal leaders, such as policy briefs, one-pagers, and talking points, and assists with testimony development, Tribal caucuses, and budget formulation preparation. NIHB has helped prepare many to advocate on a national level. Many Tribes do not have access to a federal lobbyist. While NIHB is non-partisan and does not lobby, it does provide expert policy preparation. Its assistance helps to hone the skills to educate the federal government of its responsibility to honor the treaty and trust obligation for health.

There are so many policy issues impacting the health and wellness of AI/AN people. These issues are often complex and involve the intersection of several different topical areas.

For over 50 years, NIHB has been building an unmatched expertise level. NIHB's staff are experts in many policy areas such as public health, behavioral health, budget, appropriations, and countless others. As Amber Torres, Chairman of the Walker River Paiute Tribe, explained, "When I arrived on the national advocacy scene, I already had advanced experience in public health policy and felt reasonably prepared. However, no one can know everything about everything, but NIHB's team has always been there to prepare me for all things health-related."

Congress often calls upon Tribal leaders to provide testimony on various health-related issues. NIHB coaches Tribal leaders to speak with confidence on behalf of your ancestors, those you represent today, and for




future generations. The coaching and support provided by NIHB instill confidence in Tribal leader testimony which carries the message of Tribal health advocacy more convincingly and compellingly.

NIHB also assigns a professional Federal Relations Policy Team to support and advise Tribal leaders on various health and public health issues. For example, NIHB's Federal Relations staff supports Tribal leaders serving on federal TACs by tracking policy issues, providing policy analysis and recommendations, drafting talking points, and providing other informational resources. NIHB staff works with area Indian Health Boards and other Tribal health advocates to ensure the diverse priorities and needs of Indian Country are represented. William Smith of the Valdez Native Tribe, NIHB Chairperson and Alaska

Area Representative stated, "What I find most helpful is the in-depth walk through on policy implications, budget, and appropriation needs. The detailed analyses provided by NIHB enables Tribal leaders to become experts in Federal Indian health policy or at least articulate like so."

NIHB hopes to continue to support Tribal leaders through technical assistance and capacity building. In the future, the NIHB Government Relations Team will deploy additional educational and support materials to assist Tribal leaders in advocating and representing Tribal communities. NIHB exists to support Tribal nations and will look to new and innovative ways to build capacity across Indian Country, including webinars on *Indians 101: Health Advocacy* and the *Federal Appropriations Process*.

To learn more about how NIHB provides Tribal technical assistance or the support NIHB provides to Tribal Leaders, please contact A.C. Locklear, Director of Federal Relations at ALocklear@nihb.org. 

National Indian Health Board



FEDERAL TRIBAL ADVISORY COMMITTEES:

A Revolutionary Tool for Advocacy

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

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

More Tribal participation is needed to ensure Tribal priorities are represented across all agencies. TACs are vital in enhancing the relationships between the federal government and Tribal nations. However, many agencies struggle to retain Tribal leaders on the TACs and fail to fill vacant seats. For example, six of the 12 area seats on the [Indian Health Service \(IHS\) Information Systems Advisory Committee \(ISAC\)](#) are vacant. TACs should be a vehicle for acquiring a broad range of Tribal views. However, many regions go unrepresented. TACs provide a unique opportunity for Tribal leaders and their representatives to speak directly with federal officials about how federal policies impact their respective communities. TACs share the experiences of Tribal members and the effects federal programs are having. Federal officials must hear the stories, and these committees are critical to facilitating these discussions.

Tribal leaders do not need prior specialized technical knowledge to serve on a TAC. The [National Indian Health Board \(NIHB\)](#) and various

regional health boards provide technical support to Tribal leaders serving on TACs. NIHB staff routinely serve as Technical Advisors to Tribal leaders serving on TACs. NIHB attends all TAC meetings in this capacity and provides TAC members briefing materials, policy, and budgetary analysis, talking points, and notes on priority issues.

Over the last year, President Biden's Administration expanded the role of TACs across the federal government. This is the opportunity to expand access to elevate Tribal health priorities across the federal government. NIHB must do its part to ensure all TAC meetings are meaningful and represent a wide array of perspectives from Indian Country. To develop comprehensive health policy for the benefit of Indian Country, Direct Service, and Self-governance, Tribal leaders must all be at the table to advocate for Tribal communities. NIHB stands ready to provide technical assistance to any Tribal leader who wishes to serve on a TAC.

Please see the chart for a brief overview of TACs that need Tribal voices. To learn more about the Federal Tribal Advisory Committees, request technical assistance, or stay updated on TAC news, please contact A.C. Locklear, NIHB Federal Relations Director, at alocklear@nihb.org or call 202-996-2882. To learn more about the Federal Tribal Advisory Committees, scan this QR code:



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

COMMITTEE	PURPOSE
Administration for Children and Families (ACF) Tribal Advisory Committee	To seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of ACF programs. https://www.acf.hhs.gov/initiatives-priorities/tribal
Centers for Disease Control and Prevention (CDC) Tribal Advisory Committee	Advises on policy issues and broad strategies that may significantly affect AI/AN communities. Assist in fulfilling its mission to promote health and quality of life by preventing and controlling disease, injury, and disability through established and ongoing relationships and consultation sessions. https://www.cdc.gov/tribal/consultation-support/tac/index.html
Centers for Medicare and Medicare Services (CMS) Tribal Technical Advisory Committee (TTAG)	TTAG provides advice and input to CMS on policy and program issues impacting AI/ANs served by CMS programs. Not a substitute for formal consultation with Tribal leaders, TTAG enhances and improves increased understanding between CMS and Tribes. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Tribal-Technical-Advisory-Group
Secretary's Tribal Advisory Committee (STAC)	The STAC's primary purpose is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation, or Executive Order. https://www.hhs.gov/about/agencies/iea/tribal-affairs/about-stac/index.html

COMMITTEE	PURPOSE
Health Resources and Services Administration (HRSA) Tribal Advisory Council	A vehicle for acquiring a broad range of Tribal views, determining the impact of HRSA programs on the AI/AN health systems and population, developing innovative approaches to deliver health care, and assisting with effective tribal consultation. https://www.hrsa.gov/about/organization/bureaus/ohe/populations/aian.html
National Institutes of Health (NIH) Tribal Advisory Committee	The TAC is advisory to the NIH and provides a forum for meetings between elected Tribal officials (or their designated representatives) and NIH officials to exchange views, share information, and seek advice concerning intergovernmental responsibilities related to the implementation and administration of NIH programs. https://dpcpsi.nih.gov/thro/tac
Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Technical Advisory Committee (TTAC)	The SAMHSA TTAC provides a complementary venue where Tribal representatives and SAMHSA staff exchange information about public health issues in Indian Country, identify urgent mental health and substance abuse needs in AI/AN communities, and discuss collaborative approaches to addressing these issues and needs. https://www.samhsa.gov/about-us/advisory-councils/tribal-technical-advisory-committee-ttac/council-roster
Veterans' Affairs (VA) Tribal Advisory Committee	Advises the Secretary on ways the VA can improve the programs and services to better serve AI/AN Veterans. Committee members make recommendations to the Secretary regarding such activities. https://www.va.gov/tribalgovernment/

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

[Community Health Aide Program Tribal Advisory Group \(CHAP TAG\)](#)

<https://www.ihs.gov/chap/chaptag>

[Direct Service Tribes Advisory Committee \(DSTAC\)](#)

<https://www.ihs.gov/odsct/dstac/>

[Director's Workgroup on Improving Purchased/Referred Care \(PRC Workgroup\)](#)

<https://www.ihs.gov/prc/director-s-workgroup-on-improving-prc/>

[Facilities Appropriations Advisory Board \(FAAB\)](#)

<https://www.ihs.gov/ihtm/circulars/2015/facilities-appropriations-advisory-board-charter/>

[Information Systems Advisory Committee \(ISAC\)](#)

<https://www.ihs.gov/isac/>

[National Tribal Advisory Committee on Behavioral Health \(NTAC\)](#)

<https://www.ihs.gov/dbh/consultationandconfer/ntac/>

[Tribal Leaders' Diabetes Committee \(TLDC\)](#)

<https://www.ihs.gov/sdpi/tldc/>

[Tribal Self-Governance Advisory Committee \(TSGAC\)](#)

<https://www.tribalselgov.org/advisory-committees/tsgac/> 



THE INDIAN HEALTH CARE SYSTEM – 30 Years of Progress, Yet Much More to Do

By Yvette Roubideaux MD MPH

The past 30 years was a time of progress for American Indian/Alaska Native (AI/AN) healthcare. Over the last three decades, fundamental improvements to the [Indian Health Service \(IHS\)](#) resulted in a more diverse *Indian Health Care System* comprised of IHS, Tribal, and urban Indian health programs that has made significant progress over the years. This progress was achieved in partnership with Congress, the Administration, Tribal nations, Urban Indian health organizations, and other advocates. While there is much more to do, a review of the impact of these improvements over the past three decades can help in understanding how the Indian health system needs to further improve over the next 30 years.



HEALTHCARE PROGRESS HIGHLIGHTS:

- » **The Indian Health Care Improvement Act** (P.L. 94-437) passed in 1976 with subsequent amendments and its permanent authorization in 2010 and resulted in a wide range of improvements in the scope of services and programs for healthcare of AI/ANs.
- » **The Indian Self Determination and Educational Assistance Act** (ISDEA, P.L. 93-638), passed in 1975 with subsequent amendments, allows Tribal nations to assume management of health programs formerly run by IHS. Currently, 60 percent of the IHS appropriation is managed by Tribal nations.
- » **The Contract Support Costs *Salazar v. Ramah Navajo Chapter*** Supreme Court decision in 2012 required the federal government to pay the full amount of contract support costs for Tribal ISDEA contracts to further support and enhance health care services.
- » **The Indian Health Care Improvement Fund** allocation was initially developed in 2000 to begin addressing the historic and current disparities in funding to promote equity for all Tribal nations.
- » **Purchased/Referred Care** funding increases over the past decade significantly improved access to referral care in many communities at levels beyond Medical Priority Level I emergent care.
- » **The Affordable Care Act** in 2010 increased access for AI/ANs to Medicaid and private insurance coverage resulting in significant increases in third party collections to help improve health services.
- » **Improvements in Primary Care** include efforts towards patient centered, team-based care, integration of behavioral health services with primary care, better recruitment and hiring practices, expanded community health providers, and planning for a new health records system.
- » **The Special Diabetes Program for Indians** provided grants for the prevention and treatment of diabetes in AI/ANs since 1998, improved diabetes care, and decreased the prevalence of diabetes.

- » **Facility Construction** funding significantly increased in the past decade to address the backlog of needed healthcare facilities, including funding for 105(l) leases.
- » **Tribal consultation and the more recent addition of urban conifer** has helped enable better input and partnership on decision-making in the Indian Health Care System.
- » **Increased AI/ANs in leadership and health care professional positions** in the Indian Health Care System has helped improvements be more community focused and culturally relevant.
- » **Increased IHS appropriations** in the last 12 years along with Tribal advocacy is resulting in serious consideration of innovative proposals such as Advance Appropriations and mandatory funding.

From a data perspective, some health indicators have improved over the years, but disparities still exist including persistently higher mortality rates for AI/ANs compared to other groups. The recent experience of Indian Country during the COVID-19 pandemic showed the benefit of a coordinated system of health care but exposed the vulnerabilities of a system that is still funded far below its need. While IHS recently proposed increasing appropriations from the current \$6.7 billion to \$36.7 billion in fiscal year (FY) 2032, Tribal budget formulation estimates of the actual need are closer to \$49.8 billion.

The achievements of the past 30 years have set a good foundation for progress, but even if the Indian Health Care System was perfect, Indian Country would still have health challenges. Future progress depends both on better meeting direct health care needs and addressing the underlying social determinants of health, which were revealed during the COVID-19 pandemic to be critical to the health of AI/ANs. Basic needs such as housing, water and sewer systems, jobs, education, and safety contribute to the overall health status of AI/AN communities beyond available health care services. A stronger and more comprehensive health care, public health, and community health approach is needed to finally achieve the health and well-being that AI/AN communities need and deserve. 🇺🇸

LEGACY OF U.S. INDIAN POLICY:

Historical and Intergenerational Trauma Public Health Challenge

In an announcement of the [Federal Indian Boarding School Initiative](#) the [U.S. Department of the Interior](#) Secretary Deb Haaland explained the Interior Department would, “Address the inter-generational impact of Indian boarding schools to shed light on the unspoken traumas of the past, no matter how hard it will be.”¹ One objective of the report, to establish a baseline number of Indian mission and boarding schools, found the system was expansive, consisting of 408 institutions operating from 1801 to 1969. These schools were located at 431 sites across 37 states including 21 schools in Alaska and seven schools in Hawaii. As cited in the report,

1 U.S. Department of the Interior. (2021, June 23). *Secretary Haaland announces federal Indian boarding school initiative* [Press release]. <https://www.doi.gov/pressreleases/secretary-haaland-announces-federal-indian-boarding-school-initiative>

“The twin Federal policy of Indian boarding and mission schools was territorial dispossession and Indian assimilation through militarized and identity-alteration methodologies to assimilate American Indian/Alaska Native (AI/AN) children. The Federal Indian boarding school system discouraged or prevented the use of Native languages or cultural or religious practices. These schools were also places of punishment, including corporal punishment such as solitary confinement, flogging, withholding food, whipping, slapping, and cuffing.”

Many AI/AN children simply did not survive. So far, the investigation identified marked or unmarked burial sites at approximately 53 different schools across with more burial sites expected. The report provides the most comprehensive federal report to document the experiences at the hand of the Federal Indian policy and likely explains the worst-of-the-worst statistical outcomes as borne out in the *U.S. Commission on Civil Rights Broken Promises Report*.² An exhaustive list of recommendations is made in the Newland Report.³

On the second stop of the *Road to Healing Tour*, Secretary Haaland and Assistant Secretary Bryan Newland visited Pellston, MI in the Little Traverse Bay Band territory and the broader territory of the Anishinaabe and other Tribal nations. Survivors came from several Great Lakes states to testify to the horrors they experienced including shaming, physical assault, emotional assault, neglect, locking children in cold dark sheds or left outside overnight, starvation, and barred from interacting with siblings who attended the same institutions. More stops are expected across the country and while confronting the past is a necessary step toward healing, Tribal nations look to the federal government to explain fully what comprehensive support and funding is forthcoming as victims relive the trauma unearthed.



Forty-one years before the Indian boarding school era ended, the 1928 Meriam Report recommended the abandonment of the assimilation strategy that it was, “Necessary to remove the Indian child as far as possible from his home” because “A modern point of view in education and social work lays stress on upbringing in the natural setting of home and family

2 <https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf>

3 U.S. Department of Interior (2002, May). *Federal Indian Boarding School Initiative investigative report* (p. 94). https://www.bia.gov/sites/default/files/dup/inline-files/bsi_investigative_report_may_2022_508.pdf

life.”⁴ Over the last decade, Tribal leaders on numerous Tribal advisories like the U.S. Department of Health and Human (HHS) Secretary Tribal Advisory, National Institute of Health (NIH), Health Research Advisory Council (Office of Minority Health), Substance Abuse and Mental Health Services Administration (SAMSHA), and the National Advisory Council on Indian Education (NACIE) have advocated a greater understanding of *Historical and Inter-Generational Trauma* to inform health and behavioral health practices as understood by American Indian researchers Braveheart⁵,⁶ and Newbreast⁷ with explanations to understand the worst of the worst statistical outcomes explained by *Tribal Critical Race Theory* by Brayboy⁸.

During healing from trauma, it is important to call attention to the critical need to avail federal funds to support Tribal nations with behavioral health resources. Tribal leaders on the HHS STAC partnered with NIH to make policy recommendations over several meetings with HHS Secretary Xavier Becerra including budgeting for the inevitable outcomes of unpacking over 200 years of trauma of the Indian Mission and Boarding School policy which gave birth to one of the darkest chapters in American history.

It is necessary to be mindful of the emotional and spiritual wellbeing of the victims of Indian boarding schools. Traditional ways shared by many Tribal nations explain the balance that must be met to ensure we emerge on the other side of our experiences in a healthy way in all aspects of our self – physical, emotional, mental, and spiritual.

To learn more about the Federal Indian Boarding School Initiative, scan this QR code:



4 Institute for Government Research. (1928). *The Problem of Indian administration*. https://www.narf.org/nill/documents/merriam/n_merriam_chapter9_part1_education.pdf

5 Brave Heart, M. Y. H. (2000) Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare*, 21-22, 245-266.

6 Brave Heart, M. Y. H. (2004). The historical trauma response among Natives and its relationship to substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35 (1), 7-13.

7 Newbreast, T. (2011). *Historical trauma and Native Americans: Training of trainer workshop*. Chico: CA. Connecting Circles of Care. Retrieved <https://www.nativewellness.com/events.html>

8 Brayboy, B. M. J. (2005). Toward a tribal critical race theory in education. *The Urban Review*, 37(5), 425-444. doi: 10.1007/s 11256-005-0018-y

NATIONAL INDIAN HEALTH BOARD'S LEGISLATIVE BILL MONITORING PROCESS: Special Diabetes Program for Indians

The [National Indian Health Board's](#) (NIHB), Congressional Relations Team is responsible for overseeing the congressional legislative processes and correspondence. This includes but is not limited to - monitoring legislative bills in the current congressional session, preparing testimony for congressional hearings and markups, preparing statements of support for congressional bills, drafting congressional bill language for inclusion or modification, and maintaining correspondence with Congressional members' staffers. The important congressional relations work is unified by one goal: advocating in Congress for Tribal health equity on behalf of the 574+ federally recognized Tribes.

The way in which the NIHB Congressional Relations Team advocates in Congress is guided by the resolutions set forth by the NIHB Board of Directors who govern the work of the NIHB representing 12 [Indian Health Service](#) (IHS) service areas.¹ The NIHB Board drafts and approves resolutions throughout the years which then creates priorities for the Legislative and Policy Agenda (Agenda) which sets the direction for all departments within NIHB to advance the organization's strategic direction. Last February, the NIHB Board met virtually for the Annual Board Meeting. NIHB's Chairman William Smith, of the Valdez Native Tribe, presided and facilitated discussion as it set priorities for 2022, held the Executive Committee elections, and adopted the [2022 NIHB Legislative and Policy Agenda](#).

An important priority in 2022 Legislative and Policy Agenda, the Congressional Relations Team is focusing on is reauthorizing the [Special Diabetes Program for Indians](#) (SDPI). Congress established SDPI in 1997 to address the disproportionate impact of type 2 diabetes among American Indians/Alaska Natives (AI/ANs). The SDPI has effectively reduced the incidence and prevalence of diabetes among AI/ANs and is responsible for a 54 percent reduction in rates of end-stage renal disease and a 50 percent reduction in diabetic eye disease among AI/AN adults.²

The SDPI program effectuates change in Tribal communities through health promotion and care. Tribal health or IHS team members work with and not lecture Tribal diabetes patients. Another critical component is the use of biometrics to relate dietary, exercise, and lifestyle choices to see the benefit of their participation in SDPI programs. This is incredibly empowering as it puts the monitoring of A1C levels directly in the hands of Tribal patients. Once patients see A1C rates drop as a result of their efforts and the support of Tribal health and IHS team members, they are more likely to continue to make and sustain permanent lifestyle changes. This is invaluable for improving the overall health of entire Tribal communities.

To effectively advocate in Congress to reauthorize SDPI, the Congressional Relations Team references the 2022 Legislative and Policy Agenda.

Agenda SDPI Recommendations:

1. Increase funding to \$250 million per year with annual increases tied to the rate of inflation.
2. Authorize permanency.
3. Funding distribution pursuant to the *Indian Self-Determination and Education Assistance Act* (ISDEAA).

As noted above, the Agenda references [Resolution no. 21-04 Support for SPDI](#) which was previously adopted by the Board of Directors and ultimately programs the Agenda's priorities.



NIHB is working directly with a U.S. Senator's staff to support a long-term reauthorization of SPDI including incremental budgetary increases that keep pace with inflation. This is very promising. Ultimately, whether a member of Congress introduces legislation on SPDI as a stand-alone bill or SPDI to be included in an appropriations bill, the Congressional Relations Team

makes judgement of NIHB's support based on the outlined SDPI recommendations. Unless all three recommendations – permanency, increased baseline funding, and self-governance – are met after intentional advocacy, the NIHB Congressional Relation Team, and therefore NIHB as a whole organization, will continue to push for modifications to legislation such that we can support it.

The Congressional Relations Team has stringent policies set in place to guide its legislative work in Congress. Established by Tribal leaders 50 years ago to advocate as the national, united voice of federally recognized Tribes, NIHB annually adopts an agenda from Tribal input and testimony. These recommendations stem from Tribes themselves which directly guides the Congressional Relations department so rest can be assured Tribal voices are heard in the halls of Capitol Hill.

To learn more about the 2022 NIHB Legislative and Policy Agenda, scan this QR code:



¹ <https://www.nihb.org/docs/01272016/NIHB%20Constitution%20and%20Bylaws.pdf>

² <https://www.ncbi.nlm.nih.gov/books/NBK571291/>

NATIONAL INDIAN HEALTH BOARD'S LEGISLATIVE AND POLICY AGENDA: Upholding the U.S. Trust and Treaty Obligations for Indian Health

The [National Indian Health Board](#) (NIHB) was established by Tribal leaders 50 years ago to advocate as the national, united voice of federally recognized Tribes. NIHB seeks to support and reinforce Tribal sovereignty, ensure fulfillment of the federal government's trust responsibility and treaty obligations to Tribal nations, and strengthen the government-to-government relationship between the federal government and Tribes. Successful implementation is under the strong 18 years of leadership of CEO Stacy Bohlen, Sault Ste. Marie Tribe of Chippewa Indians with governance and oversight by the NIHB Board. This year NIHB met to establish a new five-year plan (2023-2027) to *Reclaim Healthy Thriving Futures with Tribal Nations*.

NIHB is governed by Tribal nations through a 12 Member Board (and alternates) representing the following regions as selected by each area health board from: Alaska, Portland, California, Bemidji, Oklahoma City, Albuquerque, Billings, Great Plains, Nashville, Navajo, Phoenix, and Tucson.¹ Resolutions are approved by the NIHB Board which set the [NIHB Legislative and Policy Agenda](#).

Various approved [resolutions](#) include:

- *Advance Appropriations for the Indian Health Service* (Res. 14-03)
- *Improvement in the Tribal Budget Consultation Process* (Res.18-16)
- *Support for [the] Indian Child Welfare Act* (18-21)
- *Elevation of the Director of IHS to Assistant Secretary of HHS* (Res.19-07)
- *Permanent Reauthorization of [Special Diabetes Program for Indians]* (Res. 20-01, 21-04)
- *Boarding School Healing* (Res. 22-01)
- *Codification of Federal Tribal Advisory Committees* (Res. 22-04)

NIHB supports Tribal nations in ensuring the fulfillment of the trust and treaty obligations which ceded well over 500 million acres of Indian lands in exchange for the promise of "Health..." into perpetuity. Sovereign Tribal nations signed over 300 treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those treaties have been reaffirmed by the U.S. Constitution, supreme court decisions, federal legislation, regulations, and Presidential Executive Orders. Treaty obligations are pre-paid and are not welfare nor reparations.

In 1977, the senate report of the [American Indian Policy Review Commission](#) stated, "[T]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian Tribes and people." During 2010 permanent reauthorization of the Indian Health Care Improvement Act (IHCA), Congress declared:

"...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 affect that policy."

The Biden-Harris transition [plan](#) (January 1, 2021) pledged to address health care disparities in Indian Country through the following:

- Increase and ensure stable funding for Indian Health Service (IHS).
- Ensure access to health coverage including increased access under the Affordable Care Act (ACA).
- Lead a decisive public health response to COVID-19.
- Expand the pipeline of health care providers in Tribal communities.
- Deploy telehealth throughout Indian Country.
- Reduce unacceptably high maternal mortality rate, which disproportionately impacts Native mothers.
- Expand access to mental health and substance use disorder treatment.
- Help prevent suicides.
- Tackle social determinants of health.

Trust responsibility is further articulated in the [U.S. Department of Health and Human Services](#) (HHS) Strategic Plan FY 2022-2026:

"...The Constitution's Indian Commerce Clause, Treaty Clause and Supremacy clause... provide the legal authority and foundation for distinct health policy and regulatory decision making by the [U.S.] when carrying out its unique trust responsibility to provide for the health and welfare of [AI/ANs] and support for the Indian health system that provides their care."

As the old legislative adage goes, "the President proposes, and Congress disposes." This suggests even the most aspirational Presidential agenda supportive of Tribal nations must be matched with advocacy by Tribal nations lifted up by NIHB. An enhanced focus with NIHB's Government Relations Team is to work more directly with Tribal nations to elicit on going and frequent input, direction, capacity building, technical support to Tribal Advisory Committees (TACs), Tribal caucuses, Tribal town halls and listening sessions, and supporting Tribal nations with preparing congressional testimony, and consultation sessions to achieve the NIHB Strategic plan as established by Tribal nations.

To learn more about the HHS Strategic Plan FY 2022-2026, scan this QR code:



¹ <https://www.nihb.org/docs/01272016/NIHB%20Constitution%20and%20Bylaws.pdf>

National Indian Health Board's Managed Care Report

PUBLISHED JULY 2022

The [National Indian Health Board's \(NIHB\) Managed Care Report](#) summarized here is provided as part of NIHB's purpose to reinforce Tribal sovereignty, strengthen Tribal health systems, secure resources, and build capacity to achieve the highest level of health and well-being for American Indian/Alaska Natives (AI/ANs).

On Wednesday, May 19, 2021, NIHB, in conjunction with the [Centers for Medicare & Medicaid Services \(CMS\)](#) held a Medicaid Managed Care Roundtable to better understand protections for Indian Health Care Providers (IHCPs) operating with Medicaid managed care plans and to collaborate on strategies and solutions to benefit all parties. The roundtable brought together panelists from state Medicaid agencies and Tribes from Washington, Oklahoma, Texas, California, North Carolina, and Oregon. This article is a summary of that event.

In 2019, CMS and the Tribal Technical Advisory Group (TTAG) recommended holding a Medicaid managed care roundtable as a forum to better understand and showcase recommended practices in implementing the regulatory and statutory Medicaid managed care protections for Indians. The roundtable addressed access and payment issues that Tribal nations and IHCPs experience when interacting with managed care delivery systems. Originally intended to begin pulling together Tribal voices in 2020, the pandemic delayed implementation. The results and recommendations below followed a Tribal listening session on March 4, 2021, and a roundtable discussion on May 19, 2021. While financially supported by CMS and [U.S. Department of Health and Human Services \(HHS\)](#), the report is reflective of Tribal voices who participated.

Recommended Practices:

- 1. Tribal Consultation.** In the delivery of federal entitlements or benefits pursuant to the trust and treaty obligations to Tribes, states should develop a process in collaboration with the Tribes in its states to ensure Tribal consultation is timely, collaborative, and meaningful.
- 2. Early Involvement of Subject Matter Experts.** When encountering claims issues from IHCPs, it is important for any state to have subject matter experts available early in the process. There is a critical need for states with oversight from the federal government to educate and develop tools to help Tribal organizations through the Medicaid provider enrollment process.
- 3. Institutionalize Knowledge of the Indian Health Care Delivery System.** States should routinely train state administrators, so expertise transcends individuals and legislative bodies as the trust and treaty obligations do not expire. Beyond training, administrative efforts like ongoing accords with Tribes or legislation to establish permanent capacity may be helpful.



4. Single Point of Contact/Tribal Liaison. States should assign a single point of contact and/or a Tribal liaison, Tribes can contact when they have difficulties resolving issues with a Managed Care Plan (MCP) and include a contract provision requiring MCPs to do the same.

5. Use of the Indian Specific Contract Addendum. The Indian Managed Care (ITU) Addendum outlines the federal laws, regulations, and several specific provisions that have been established in federal law that apply when contracting with IHCPs.

6. Develop Internal Claims Processing Practices. MCPs should develop internal claims processing practices that recognize and/or treat IHCP as “in-network” providers to avoid claim denial for providing services “out-of-network” when IHCPs serve AI/AN clients that are enrolled in the plans.

7. Require Managed Care Plans to Pay the Indian Health Service (IHS) Encounter Rate Directly to the Indian Health Care Provider. States can amend its contracts to have the MCP pay the entire IHS Encounter Rate directly to IHCPs.

8. MCPs should avoid auto-assignment of AI/ANs to a Primary Care Provider (PCP). Auto assignment of AI/AN beneficiaries to non-IHCP PCPs can cause confusion and disrupt care a client is receiving from the IHCP. MCPs should avoid assigning AI/AN beneficiaries to PCPs to the maximum extent possible.

Next Steps to Implement Recommended Practices:

1. Develop a Tribal Managed Care Oversight Toolkit.
2. Provide training to state Medicaid managed care staff and MCPs.
3. Develop Tribal-specific contract language for states to use when amending MCP contracts.
4. Establish a workgroup of TTAG members, CMS staff, state Medicaid staff, and MCP staff to engage and collaborate on Indian managed care protections implementation and enforcement.

To learn more about the NIHB Medicaid Managed Care Report, scan this QR code:



NATIONAL INDIAN HEALTH BOARD PARTNERS WITH INDIAN COUNTRY MEDIA: Podcast on Indian Health Care Delivery, Insurance Coverage, and Efforts to Advance Health Equity

The [National Indian Health Board](#) (NIHB) is partnering with [Indian Country Media](#) to produce a six-episode podcast series to help prepare American Indian/Alaska Natives (AI/ANs) for the open enrollment period coming up this fall to ensure maximum health insurance coverage for 2023. Episodes will individually cover the Medicare program, state Medicaid programs, the health insurance Marketplace, health equity, and a closing episode on hot topics currently at the forefront of national advocacy efforts. Each episode will feature guests that will further elaborate on the topics that have impacted their Tribal communities.

National Indian
Health Board




The NIHB team continues to seek new avenues to further enhance how it reaches its audience and are excited to bring information to the community in a new media form. The talented group at Indian Country Media has been an extraordinary partner in this process and NIHB is lucky to have its expertise in delivering the message to Indian Country. NIHB hopes this will be a digestible means of getting this complex and often misinterpreted information out to the community so health care consumers can choose the coverage that is best for them, and the AI/AN community knows what kind of protections it has in seeking out quality care. NIHB will highlight the work that it and its partners engage in on a regular basis with Area Health Boards, Tribal leaders, technical advisors from across the country, and federal partners.

NIHB hopes this podcast will reach a new audience, outside of the range of the community it reaches through its newsletters and website including:

- » AI/ANs who want to know more about Medicaid and Medicare.
- » AI/ANs with little to no understanding of health policy.
- » Students and researchers of academia.
- » General podcast listeners.

Podcasts have become an increasingly popular medium for receiving news, especially for the younger demographic of listeners, and NIHB is excited to reach a new audience. Several Indigenous podcasts have gained widespread attention over recent years, and we look forward to further elevating the voices of Indian Country.

NIHB is thankful for the support of the [Centers for Medicare and Medicaid Services](#) (CMS) in this venture, and for the continued engagement of the CMS Division of Tribal Affairs (DTA) on issues that impact AI/AN people across the country. They are a strong partner in the effort to ensure quality health care and improved well-being of Tribal people. NIHB looks forward to the opportunities this podcast can offer Indian Country on top of educating AI/AN people. NIHB hopes this will bring attention to, and focus to, the incredible efforts of Tribal communities and the lessons that can be learned from these communities. The COVID-19 pandemic and the climate crisis both have made clear that our people have systems in place to address many of the current crises and have knowledge that would help the greater population address these concerns. This is just the first move that NIHB will embark on to get the message from Indian Country out. 



THE POWER OF IDENTITY: A Path to Tribal Health Equity

There were many stories to come out of the COVID-19 pandemic. Abigail Echo-Hawk, Pawnee Nation of Oklahoma, tells a story about her work at the [Seattle Indian Health Board](#) during the first wave of the COVID-19 pandemic, as the clinic reached peak capacity and the medical staff ran short on personal protective equipment (PPE). The clinic petitioned the government to supply additional PPE and soon received a box. But instead of PPE, the box contained body bags. “I remember crying all the way home,” said Echo-Hawk. “The CEO and myself, we met afterwards. And we’re like: We could just take these body bags, because that, unfortunately, is what the United States government has always given us, the limited resources to bury our people, versus ensuring their life’s livelihood, thriving and ever continuing. And we could accept that, or we could get to work. And so, we didn’t accept it; we got to work.”

The pandemic has made it impossible to ignore the stark disparities in deaths and other health outcomes experienced by American Indians/Alaska Natives (AI/ANs). As health equity has risen to a national priority, the [National Indian Health Board](#) (NIHB) has recognized the need for a Tribal definition of health equity – one that places current circumstances into historical context and centers identities as Native peoples. NIHB continues to ask Tribal elders, leaders, and community members what health equity means to them. Across Indian Country, NIHB has heard health equity means joy and safety; dignity and kindness; justice and sovereignty; health and wholeness for the entire community. It means generosity, since taking care of others is important for one’s health. It means creating the conditions on a societal level that supports health for everyone. It means understanding the interconnectedness of human health with Tribal homelands and waters and all living things.

During the Tribal Health Equity Summit hosted by NIHB in August 2022, leaders in health equity from across Indian Country gathered to share perspectives on health equity and the steps needed to make it a reality for all AI/ANs.

Various summit speaker recommendations:

- » **Center Native Identity.** “We have the answers to solve all the gaps that are identified as disparities within our communities, but only when they are rooted in our stories, our land, our very DNA, when those are valued and incorporated in leading these conversations on health equity – only then will we see the change that we need to see within our communities,” explained Abigail Echo-Hawk, Pawnee Nation of Oklahoma, Executive Vice President at Seattle Indian Health Board and Director of Urban Indian Health Institute.
- » **Shift the Deficit Orientation.** “Let us endeavor to see the ubiquity of brilliance and learning, to be guided by a belief in the abundance of possibilities and peoples, reject ideologies of scarcity, and move toward understanding the power that resides in us all,” said Bryan McKinley Jones Brayboy, Lumbee, Director of the Center for Indian Education at

Arizona State University. Harlan Pruden, First Nations Cree, Indigenous Knowledge Translation Lead at the British Columbia Centre for Disease Control, discussed how, in decolonizing our data science, “You find you’ll mentally get a different conversation, one that is based in strength and that is supportive of who we are as Indigenous people.” After all,



said Echo-Hawk, “We are not a historically underserved community. We are a colonially underserved community. We are an institutionally underserved community, but I am historically loved.”

» **Trace Policy Genealogies.** “Whenever new policies get instituted, looking at where they come from because they don’t just come out of nowhere, and understanding if those policies are really designed to uplift who we are and see our uniqueness,” explained Malia Villegas, Sugpiaq/Alutiiq, Senior Vice President of Community Investments for Afognak Native Corporation. We need to ask: Who created this policy? Who does it serve? Who does it harm? We need to be able to trace the legacy of colonization and white supremacy so we can recognize when and where these forces influence current policy. Brayboy explained, “Taken together, colonization and racism create the conditions where federal health officials ignore the unique needs and histories of Native peoples when considering what health equity is, should, or can be.”

» **Disrupt the Structures of Inequity.** “We are told the system is failing,” said Brayboy. “It isn’t failing...we have designed perfect health and social mechanisms to create failure for certain peoples.” He argued that the onus for change should not be on individuals or Tribal communities to be resilient over and over again in the face of trauma, but to, “Disrupt the structures that have led to the constancy of trauma.”

» **Increase Visibility.** Colonization has fostered health inequities through the erasure of American Indians and Alaska Natives from the larger societal consciousness. Pursuing health equity, therefore, means ensuring Native people are visible. Villegas explained, “We have to make a multiple-pronged effort to continue to be at the table, and that means we need to grow our leadership into those roles to continue to push and talk about the importance of being at the table because I don’t believe that systems are capable at this point of representing us without us.” In discussing the urgency of addressing data that leaves out AI/AN, Echo-Hawk explained, “When you eliminate us in the data, you eliminate our ability to receive the federally allocated resources that we have been mandated by treaty rights.”

» **Demand Fulfillment of Trust & Treaty Responsibilities.** “What makes health equity different for Tribal communities fundamentally is that this country is built on Tribal lands, on Indian lands, some of which were ceded, and many of which were not,” said Brayboy. Echo-Hawk later added, “I see that now even within this definition [of health equity] that’s been presented by [federal agencies] a general bucket definition that does not recognize the political implications that we have, and the treaty and trust responsibilities that exist to American Indians and Alaska Natives as a result of the land.”

» **Heal Backwards and Forwards.** “That historical trauma, while we recognize it, we see it, we measure it, we work to overcome, it has to be coupled with historical healing. Because when we heal now, when we

demand our treaty and trust rights...we are not only healing for this generation, we’re healing for my children’s children, and we are also healing for my grandmother’s grandmother,” said Echo-Hawk.

» **Focus on Relationships and Connectedness.** “To craft a definition of ‘Tribal health equity,’ we must be willing to embrace relational health matters, measures like safety. It is not, for example, enough to imagine a whole community of individuals who have attained perfect health in their bodies if they do not feel safe in their world,” said Villegas. Brayboy also added, “We have millennia of knowledge that is cumulative in terms of thinking about relationships that took place...[including] these knowledges about connectedness to land and health.”

» **Share our Knowledge.** “I think that’s distinctive, in that we want to share, and we want to build collectively. It’s not just about what’s mine is mine, and what’s yours is yours, but figuring out how we can raise the tide for all of us going forward,” said Villegas.

The best paths forward toward health equity are grounded in traditional Native values and worldviews that center relationships and connectedness, joy and generosity. When Tribes are fully empowered and sufficiently resourced to exercise inherent sovereignty, we have seen the gains that Native brilliance can achieve. As Malia Villegas beautifully stated the goal of all our work towards Tribal health equity, “We have deep capacity for joy, and we deserve to be joyful.” 🍷



988 SUICIDE & CRISIS LIFELINE: Current Resources and Future Directions for Indian Country

On July 16, 2022, the [National Suicide Prevention Lifeline](#) transitioned from its original number of 1-800-273-TALK (8255) to its new name and access number: the 988 Suicide & Crisis Lifeline. The Lifeline was launched by the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) in 2005 as a part of the National Suicide Prevention Initiative (NSPI). Vibrant Emotional Health, a non-profit mental health organization, is Lifeline's administrator.

The implementation of 988 is a welcome enhancement of mental health and suicide prevention service access for American Indians/Alaska Natives (AI/ANs). Now that 988 is fully operational, it is important to understand the current resources the Lifeline offers—what 988 is and what it is not—as well as considerations for future directions that would most benefit Tribal communities and respect Tribal sovereignty.

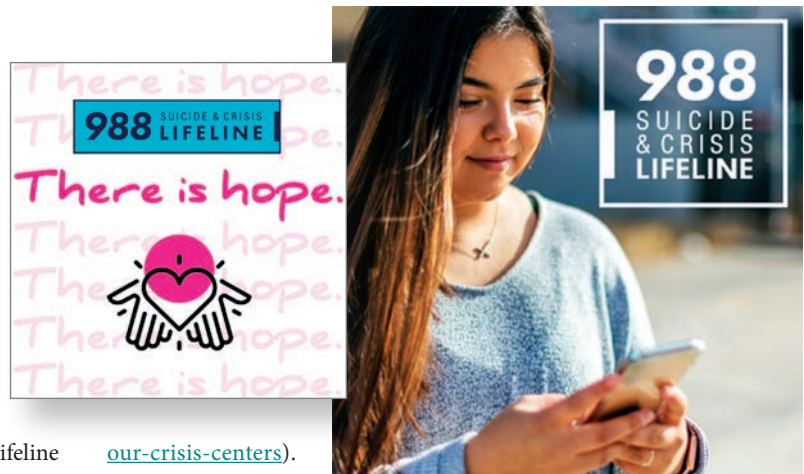
What 988 Is

- » 988 is for any mental health emergency, emotional distress, and access to mental health crisis care—including but not limited to suicide prevention.
- » The Lifeline is available 24/7 and is free and confidential.
- » 988 can be called *and* texted. The texting option is new to the Lifeline system as of July, 16 and was added under the direction of the [Federal Communications Commission](#) (FCC). Website users can also access a chat function at [988lifeline.org](#) to connect to a counselor.
- » Veterans can connect to the Veterans Crisis Lifeline by pressing “1” after dialing 988. For texting, Veterans are encouraged to continue using the Veterans Crisis Lifeline short code 838255.
- » 988 is also for friends and family members who are concerned about a loved one in need of crisis support.

What 988 Is Not

- » 988 is not a new operational system. It is simply an easy to remember access number for contacting the existing Lifeline network and its over 200 local crisis centers. When a local crisis center is not available, calls are routed to a national backup crisis center.
- » 988 did not eliminate the original number of 1-800-273-TALK (8255), which will continue to work indefinitely for accessing the Lifeline network.
- » 988 is not 911. 911 is the appropriate number for police, fire, medical, and rescue emergencies. 988 is for mental health emergencies—to provide emotional support and connect to mental health resources.
- » The **988 Suicide & Crisis Lifeline** is not the same network as the [Crisis Text Line](#), which can be accessed by texting NATIVE to 741741. Now that texting is available for 988, it is easy to confuse the two networks. The Crisis Text Line was launched in 2013 and offers free and confidential 24/7 mental health support through text messaging. Both lines are valuable resources for AI/ANs who need immediate connection to a trained crisis counselor. For more information on the Crisis Text Line, visit [crisistextline.org](#).

While the new ease of access to the 988 Lifeline is a critical development in the enhancement of mental health crisis care, there is much work to be done to ensure the program serves Tribal communities equitably and effectively. For example, local crisis centers are the heart of the 988 Lifeline network (you can access a searchable map of all crisis centers at [988lifeline.org/](#)



[our-crisis-centers](#)).

Though the Lifeline is a national initiative, funds for crisis centers come from state and local sources (which may include federal grant funds), and states can vary in their capacity, readiness, and culturally informed training. This means Tribes must often rely on the relationship it has with its surrounding states, and much depends on how proactive individual states are in collaboration, communication, and coordination with Tribes to address Tribal needs.

President Biden's proposed fiscal year (FY) 2023 budget includes approximately \$700 million for 988 Lifeline expansion and infrastructure development—an impressive and encouraging investment. However, Tribes must often rely on competitive, grant-based funding to address the mental and behavioral health needs of their communities. This piecemeal approach to mental health care prevents Tribes from implementing comprehensive services that grow from Tribal-led community assessments. The [National Indian Health Board](#) (NIHB) advocates for direct, non-competitive funding for Tribal nations in honor of the federal trust responsibility and respect for the sovereign government-to-government relationship that federally recognized Tribes have with the U.S. government. Tribes should not be dependent on states for mental health crisis care, but should receive robust, set-aside funding for increasing crisis care response capacity and infrastructure as sovereign nations.

To find out more about the Lifeline's administrator, [Vibrant Emotional Health](#), visit [vibrant.org](#). SAMHSA also maintains a helpful “988 Frequently Asked Questions” (FAQ) page at [samhsa.gov/find-help/988/faqs](#).

To learn more about the 988 Suicide & Crisis Lifeline, scan this QR code:





Dəxʷəyəbus's Dental Therapy Simulation Lab.



Skagit Valley College Mt. Vernon Campus.

Accreditation Opens New Doors for Dental Therapy Education Programs

In August 2022, the [Commission on Dental Accreditation \(CODA\)](#) awarded accreditation to the dental therapy* education program at [Skagit Valley College](#) in Washington State. The newly accredited program, called dəxʷəyəbus (say “dahf-hi-ya-buus”) which means “Place of Smiles” in the Lushootseed language, operates through a partnership with the college and the Swinomish Indian Tribal Community. This is the second dental therapy program to receive accreditation following Alaska’s [Iisagvik College’s](#) accreditation in Spring 2020.

Beginning in Autumn 2022, dəxʷəyəbus will enroll up to 12 dental therapy students in each cohort in the two-calendar year program. Because Tribes and the Indian health system are currently the only employers of dental therapists in the Pacific Northwest, the program expects most of its initial students to be citizens of Tribes.

Dental therapy is an established profession first brought to the U.S. through Tribal leadership. These oral health providers work with dentists and dental hygienists to fill a critical gap in oral health care services. The scope of practice focuses on the most common and easiest to treat cases, which allows dentists to meet nearly two-thirds of patient needs and lets dentists prioritize the hardest to treat cases. In the nearly two decades since the first dental therapists began practicing in Alaska Native communities, studies have shown that preventative services have gone up, and the need for restorative services have gone down in communities served by dental therapists.

Over 100 dental therapists practice nationwide, and over 40 are American Indian/Alaska Native (AI/AN). Compare that to fewer than 200 AI/AN

dentists out of nearly 200,000 practicing in the U.S. dental therapy represents an accessible pathway for AI/AN community members to become oral health providers and—for some—a steppingstone on the way to becoming a dentist. With so many dental therapists coming from the same Tribal communities where they work, they form bonds with the patients. As those bonds continue and trust develops, people become more likely to seek care and follow their provider’s advice. The two accredited programs devote considerable time to clinical training, so the dental therapy students gain experience making the patient feel comfortable, validated, and above all, safe.

Accreditation brings many benefits to education programs. CODA’s accreditation—recognized by the federal Department of Education—is responsible for accrediting all oral health education programs, including dental schools and dental hygiene programs, in the U.S. By accrediting dəxʷəyəbus, CODA states the program meets the rigorous education standards for dental therapists, provides a quality education for the providers, and has legitimacy as an instructional program. Education institutions generally find faculty and student recruitment to be easier

following accreditation. Not to mention, most states that license dental therapists to practice require individuals to graduate from accredited programs.

While more dental therapy education programs are expected to receive accreditation in 2023, for now, the two accredited programs are both focused on Indian Country, with Iłisagvik a Tribal college and dæxʷx̣ayəbus run in partnership with a Tribe. Once again, Tribes find themselves leading in health care innovation and coming up with solutions tailored to meet their own needs.

That is why the [National Indian Health Board](#) (NIHB) has been such a strong champion of dental therapists. These culturally competent, effective providers have shown time and again how impactful they can be in addressing Indian Country's unmet oral health care needs. NIHB co-chairs the [National Partnership for Dental Therapy](#), a national effort to elevate the work dental therapists do every day. NIHB was also proud to support the Swinomish Tribe on the journey to CODA accreditation.

Currently, NIHB is supporting dental therapy through its [Dental Therapy Student Sponsorship Fund](#). The fund will support Tribes and Tribal organizations sponsoring students through either of the accredited dental therapy programs. NIHB is offering six \$10,000 awards to support students in the 2022-2023 academic year. Typically, a Tribe or Tribal organization will sponsor a student, paying the tuition and living expenses for the two-calendar year program in exchange for the graduate coming home to serve the community for a set amount of time. While this benefits both the student and the community, the Tribe must take

on all the costs up front. NIHB's Dental Therapy Student Sponsorship Fund alleviates some of this burden and makes dental therapy sponsorship more accessible to Tribes.

To learn more about dæxʷx̣ayəbus at Skagit Valley College, scan this QR code:



*Dental therapists may also be called Dental Health Aide Therapists (DHATs). Dental therapists are the same, but a DHAT is a dental therapist working within the Indian health system. 🇺🇸



National Indian Health Board Tribal Oral Health Initiative



At Long Last, Congress Acts on Climate

Warmer summers. Declining water reserves. Stronger storms. Frequent wildfires. Less access to traditional food sources. Indigenous people have known since time immemorial how a changing climate impacts the health—and perhaps very survival—of human communities.

Climate change is a well-documented phenomenon, as is its primary cause—human activity. Industrialized nations have for centuries relied on unsustainable land management practices and unsustainable energy consumption to fuel their industrialization. Fossil fuels like coal and oil emit carbon dioxide and other greenhouse gases, so named because they linger in the atmosphere and create a greenhouse effect — the gases keep heat in, warming Earth's lands and oceans.

Natural carbon sinks like rainforests, which actively purify the air of carbon and other pollutants, are becoming depleted as capitalist pressures incentivize converting these lands to open grazing.

The [United Nations estimated](#) in 2018 that by 2030, the world would warm by 1.5 degrees Celsius compared to average global temperatures in 1800 unless the industrialized nations committed to strong and sustained action to reduce greenhouse gas emissions. Failing to take these actions would, scientists predict, lead to irreversible consequences, such as crop failure, ecological collapse, and water shortages that directly threaten human existence.

In the face of this dire threat, the federal government's actions on climate have been tepid, piecemeal, and inconsistent. While federal investments



Senator Joe Manchin is widely credited with shepherding the Inflation Reduction Act through Congress.

in energy technology have made the nation less dependent on fossil fuels for energy and transportation, just this year the supreme court reigned in federal efforts to regulate electricity generation from fossil fuels on an industry wide scale.

It may seem surprising for Congress to suddenly enact the most substantial climate legislation ever written not only in this country, but in any country. That is exactly what happened on August 16, 2022, when

President Biden signed the [Inflation Reduction Act \(Public Law 117-169\)](#) into law. Less than three weeks earlier, Senator Joe Manchin (D-WV), a key vote in the Senate, had announced a deal with Senate Majority Leader Chuck Schumer on a reconciliation package including long sought climate and health provisions. Reconciliation is a unique congressional procedure that allows certain spending and revenue policies to pass the Senate with a simple majority instead of the 60 votes typically required to beat a filibuster.

The Inflation Reduction Act, as the deal between Sens. Manchin and Schumer came to be called, provides [\\$369 billion on efforts to mitigate and adapt to climate change](#), which estimates predict will [lower carbon emissions by 40% compared to 2005 levels](#) in the next decade.

The Act includes [several funding streams for Tribal climate efforts](#):

» **\$235 million for Tribal climate resilience**

This can support Tribal climate mitigation and adaptation efforts, including \$10 million for upgrading Tribal fisheries, a vital source of food and revenue for some communities. Funding will come from the Bureau of Indian Affairs through self-determination compacts and contracts. This funding does not require cost sharing or matching with the Tribe and will not negatively impact the Tribes in the “small and needy” program.

» **\$225 million for Tribal high-efficiency electric home rebate programs**

The high-efficiency electric home rebate program allows moderate- and low-income homes to receive up to \$14,000 in direct tax rebates for installing energy efficient appliances and weatherization (making a home more efficient by insulating walls and sealing cracks). Tribes can operate this program within guidelines set by the Department of Energy.

» **\$150 million for Tribal home electrification**

This funding will provide electricity from renewable sources to Tribal communities and assist electrified communities transition from fossil fuels to renewable energy. In places like Alaska, this means fewer communities will rely on imported diesel to meet their electricity needs. This funding does not require cost sharing or matching with the Tribe. Similarly, funding will go to Tribes through contracts and compacts from the Bureau of Indian Affairs and will not negatively impact Tribes in the “small and needy” program.

» **\$75 million for the Tribal Energy Loan Guarantee Program and \$20 billion in allowable loan guarantees**

Tribes have long been able to establish their own energy systems and programs on their land, but too often the startup costs prohibit Tribes from taking on this exercise in sovereignty. This funding from the Department of Energy will allow Tribes to borrow funds to establish their own clean energy sources without incurring startup costs. Previously, only \$2 billion in loans had been made available to Tribes.

» **\$25 million for Native Hawaiian climate resilience**

Hawai'i is one of the most vulnerable places in the U.S. when it comes to climate change. Endemic flora and fauna thrive on the islands, and Native Hawaiians used these natural resources for centuries before colonization. However, as the U.S. and other colonial powers alienated Native Hawaiians from their lands, these places became more exploited and vulnerable to the impacts of climate change. This funding does not require cost sharing or matching.

» **\$12.5 million for Tribal emergency drought relief**

As dry seasons lengthen, and as cities in the Southwest continue to grow, water resources are stretched thin. Funding for drought relief will ensure vulnerable Tribal communities have access to clean water for drinking and bathing, and to mitigate the loss of Tribal trust resources. This funding does not require cost sharing or matching with the Tribe.

All told, \$720 million in funding is specific for Tribes. Additional funding streams are available to Tribes and Tribal organizations through block grants to Tribes and other entities or through competitive grants, which is not the most impactful way to ensure funding goes to the Tribal communities that need it most. That is why having Tribal specific programs and funding opportunities is vital to climate work. These investments will help the U.S. meet international climate goals and establish the U.S. as a leader among developed nations combating climate change.

While the Inflation Reduction Act is a positive first step, and its passage surprised many and reassured more still that meeting this challenge is possible, more work needs to be done before future generations can rest easy knowing their planet is a thriving home for their children's children and their children.

To learn more about the White House's Inflation Reduction Act's fact-sheets, scan this code:



**TRIBAL CLIMATE &
ENVIRONMENTAL HEALTH
PROJECT** 

BACK-TO-SCHOOL: COVID-19 Safety in Indian Country

Back-to-school season can be an exciting time for many across Indian Country. However, for numerous families, this is the first time since before the COVID-19 pandemic began that in-person learning has been prioritized. For some people, these past few years have been full of anxiety, confusion, and uncertainty. Those feelings may be heightened for families who are sending their child(ren) back to school.

At the beginning of the pandemic, Tribes led the way in COVID-19 vaccine rollout and uptake. Today, according to the [Centers for Disease Control and Prevention](#) (CDC) data, only 68.9 percent of American Indians/Alaska Natives (AI/ANs) are fully vaccinated, and 71.7 percent have received at least one COVID-19 vaccine dose.¹ At this time, only 46.2 percent of eligible AI/ANs have received a COVID-19 booster shot, and of those who are eligible for a second booster dose, only 16.1 percent have received one.¹ Considering how well Tribes did at the beginning of the pandemic, these numbers are lower than expected, and a bit shocking.

As school resumes, the [National Indian Health Board](#) (NIHB) wants to remind people that vaccinations are an important part of back-to-school success and overall health and well-being. Vaccines are one of the most successful means of preventing disease and death and help protect our entire community by reducing and preventing the spread of disease.

Based on the most recent CDC data, 60 percent of all children ages 12-17 are fully vaccinated, 30 percent of all children ages 5-11 are fully vaccinated, 1.1 percent of children ages 2-4 are fully vaccinated, and only .6 percent of children under the age of two are fully vaccinated.¹ These numbers are lower than the adult vaccination rates, which is ok, but are still lower than NIHB wants them to be. Children ages 12-18 have been eligible for the COVID-19 vaccines since 2021, and children under the age of five only just became eligible for their COVID-19 vaccine in June of 2022.

Over 14 million children under the age of 18 have tested positive for COVID-19, and over five million of those have been in 2022 alone.² These numbers are alarming and may make parents and caregivers nervous to send their child(ren) off to school. This wariness is understandable, however, there are several steps you can take to reduce the risk of children getting sick.

The first, and most important step, is to make sure you and your child(ren) are vaccinated against COVID-19. Vaccines are the strongest defense against COVID, and because many indoor mask mandates have been lifted, vaccination can be the only defense. Keeping child(ren) home from school if not feeling well, or even if you are not feeling well, will be important in preventing the spread of COVID-19, and other illnesses that



children can pick up at school. Make sure to highlight the importance of handwashing at home so children will be sure to wash their hands while away from home as well. Additionally, while no longer mandated, parents and caregivers can encourage child(ren) to wear a face mask and practice physical distancing while in school. Although mask and distancing mandates have been lifted in many places, a face mask is a great way to prevent the spread of disease.

NIHB urges all to consider vaccination for COVID-19, or any other vaccine-preventable disease, as an Act of Love to your community. In 2020, NIHB developed the [Act of Love](#) campaign, originally to depoliticize wearing a mask at the beginning of the COVID-19 pandemic. However, it has evolved to promote all healthy behaviors as an Act of Love. While many of these are COVID-19 specific, such as wearing a mask in crowded areas and keeping your distance from others, other healthy behaviors such as washing your hands often and getting necessary vaccinations can keep you and your community safe from other diseases. NIHB encourages you to proudly show your Acts of Love to keep yourself and your loved ones safe, now, and in the future.

Tribal nations have more than proved their resiliency in the past and are continuing to do the same today. Tribes are hopeful the end of this pandemic comes to us sooner rather than later, but until then, all still need to be diligent in protecting ourselves and others from COVID-19. NIHB wants to reinforce getting a COVID-19 vaccine and taking other steps to prevent COVID-19 is not political; rather, it is a healthy, caring measure and, therefore an Act of Love to our Tribal elders, youth, and communities.

To learn more about how to show your Acts of Love for your community, scan this QR code:



¹ <https://covid.cdc.gov/covid-data-tracker/#vaccination-demographics-trends>
² https://downloads.aap.org/AAP/PDF/AAP%20and%20CHA%20-%20Children%20and%20COVID-19%20State%20Data%20Report%208.18.22%20FINAL.pdf?_ga=2.132459531.408662701.1661198677-1192725839.1661198677

Climate Change and Mental Health in Tribal Communities

As Tribal communities pursue holistic and authentic mental health and wellness, researchers and health care professionals have increasingly looked to connections between mental well-being and specific social determinants of health: education, employment, income, housing, and access to health care services, among others.¹ A key determinant of health for all communities is physical environment. For Tribal communities, however, the connection to the physical environment often goes far beyond standard measures of air and water quality or potential exposure to environmental toxins. The connection is historical, spiritual, and tied to ancestral traditions and practices that form both individual and community identity. When disrupted, there can be devastating effects on the mental health of Tribal community members, and we are seeing these effects particularly as climate change alters the environments that Tribes have thrived in since time immemorial.

1 Alegría, M., NeMoyer, A., Falgàs Bagué, I., Wang, Y., Alvarez, K. Social determinants of mental health: Where we are and where we need to go. *Curr Psychiatry Rep.* 2018 Sep 17;20(11):95.

Tribal nations have already faced unique and specific challenges that, today, are discussed openly and categorically as historical and intergenerational trauma. Land dispossession, forced relocation, and separation of families have created negative health outcomes and disparities from which Tribes are still healing in the pursuit of health equity and recognition of Tribal sovereignty. For good reason, Tribes are discussing the need for Tribal-specific determinants of health that honor these unique lived experiences of American Indians/Alaska Natives (AI/ANs). It is difficult to think of many needs more pressing in Tribal communities than to combat climate change—not only for the obvious physical well-being of AI/ANs, but also for thriving mental health.

Alaska Native communities have been especially vulnerable to climate change. Subsistence living and the use of renewable natural resources for food, shelter, and clothing is under threat as communities in the Arctic Circle, for example, face coastal erosion, shallowing water, and warming rates four times faster than the rest of the globe.² For these communities, subsistence living is not simply means of production or survival. Rather, it is a core part of identity, culture, ceremony, and the ways in which entire Tribal communities define themselves.³ Alaska Native communities in the Arctic Circle are facing loss of food sources and the prospect of having to physically relocate to escape the effects of warming. These changes, which constitute a loss of individual and community identity, remove cultural protective factors, and increase risk factors related to mental health.

2 Harvey, C. (2022). The Arctic is warming four times faster than the rest of the planet. *Scientific American.*

3 Thornton, T.F. (1998) Alaska Native subsistence: A matter of cultural survival. <https://www.culturalsurvival.org/publications/cultural-survival-quarterly/alaska-native-subsistence-matter-cultural-survival>



Kivalina, AK. Due to climate change, the village could be uninhabitable by 2025. There are plans to relocate the village 2.5 miles away.



Arctic National Wildlife Refuge, traditional homelands of the Gwich'in peoples.

Between 2015 and 2018, The [U.S. Arctic Research Commission](#) coordinated an Arctic Mental Health Working Group to work with Tribes to explore behavioral health disparities, to promote early intervention and primary prevention, and to strengthen protective factors for mental health. One area of focus concerned suicide prevention efforts, including those related to climate change. Several studies suggest a high correlation between accelerated climate change and increased suicidal ideation. Contributing environmental factors include drought, crop failure, and declining air and water quality. However, of equal interest are the ways in which accelerated heat and humidity disrupt sleep and interfere with the body's ability to regulate emotions. And finally, the despair that accompanies the loss of sense of self and community—of particular concern for Tribal communities who are so intimately connected to the physical environment.⁴

The [National Indian Health Board](#) (NIHB) operates the [Climate Ready Tribes \(CRT\) Initiative](#), which helps Tribes prepare, mitigate, and adapt for climate change effects by hosting climate change-related events, sharing resources, and funding Tribes to conduct local climate health work or research. As NIHB supports capacity building to act on climate-related health threats, NIHB encourages Tribal communities to remember the threats that accompany climate change are not only physical. All must work together to protect the mental health of our communities that are culturally and spiritually connected to the lands under threat. ❄️

4 Cummins, E. (2021). We need to talk about climate change and suicide. *The New Republic.* <https://newrepublic.com/article/164861/need-talk-climate-change-suicide>

Primary Public Health Data Collection Advancements of American Indian/Alaska Natives Critically Needed

Given the Presidential Administration's expressed commitment to equity, it is an opportune time for Tribal nations to set the agenda for what this means beyond racial or ethnic classifications. An informed policy that is data-driven and shaped by Tribal nations is best as data reference points are at the heart of health equity. Without accurate data, it is impossible to determine the health status of American Indians/Alaska Natives (AI/ANs). The COVID-19 pandemic highlighted some of the ongoing concerns regarding data for AI/ANs. There are four issues around data concerns.

Data Sovereignty: Tribal nations have a right to govern their citizens and the right to ensure the health and wellbeing of their people. Lack of data and access has hampered this right including data the Tribal Epidemiology Centers (TECs) must access to provide accurate and timely public health information to the communities it serves. A recent [Government Accountability Office \(GAO\) report](#) highlighted some of the challenges that TECs have in accessing data and discussed the difficulty TECs experience accessing data from Indian Health and Human Service agencies.¹ **Solution:** Guidance, protocols, and agreements are needed from the [U.S. Department of Health and Human Services \(HHS\)](#) to enhance data access for TECs.

Absence of Data: Accurate data leads to appropriate resource allocation and disease prevention. According to Dr. Malia Villegas, Native Village of Afognak in Alaska, the term "Asterisk Nation" has been coined to refer to the practice of using an asterisk for in data displays when reporting racial and ethnic data due to "small n" sample size, large margins of error, or other issues related to the validity and statistical significance of data on AI/ANs. **Solution:** The trust and treaty obligations necessitate the federal government to more intentionally employ strategies to collect and report data on AI/AN populations.

Misclassification of Data: The misclassification of AI/ANs is a persistent problem. For example, death data reported by the [Centers for Disease Control and Prevention \(CDC\)](#) through its National Vital Statistics System is problematic as data are provided at the interpretive discretion of medical providers, coroners, medical examiners, or funeral directors. Since state-reported data on race is often not verified, incomplete death data is then reported to the CDC.² When AI/ANs causes of death data are not properly recorded, it creates invalid or unreliable data and then makes it impossible to allocate resources properly for the achievement of health equity. **Solution:** Operationalizing AI/AN data is incredibly complex and confounded by various public agencies that collect data. A series of webinars followed by listening sessions with Tribal data experts should occur to initiate a dialog to formulate recommendations to reform Tribal data collection and use.

1 US Government Accountability Office (March 2022). *Tribal Epidemiology Centers: HHS actions needed to enhance data access*. Retrieved August 22, 2022, from <https://www.gao.gov/products/gao-22-104698>

2 Kalweit, A., Clark, M. & Ishcomer-Aazami, J. (2020). Determinants of Racial Misclassification in COVID-19 Mortality Data: The Role of Funeral Directors and Social Context. *American Indian Culture and Research Journal*, 44(3), pages 15-36. <http://www.books.aisc.ucla.edu/abstracts/44.3.KALWEITCLARKISHCOMER-AAZAMI.pdf>

Cultural Relevance: Methods of data collection need to consider the AI/AN population. The [National Indian Health Board \(NIHB\)](#) aspires to help Tribal nations achieve health equity. Data collection and messaging must be culturally sensitized and appropriate. When COVID-19 first came into the community, what was the media message? "Wash your hands!" This messaging belies a disconnect and lack of knowledge about many homes on Tribal homelands and rural Tribal communities that do not have access to running water or need water, sewer, or solid waste systems.³ The simple piece of advice to wash your hands was not a reality for many AI/AN families. **Solution:** Oversampling of AI/AN populations is a minimum. Also, using data and knowledge about the community to ensure cultural relevancy can make a difference in the health and well-being of AI/ANs.

During the well-attended NIHB Health Equity Summit held in August 2002, experts in American Indian Policy and Tribal Demography and the people behind the numbers shared several insights and recommendations. In particular, the link between the impacts of federal Indian policy, Indian boarding schools, assimilation, and inter-generational trauma all confound data collection of and for AI/AN people. The video and proceedings can be found here: <https://www.nihb.org/health-equity/health-equity-videos.php>. 📺



3 Tebor, Celina (June 26, 2021). On Native American reservations, the push for more clean water and sanitation. *Los Angeles Times*. <https://www.latimes.com/world-nation/story/2021-06-26/native-americans-clean-water>

THE SPECIAL DIABETES PROGRAM FOR INDIAN SPOTLIGHT:

Health O'odham Promotion Program

Since the inception of the [Special Diabetes Program for Indians \(SDPI\)](#), the [Tohono O'odham Nation](#) has leveraged the funding to promote the health of the O'odham people. With over 30,000 citizens on 2.8 million acres of land, Tohono O'odham Nation is the third largest Native nation by landmass. To serve the large population, the nation manages 10 wellness centers, and employs approximately 20 SDPI staff.

The [Healthy O'odham Promotion Program \(HOPP\)](#) focuses on diabetes related education. SDPI staff lead physical and nutritional education classes, provide health screenings, teach diabetes management, and implement the Diabetes Education in Tribal Schools (DETS) curriculum. HOPP also hosts community events throughout the year, including a gardening project where they grow traditional foods such as tepary beans (ba:wi) and corn (huñ) and harvest wild foods such as Sauguardo Cactus Fruit (Bahidaj), which is turned into Sitol, a type of syrup. Cholla buds (Ciolim) and Prickly Pear Fruit (I:ibha'i) - a fruit known to lower blood sugar - are also harvested. HOPP holds an annual diabetes health fair, which generally attracts over 1000 attendees, and hosts a popular annual half marathon. Each year, people from across the nation come out to cheer on the runners, who can choose between a 5k, 10k, or can run the half marathon.

Wellness and Running are O'odham Values

The HOPP program is not only focused on promoting community wellness, but is also deeply connected with Tohono O'odham values, traditions, and culture. "O'odham people have always been traditional runners," stated Kevin Fortuin, HOPP Program Manager. HOPP integrates O'odham culture into their wellness initiatives, whether by promoting running during the half-marathon or by tying in traditional foods and festivals. For example, the Bahidaj Harvest is a symbol of the O'odham new year and a time of renewal before the monsoon rains begin. As Fortuin shares, "The connection between traditional foods, activity, and exercise is tied not only to health, wellness, diabetes prevention and management, but also in terms of who the O'odham people are. It's part of the O'odham culture."

Adapting to COVID-19

Like many other programs, HOPP faced significant challenges during the COVID-19 pandemic. However, HOPP approached these challenges from a place of strength, stating adapting to COVID-19 allowed SDPI staff to identify gaps and widen its reach.

Community members with diabetes and other chronic diseases are at a higher risk of severe COVID-19 symptoms. HOPP faced a difficult choice in keeping the community safe at home while also reaching those who needed diabetes prevention and management services. HOPP adapted by developing virtual programming; its Facebook page gained popularity during the pandemic, which allowed the program not only to serve their current client base, but to also gain a wider reach and bring in new clients that had not previously participated. This extension also allowed the program to reach O'odham people who lived outside of the nation,

including those as far away as the east coast. The virtual engagement enabled staff to monitor social media data and use it to determine which programs were most successful at reaching the target audience.

While the team's resiliency allowed HOPP to maintain a community presence, the program staff are excited to move forward and begin in-person activities again. Many citizens, particularly elders, those with difficulty accessing the internet, and those with other technological limitations were difficult to access virtually. However, HOPP is eager to continue to innovate, leverage its new skills, and plans to continue to offer new ways of connecting HOPP with the community.

Renew SDPI to Promote HOPP, and Other Successful Programs

Programs like HOPP are making incredible progress in promoting wellness in communities while embracing both tradition and innovation. SDPI





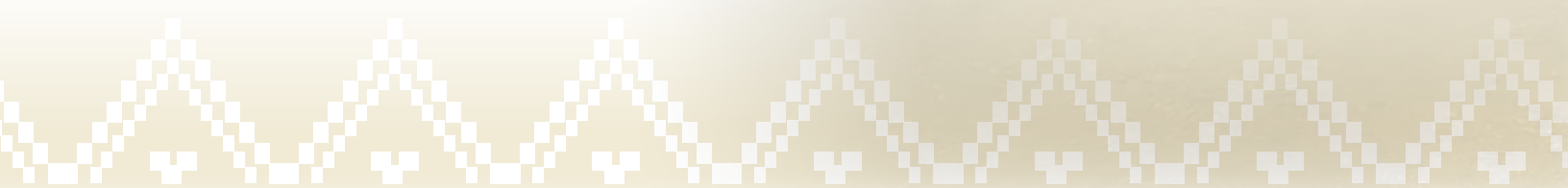
enables this success by providing needed resources, and by supporting Tribes in adapting the program locally to fit its communities' needs.

Despite its incredible achievements, SDPI programs face significant challenges due to insecurity at the national level, including short-term congressional reauthorizations and flat funding. "This has already

impacted our work," Fortuin shared, "We can't address diabetes year to year, not knowing what is going to happen...all we are doing is real short-term planning. We know working with public health issues, we need systemic changes."

SDPI is set to expire in September 2023. Congress must act to avoid a lapse in funding, and to ensure the sustainability of the program. National efforts will allow programs like HOPP to continue to support its community, reduce diabetes, and support healthy generations of Tribal people.

To learn more about SDPI, scan this QR code:



National Indian Health Board

910 Pennsylvania Avenue, SE
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Health Reporter

FALL 2022

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