National Indian Health Board
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MMIP: No More Stolen Relatives

Please note that this article discusses the topic of violence and deaths broadly. The National Indian Health Board recognizes this topic may be sensitive for many readers and encourages all those impacted by this issue to connect with their support networks.

For generations, Indigenous people have experienced disproportionately high rates of violence. In the United States, 84% of American Indian and Alaska Native (AI/AN) women and 82% of AI/AN men reported experiencing violent victimization in their lifetime.[1] When examining intimate partner violence (including physical, sexual, and psychological violence), AI/AN had significantly higher lifetime prevalence rates than women and men who identified themselves as white — 38.2% of AI/AN women and 41.2% of AI/AN men had experienced intimate partner violence (IPV) in their lifetime (compared to 29.3% of white women and 22.2% of white men).[1] Similarly, AI/ANs experience higher rates of missing and murdered persons.

MISSING PERSONS

Many adults go missing or disappear for a variety of circumstances. Some adults may choose to disappear to escape IPV or some other form of violence. Others may be victims of homicide by an intimate partner. From 2003-2018, the Centers for Disease Control and Prevention's (CDC) National Violent Death Reporting System revealed that 87.2% of AI/AN female victims were killed by a current or former intimate partner.[3]

The federal government has two primary sources of data on missing persons: the National Crime Information Center (NCIC) and the National Missing and Unidentified Persons System (NamUs). Unfortunately, neither database captures the totality of missing persons in the United States. In December 2022, a NamUs report showed 793 missing persons cases from 36 states and 181 unidentified persons cases from 29 states (**This report contains information only on individuals who have been reported missing to NamUs and whose cases include indication of enrollment or affiliation with state- or federally recognized tribes; it does not include all American Indian and Alaska Native missing persons*).[2]

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The Not Invisible Act Commission is developing recommendations to improve intergovernmental coordination for state, Tribal and federal law enforcement to bolster resources for survivors and victim's families, and combat the epidemic of missing persons, murder and trafficking of American Indian and Alaska Native peoples. (Photo/ Bureau of Indian Affairs)

INSIDE

MMIP

Thousands of American Indians and Alaska Natives have mourned their missing and murdered relatives and loved ones. Their calls for justice and healing through activism and advocacy have garnered nationwide attention and increased support for the Missing or Murdered Indigenous Persons (MMIP) crisis. The MMIP movement advocates for the end of violence against Natives and seeks to draw attention to the high rates of disappearances and murders of Native people. The red handprint is a symbol of the MMIP movement and represents the thousands of Indigenous persons who have been silenced.

SUPPORT FOR VICTIMS

April 29 - May 5 serves as the National Week of Action for Missing and Murdered Indigenous Persons.

If you or a loved one are experiencing human trafficking or domestic violence, you are not alone.

Strong Hearts Native Helpline and the National Human Trafficking hotline are available 24/7 to listen. All conversations over phone, text, and online chat are confidential and anonymous.

- Strong Hearts Native Helpline - 1-844-7NATIVE (762-8483) is a 24/7 safe, confidential, and anonymous domestic, dating and sexual violence helpline for American Indians and Alaska Natives, offering culturally appropriate support and advocacy.
- National Human Trafficking Hotline - 1-888-373-7888, text «BeFree» (233733), or live chat at humantraffickinghotline.org.

"Far too often, murders and missing persons cases in Indian Country go unsolved and unaddressed, leaving families and communities devastated."
- Deb Haaland, US Secretary of the Interior

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2. NamUs, NamUs AIAN Missing Persons Cases, https://namus.nij.ojp.gov/sites/g/files/xyckuh336/files/media/document/namus-stats-ai-an-december-2022.pdf
3. Petrosky, E., Mercer Kollar, L. M., Kearns, M. C., Smith, S. G., Betz, C. J., Fowler, K. A., & Satter, D. E. (2021). Homicides of American Indians/Alaska Natives — National Violent Death Reporting System, United States, 2003-2018. *Morbidity and mortality weekly report. Surveillance summaries (Washington, D.C.: 2002)*, *70*(8), 1–19. https://doi.org/10.15585/mmwr.ss7008a1

Special Diabetes Program for Indians Up for Renewal – It is time for Action!

The Special Diabetes Program for Indians (SDPI) will expire on September 30, 2023. This program is one of the most successful chronic disease prevention programs ever created. SDPI focuses on community-directed, culturally informed approaches to treat and prevent Type 2 diabetes in Tribal communities.

By allowing Tribes to determine their own approach, SDPI has become the nation's most effective federal initiative to combat diabetes and serves as a useful model both for diabetes programs nationwide and public health programs in Indian Country. SDPI has resulted in documented lower incidence of end-stage renal disease and lower prevalence of Type 2 diabetes among American Indians and Alaska Natives. This saves taxpayer dollars in medical costs.

SDPI is a mandatory funded program, but when the program expires, the funding will also expire. The National Indian Health Board (NIHB) is leading efforts to renew SDPI this year so that the 302 SDPI grantees do not experience a lapse or loss of funding.

This year, Tribes and their advocates are requesting that SDPI be permanently authorized and funded at a level of at least $250 million per year (with annual increases tied to medical inflation). Fortunately, the Biden-Harris Administration's Fiscal Year (FY) 2024 budget request also recommended $250 million for SDPI in FY 2024, $260 million in FY 2025, and $270 million in FY 2026. SDPI has not had a funding increase since FY 2004, which means that there has been significant value lost due to inflation. An increase will allow for important program expansion and keep SDPI programs from experiencing a further loss of resources. Last year, the Department of Health and Human Services (HHS) expanded the pool of potential grantees beyond current grantees to all eligible grantees, so it is no longer only inflation cutting into available program dollars. More recipients are accessing the same amount of funding. If we do not act to improve funding for this extraordinarily successful program, we risk losing all the accomplishments that SDPI has seen over the last several decades.

In addition, Tribes and Tribal organizations have repeatedly called for a change to the SDPI program structure to allow recipients the option to receive funding through P.L. 93-638 contracts and compacts. This change will establish SDPI as an essential health service and remove the barriers of competitive grants – which do not honor the Trust and treaty obligation to Tribal nations. Self-governance also removes unnecessary administrative burdens, which leaves more funding available for services. Most importantly, self-governance supports Tribal sovereignty by transferring control of the program directly to Tribal governments.

Members of the Tribal Leaders Diabetes Committee Visit with Senator Brian Schatz (D-HI), Chairman of the Senate Committee on Indian Affairs, on the need to Reauthorize SDPI

LEGISLATIVE OUTLOOK

The 118th Congress is closely divided between Republicans and Democrats, with Republicans controlling the House of Representatives with 222 votes (Democrats have 213). House Republicans have vowed to severely limit new funding and are looking to cut programs. This means, even successful, popular programs like SDPI are at risk. In the Senate, Democrats control only 51 votes, meaning, that Republicans will also have a large say in anything passing out of that body, as 60 votes are needed many major pieces of legislation will be to enact major legislation. Additionally, with Congress so divided, it is unlikely that there will be many major pieces of legislation introduced this year. SDPI advocates must continue to educate their members of Congress on the importance and success of this life-saving program.

At this stage in the legislative process, there is no certain legislative vehicle identified for SDPI renewal. That may become more apparent this summer as conversations on the federal debt ceiling progress. Currently, we are working to raise SDPI renewal with Members of Congress and their staff and share the success of this program. One option to consider is inviting your local representatives and Senators to visit your SDPI program. Seeing a program firsthand can often turn a supporter into an advocate! NIHB has resources if you would like to plan a site visit including fact sheets that you can share with your representatives. You can view these at https://www.nihb.org/sdpi/fact_sheets.php.

NIHB will be working tirelessly to share the great things that SDPI is doing with Members of Congress and their staff. But we need your help! Please share information about how your program has helped reduce the incidence and impacts of Type 2 diabetes in your community. It is also important to share how current SDPI funding levels are inadequate for the population you are serving – or what you could do with more available funding.

Please visit NIHB's SDPI website for more information and resources on how you can assist with SDPI renewal or contact Caitrin Shuy, Director of Government Relations, for more information at cshuy@nihb.org.

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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.

FEDERAL TRIBAL ADVISORY COMMITTEES:

A Revolutionary Tool for Advocacy

To help shape federal Indian health policy, we need to make sure that Tribal voices and leadership across Indian Country are being heard. Federal Tribal Advisory Committees (TACs) can be a revolutionary tool for advocacy, but only if the committees are Tribally led with 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.

Established to enhance government-to-government relationships, 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, councils, or groups provide a forum for regular and meaningful collaboration and consultation with Tribal leaders on policies that have Tribal implications and a substantial, direct effect on Tribal communities.

Increased Tribal participation is crucial in ensuring Tribal priorities are represented across all agencies. TACs are vital to enhancing the relationship 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 twelve area seats on the Indian Health Service (IHS) Information Systems Advisory Committee (ISAC) are currently vacant. TACs should be a vehicle for acquiring a broad range of Tribal views; instead, many regions are going entirely 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 by sharing the experiences of Tribal citizens and the effects federal programs are having on individuals. Federal officials must hear these stories; these committees are critical to facilitating such 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. Additionally, NIHB attends all TAC meetings in this capacity and provides TAC members briefing materials, policy, budgetary analysis, talking points, and notes on priority issues.

The Biden administration has expanded the role of TACs across the federal government. This provides an unprecedented opportunity to expand access and elevate Tribal health priories across the federal government. NIHB is prepared do its part to ensure all TAC meetings are meaningful and represent a wide array of perspectives from Indian Country. To develop a 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.

Centers for Disease Control and Prevention (CDC) Tribal Advisory Committee members at the CDC's Atlanta Campus

Please see the chart on page 6 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. You can also find more information on NIHB Tribal Advisory Committee Resources at https://www.nihb.org/tribal_resources/committees.php.

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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 Group (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)	To seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation, or Executive Order. https://www.hhs.gov/about/agencies/iea/tribal-affairs/about-stac/index.html
Health Resources and Services Administration (HRSA) Tribal Advisory Council	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/ihm/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.tribalselfgov.org/advisory-committees/tsgac/

NATIONAL INDIAN HEALTH BOARD'S

Medicaid Unwinding

Toolkit for Tribal Enrollment Assisters

HTTPS://WWW.NIHB.ORG/TRIBALHEALTHREFORM/MEDICAID-UNWINDING/

What Medicaid Unwinding Means for Indian Country

The National Indian Health Board (NIHB) remains committed to providing outreach and education on Medicaid Unwinding for the American Indian and Alaska Native (AI/AN) community. Through the Centers for Medicare and Medicaid Services (CMS), "Medicaid Unwinding" has become an increasingly important change that can have potentially drastic consequences for Indian Country. Since Congress's passage of the Families First Coronavirus Response Act (FFCRA), Medicaid programs have been required to keep enrollees continuously enrolled, regardless of a change of status – like income – which would normally render them ineligible for coverage. This has been incredibly beneficial for keeping the uninsured rate low within Indian Country. Recently, however, CMS has proposed a new period of Medicaid Unwinding, where many individuals, most notably AI/ANs, could lose health insurance due to the end of continuous enrollment.

NIHB continues to provide Tribal communities with information to help understand the impact of the Medicaid Unwinding and how many members it could impact. NIHB also continues to demonstrate how individuals can retain their health care insurance even through the Medicaid Unwinding period. Specifically, NIHB has constructed a Medicaid Unwinding Webpage that can be accessed and disseminated to all Tribal communities across Indian Country. This page will be updated with relevant data and information on how Tribal Enrollment Assisters and Certified Assistant Councilors (CACs) can navigate the Medicaid Unwinding period for their Tribal members.

Based on national data, NIHB estimates that as many as 236,000 AI/ANs could lose their Medicaid coverage due to Medicaid Unwinding. The specific Medicaid enrollment size within your community can be used to estimate the number of potential AI/ANs who may be disenrolled. This estimate can be found by multiplying your Medicaid enrollment total by 0.129 (or 12.9 percent). Communities must do all they can to protect their members through Medicaid Unwinding as health care insurance through CMS programs not only protects AI/ANs from incredibly high health care costs for services provided outside of the Indian Health Service (IHS), but it also provides additional resources for IHS clinics and hospitals.

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AI/ANs cannot afford the loss of health care insurance. It is essential to do everything in our power to retain the health of the AI/AN population for generations to come.

2SLGBTQ+ HEALTH

Interview with the Paths (Re)Membered Project

PATHS (RE)MEMBERED PROJECT

The Paths (Re)Membered Project at the Northwest Portland Area Indian Health Board "centers the Two Spirit and LGBTQ+ (2SLGBTQ+) community – its strengths, resiliencies, and histories – our movement towards health equity."[1] The Paths (Re)Membered Project engages in capacity building through clinician training, data collection, mental health services, storytelling, and community engagement. The National Indian Health Board (NIHB) public health team had the gift of learning more about the program, and Indigenous-focused 2SLGBTQ+ health promotion efforts from their team members – Jerico and Itai.

BACKGROUND ON TWO SPIRIT AND LGBTQ+ HEALTH

2SLGBTQ+ communities are resilient, joyful, powerful, experts on our own communities. 2SLGBTQ+ is used to describe Two Spirit and lesbian, gay, bisexual, and transgender, and queer/questioning. The term Two Spirit is unique to the Indigenous 2SLGBTQ+ community, and describes "the sexual, cultural, gender, and spiritual identities" of some Indigenous people.[2] In their interview with NIHB, Itai and Jerico discuss the importance of gender affirming care, meeting people where they are, and their visions for 2SLGBTQ+ health. We thank Itai and Jerico for sharing their voices and for their beautiful work towards Indigenous 2SLGBTQ+ health equity and collective liberation.

Itai Jefferies, PhD, *uses they/them/y'all pronouns and is Yesah/Occaneechi. They are a Two Spirit researcher, educator, and equity consultant, and Program Director of the Paths (Re)Membered Project.*

Jerico Cummings *uses they/them pronouns and is a member of the Cheyenne River Sioux Tribe in South Dakota. They are a Two Spirit adventurer, poetry lover, rez-dog owner and the Training and Community Engagement Specialist for Paths (Re)Membered.*

INTERVIEW

NIHB: *How can Paths (Re)Membered become a model for other organizations?*

Jerico: "One thing that I take a lot of pride in, and ultimately love to elevate, is that our team identifies as Indigenous, Two Spirit, or an accomplice. Ultimately, we're people who are impacted by this work are also doing the work. [This work] is not removed from our communities or lived experiences. Oftentimes we are getting to take the lead and take the charge and to bring other members from our community into the fold… that's something very special to me…"

Itai: "I don't want there to have to be special programs that are going to be protecting 2SLGBTQ+ health. What I would really love is that each one of these clinical programs has [2SLGBTQ+ health] as a component woven through…that we're considered within each one of those programs. So, really, the way that I see Paths (Re)membered and other folks doing similar work, is that we're a stop gap until our health system, including the Indian health system, can really get behind what that integration looks like and what it looks like to decolonize our health and ideas about wellness."

NIHB: *What do you want folks to know about 2SLGBTQ+ health?*

Itai: "2SLGBTQ+ people are highly connected to and proud of our cultures and communities, and also derive our identities – gender, sexual orientation, and otherwise - through that connection. Even within our data set, among 2SLGBTQ+ people as well, our Trans and gender diverse folks show even higher levels of connection to culture and community and cultural meaning. Largely we believe that connection has to do with the idea of our genders originate in our cultural histories… are connected to the act of decolonizing."

"I want people to know as well that we learned from our data that leaving home, or, you know, building a chosen family around yourself that is not your blood family, has very little to do with disowning one's community. In fact, it's quite the opposite. That love is there, and I think Indigenous 2SLGBTQ+ people are really waiting for our communities to level up."

– Itai

"There is so much room within our communities where what we know works is connection to culture that is protective. If we are able to reduce stigmatization and increase acceptance and affirmation within our community spaces, we as Native people have the ability to reduce a lot of the disparities that we see in health…we actually hold the answer to [health disparities] …We know that people experience this lack of affirmation and acceptance as a direct result of colonization. So, it is a multifaceted truth."

1 https://www.pathsremembered.org/
2 https://www.pathsremembered.org/celebrating-our-magic-toolkit/

NIHB: *How do we define affirming care and why does it matter?*

Jerico: "Affirming care is suicide prevention. It is violence prevention. It is substance use and abuse prevention…I believe that the affirmation piece is a is a place that we can help lessen these saddening statistics about the loss of members of our community, both 2SLGBTQ+ and beyond…"

Itai: "There is a hesitation and a resistance sometimes in clinical spaces to meet the needs of 2SLGBTQ+ people, largely because those needs are misunderstood…[there's] this idea that there is a normal and natural way of being and that is somehow tied to the binary and tied to the sex you are assumed…To really be affirming, I think a provider needs to have that baseline understanding that the things that are assumed in the medical system are not natural, that [assumptions are] social, in fact.

"To really be affirming, I think a provider needs to have that baseline understanding that the things that are assumed in the medical system are not natural, that [assumptions are] social, in fact."

– Itai

"If [providers] can do that and begin to approach clinical encounters with everybody (cisgender folks, Transgender folks, Queer folks) as a human-to-human interaction where you are working with the facts of everything that this person's case presents…If we can do that, we will affirm everybody. I mean, even cisgender folks who have undergone different operations due to the things that have happened in their life experience. [Cisgender folks] may not have the organs that they're assumed to have [and] may not go by the name on their birth chart. So, if we can learn to challenge and confront ways that assumptions are built into this current medical system and the way people are medicalized specifically, I think we can create more affirming encounters with that system for everybody. With that, that [understanding] reduces the burden on having to [create affirming care] for the Trans community or for the 2SLGBTQ+ community. [Creating affirming care] is more about: how do we do this to strengthen our ability to meet people's needs in general?"

NIHB: *What is your vision for 2SLGBTQ+ health?*

Itai: "It's not enough to bring [Indigenous 2SLBGTQ+ communities] to the level of wellness that our [Indigenous] communities currently have. That's garbage, right? I want for our entire [Indigenous] communities to get a sense of our health that comes from engaging with our traditions and our community practices in healthy way – regaining access to our foods and languages and all the things that we know will actually precipitate good health again."

CONNECT WITH PATHS (RE)MEMBERED

There are countless ways to connect with the Paths (Re)Membered Project, including the following:

- ***Mental health services***: The Paths (Re)Membered Project provides *no cost* mental health services to Indigiqueer 2SLGBTQ+ persons aged 15 and older in 32 states.
- ***Children's books***: Co-authored by Victoria Persinger Ferguson (Monacan) and Itai Jeffries (Yesah/Occaneechi), *Sassy Sassafras: A Two Spirit Story* is a children's book available at no-cost.
- ***Clinician consults***: Indian Country ECHO offers free, one-on-one confidential consults for clinicians caring for Indigenous 2SLGBTQ+ patients.
- ***Order the toolkit***: Digital and print copies of the Celebrating Our Magic Toolkit are available. Two Spirit and LGBTQ+ Pride Toolkits include pronoun pins, one-pagers about pronouns and gender identity, pamphlets, and more.
- ***Strategic plan***: The Trans and Gender-Affirming Care Strategic Vision and Action Plan provides tools to transform clinical environments to be 2SLGBTQ+ affirming.
- ***Blog, podcast, and films:*** The Two Spirit Talks podcast and monthly blog posts are available through the Paths (Re) Membered website, along with three films highlighting the importance of 2SLGBTQ+ pride.
- ***Text lines:*** Text ALLY to 97779 to learn more about creating affirming spaces for 2SLGBTQ+ communities. Text 2SLGBTQ to 97779 for 2SLBGTQ+ persons seeking support.

Remember, the solutions to affirming 2SLBGTQ+ people already live in Indigenous communities. Itai shares, "We have really great examples in our community for what it means to affirm people, and we have to apply those same things that we know to 2SLGBTQ+ people. Look at aunties…if you go into an auntie's house, how many times are you going to be asked if you want some food or you want something to drink? You're going to be made to feel comfortable…Give yourself a pat on the back for what we already know from our community…I don't want people believing it's so difficult to meet the needs of 2SLGBTQ+ people because I don't think most of the solutions are actually that complex."

To connect with Paths Re(Membered) Project, please visit pathsremembered.org.

Members of the IHS National Tribal Budget Formulation Workgroup celebrate two long days of work on the Fiscal Year (FY) 2025 Budget Request.

National Tribal Budget Formulation Workgroup Publishes Fiscal Year 2025 IHS Budget Request

Imagine having only one day's worth of food for a week: for generations. In terms of federal funding, Congress provides about seven times less than the estimated need for Indian Health Service (IHS) by the National Tribal Budget Formulation Workgroup (NTBFW), an estimate that currently excludes authorized but unfunded provisions in the Indian Health Care Improvement Act. Tribal leaders hope to change this in collaboration with the Biden-Harris Administration through the NTBFW.

Tribal leaders on the NTBFW, serving all 574 federally recognized sovereign Tribes throughout the twelve IHS Areas, met February 14-15, 2023, to exercise their right to provide meaningful input on IHS budgets and policy in formulation of the President's Fiscal Year (FY) 2025 Budget Request to Congress. Since 2003, Tribal leaders, technical advisors, and other policy advisors have met each year during the annual National Tribal Budget Formulation work session to collaboratively develop an estimate of the cost to fully fund the obligations of the IHS.

The Workgroup maintained its request for full and mandatory funding for the IHS, estimated at $53.85 billion in FY 2025, but also discussed the need to hold IHS harmless from any spending cuts or control measures by Congress and the unique impacts of substance use and mental health crises in tribal communities that need special resources. The Workgroup held firmly that IHS advance appropriations should be expanded to include all IHS accounts and must be sustained and increased until Congress fulfills its duty the way it was intended – as a mandatory obligation in the performance of a bargained-for exchange. The Workgroup also discussed proven successful programs that result in cost savings for the federal government, such as Special Diabetes Program for Indians (SDPI). The Workgroup called for an increase, improvements, and permanent reauthorization for SDPI. Lastly, the Workgroup continued to recognize that wraparound care and operational efficiency depend on programs and services outside of IHS, calling on continued collaboration across agencies on Tribal policy.

On March 10, 2023, NIHB Chairman William Smith testified before the House Appropriations Subcommittee calling on Congress to enact the Tribally-driven, data-based cost estimates and justifications of the NTBFW. In direct response to Smith's testimony, Congressman Mike Simpson (R-ID), chairman of the subcommittee, identified a spending disparity for healthcare costs between the general population and American Indians and Alaskan Natives (AI/ANS) and said the subcommittee would not cut Indian Healthcare in the budget.

"We are going to have to prioritize Indian Healthcare in these budgets," said Chairman Simpson. "I spoke to my staff and said, 'what are we going to do when we get a budget that requires 25% cuts?' There are some areas we are going to have to protect. Indian Healthcare is going to be one of them."

In the Workgroup's FY 2025 request, Tribal leaders commented that at 1/7, or roughly 14 percent, of the estimated obligation for IHS, federal spending on Tribal health is stuck in the Termination Era. Tribal nations seek no more than the duty affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law. The Workgroup asserts that the US is only as strong as its word to its people, and to honor its promise to the people, the US must honor its promise to this land's First People.

THE SPECIAL DIABETES PROGRAM FOR INDIANS SPOTLIGHT:

Cheyenne River Sioux Tribe Youth Diabetes Prevention Program

"I am proud we can teach our kids that diabetes won't be part of their lives. It doesn't have to ever affect them"

Michelle Moran - Walking Elk, Program Coordinator, CRST Youth Diabetes Prevention Program

SDPI
SPECIAL DIABETES PROGRAM FOR INDIANS

Since 1998, The Cheyenne River Sioux Tribe (CRST) Youth Diabetes Prevention Program (YDPP) has aimed to stop diabetes before it starts. The YDPP is unique in their approach, which focuses on prevention and targets high risk school-aged children and empowers them and their families to change the narrative that diabetes will impact their lives.

Although the program is small in terms of staffing, the eight team members of the YDPP have a huge reach. CRST is a very rural community spanning 4000 sq miles, with 16 outlying communities in South Dakota. The dedicated team at the YDPP built partnerships with all five reservation school systems to ensure they can screen children across their Tribal nation and start prevention early. This past fall, the program screened 551 children, and identified 353 (64%) that were at high risk for diabetes based on Body Mass Index (BMI) percentile. These children are offered blood sugar (A1C) screenings, and referred to primary healthcare providers, in addition to receiving community-directed prevention and education activities meant to empower children and their families to take action and prevent diabetes.

Despite challenges with COVID-19, the program has proved that being a consistent presence has led to a deep trust in the community. "When parents or grandparents receive the letter stating that their child is at risk- we tell them don't panic, we can help you!" shared Michelle Moran-Walking Elk, the Program Coordinator for the YDPP, "If we have five or fifty participants, we keep showing up in the community to show we aren't going anywhere, and we are here to help."

SUCCESSFUL PROGRAMS EMPOWER AND EXCITE FAMILIES

The YDPP hosts a variety of activities for all the youth in their community and prioritizes the participation of the whole family to ensure a child's success. Up to 3000 people participate in the program's activities each year, and activities often emphasize connection across the community. YDPP hosts both walking and bike clubs. They've held bike competitions for all age groups, including bike races and relays where adults and children team up. They also hold lunch and learns and invite both children and their parents to attend to learn together. Many of these programs are guided by feedback from parents, and the program always strives to offer events and services that the community enjoys and finds valuable.

The YDPP's success stems from their willingness to go out into the community. Their longstanding partnerships with the school systems have proven invaluable in opening doors and reaching children. Securing a mobile unit for the program in 2015 has also been one of the program's greatest successes! The mobile unit lets the team create a meeting place anywhere they go, even in remote parts of the reservation, and has helped create visibility in communities across the Tribe.

SDPI CHANGES LIVES AT THE CHEYENNE RIVER SIOUX TRIBE

Program staff have seen an incredible impact from YDPP since SDPI began. Moran-Walking Elk has been with the program for 22 years and has watched children grow up without diabetes thanks to the education they received.

"We have the opportunity to prevent diabetes, and diabetes is huge here. I am proud we can teach our kids that diabetes won't be part of their lives. It doesn't have to ever affect them. Having that opportunity to change…

Continued on page 12

the mentality that 'my mom had it, my grandma had it, I'll have that too'- to change that, and empower children to make healthy decisions – I'm proud that we pick up that battle every day knowing this child will grow up and we had a part of contributing to the decision making of how they will choose to live," Moran-Walking Elk shared.

The YDPP has been recognized for their success at the national level, having received both the 2016 John Pipe Voices for Change Award for Outcomes Achievement by the American Diabetes Association, and the 2019 National Indian Health Board Local Impact Award. The YDPP has also presented diabetes prevention mobile unit services to the University of South Dakota, Sanford School of Medicine, Department of Family Medicine Grand Rounds.

RENEW SDPI TO SUPPORT THE CRST YDPP, AND OTHER SUCCESSFUL PROGRAMS

Programs like YDPP are making incredible progress in eradicating diabetes in their communities. SDPI enables this by providing needed resources, and by supporting Tribes in adapting the program locally to fit community 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. "Our funding hasn't increased with inflation — we end up topping out and not being able to extend or enhance. The funding delays and stagnant funding affects programs where you have to decrease staff- when I very first came, I had five outreach staff, now I'm down to three," Moran-Walking Elk shared,

> ***"You don't want to always be focused on money and programs — but it makes or breaks the program. We have to have funding come in on regular basis to be able to do the work."***

Funding limitations have limited the program's ability to track data on diabetes markers- something that is vital for the program to identify high risk children. The current grant structure of SDPI, which is legislated by Congress, includes data funds for SDPI, however, the data funds don't trickle down to Tribal programs. A lack of funding to modernize data systems slows progress and interrupts interventions for the students who need it the most.

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

INCREASES IN AI/AN HEALTH COVERAGE ENROLLMENT:

What's the Whole Story?

The newest American Community Survey data has been released. This article compares the Indian/Alaska Native (AI/AN) enrollment patterns from 2012 to 2021 to the enrollment patterns for the United States population in the areas of Medicare, Medicaid, Uninsured.

When looking at absolute changes, the data from 2012 to 2021 reflect that:

- AI/AN Medicaid Enrollment grew by almost 1.5 times more than US Medicaid Enrollment
- AI/AN Medicare Enrollment grew by 2.2 times more than US Medicare Enrollment
- Uninsured in the US fell by 1.5 times more than AI/AN Uninsured

However, when we consider the growth in population was 3.7 times larger for AI/ANs than for the US population, it is more informative to examine **changes in enrollment as a proportion of the population**. And we learn that:

- The percentage increase in Medicare enrollment from 2012 to 2021 as a proportion of the population for AI/AN and the US is almost the same.
- The percentage decrease in Uninsured from 2012 to 2021 as a proportion of the population for AI/AN and the US is almost the same.
- The percentage increase in Medicaid enrollment from 2012 to 2021 as a proportion of the population is almost 1.5 times higher for the US than AI/ANs.

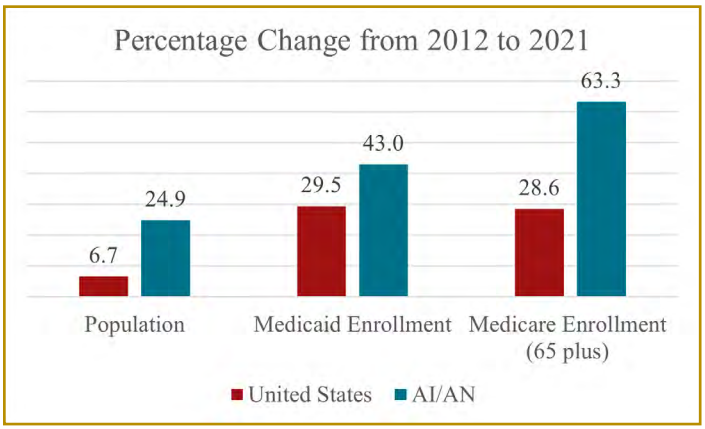
Overall, while it appears as though there are big differences in enrollment changes between AI/ANs and the US population, those differences lessen once the growth in population is accounted for.

DATA AND METHODS

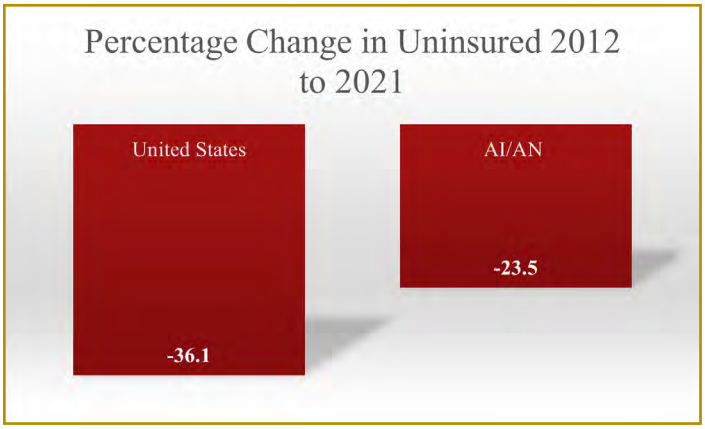
All data are from the American Community Survey five-year estimates for 2012 through 2021.[1] Please note that every estimate has a sampling error. The five-year estimates have increased statistical reliability for small population subgroups over the one-year data.[2] The analysis begins with 2012 as it is the year prior to the full implementation of the Affordable Care Act in 2013. AI/AN population is reported as the people who are American Indian or Alaska Native alone or in combination with one or more races.

POPULATION AND ENROLLMENT CHANGES FROM 2012 TO 2021

The chart below shows the percentage change in population, Medicaid enrollment, and Medicare enrollment for those age 65 and up from 2012 to 2021. Notice that from 2012 to 2021, the percentage growth in AI/AN population is 3.7 times more than the percentage growth in the US population. The US population grew from 309.14 million to 329.73 million. The AI/AN population grew from 5.04 million to 6.29 million. Thus, looking at the growth in Medicaid and Medicare enrollment shows that changes will be exaggerated by the differences in the growth in the respective population. However, note that from 2012 to 2021, the percentage growth in AI/AN Medicaid enrollment is about 1.5 times higher than the population as a whole and the percentage growth in AI/AN Medicare Enrollment is about 2.2 times higher.



The next chart below shows the percentage change in the number of Uninsured for AI/ANs and the US population. In this case, the percentage of Uninsured decreased. The percentage drop in Uninsured is about 1.5 times larger for the US than for AI/ANs from 2012 to 2021.



1 United States Census Bureau. (2023) American Community Survey (ACS) five-Year Estimates Public Use Microdata Sample, Vintage 2012- 2021. https://data.census.gov/mdat/#/. The five-year estimate data represents data collected over a period of the preceding five years. For example, the 2021 ACS five-year estimate data includes survey data from 2017-2021

2 United States Census Bureau. (March 17, 2022) American Community Survey 5-Year Data (2009-2020). https://www.census.gov/data/developers/data-sets/acs-5year.html

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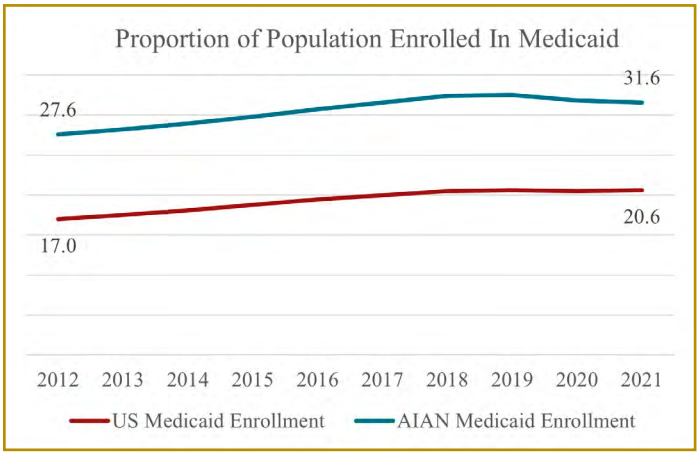
CHANGES IN ENROLLMENT AS A PROPORTION OF THE POPULATION

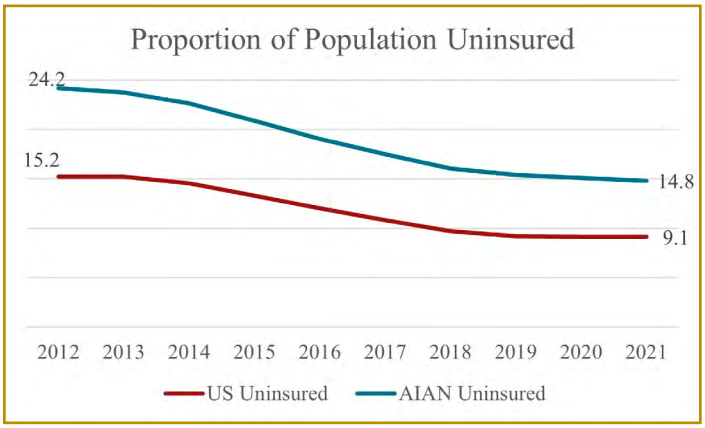
Because of the differences in the growth in population, it is difficult to compare the changes in enrollment by the actual enrollment numbers. To get a better idea of how enrollment changes compare between AI/ANs and the population, it is better to compare enrollment as a proportion of the population. The graph below shows the percentage of the population enrolled in Medicaid for AI/ANs and the US.



According to the graph above, in 2012, 17 percent of the US population was enrolled in Medicaid. In 2021, 20.6 percent of the population was enrolled in Medicaid. The proportion of the US population enrolled in Medicaid changed by 3.6 percentage points, or 21.4 percent, from 2012 to 2021. In contrast, the proportion of AI/ANs enrolled in Medicaid grew by 14.5 percent, or 4 percentage points, from 27.6 to 31.6 over the same time. In this case, AI/AN Medicaid enrollment is consistently above that of the US population, but the growth in the proportion of the population enrolled in Medicaid is almost 1.5 times greater than the growth of the proportion of AI/ANs enrolled in Medicaid from 2012 to 2021.

The proportion of the population age 65 and over enrolled in Medicare dropped by one percentage point from 2012 to 2021 from 96.7 percent to 95.7 percent. Similarly, the proportion of AI/ANs age 65 and over enrolled in Medicare also dropped by 1 percentage point from 2012 to 2021 from 95.8 percent to 94.8 percent. Note almost 95 percent of the elders aged 65 and up in the American Indian/Alaska Native community are enrolled in Medicare in 2021.

The final comparison can be seen in the chart below. The proportion of Uninsured in the US fell from 15.2 percent to 9.1 percent, a 40.1 percent decline. Similarly, the proportion of Uninsured AI/ANs fell by 38.8 percent from 24.2 percent to 14.8 percent. Note that the proportion of the AI/AN population uninsured is higher than in the US. But the percentage decline is very similar for the decrease in the proportion of AI/ANs uninsured to that of the US population.



Overall, while it appears as though there are big differences in enrollment changes between AI/ANs and the US population, those differences lessen once the growth in population is accounted for.

MATERNAL MORTALITY PREVENTION: Hear Her™ Campaign Centers American Indian/Alaska Native Families

Please note that this article discusses the topic of pregnancy-related deaths broadly. The National Indian Health Board recognizes this topic may be sensitive for readers and encourages all those impacted by maternal mortality to connect with their support networks.

STORYTELLING TO PREVENT MATERNAL MORTALITY

Mona experienced urgent maternal warning signs associated with pre-eclampsia, which can be fatal. Thankfully, Mona listened to her body and insisted that something was not right. Mona shared: "And that was really important to me to try and incorporate those traditional birth practices, some traditional teachings into that, because that's definitely gotten lost. I decided to go with the midwifery route. I really seeked out the wisdom and experience of a doula in that Taos Pueblo Doula provided so much information to me that nobody else really knew."

"Trust yourself. You are the expert of yourself, of your body, of your experience. And because you're the expert, you have the ability and the knowledge to really advocate for yourself. And if somebody is not listening to you, then talking to somebody else and saying this doesn't feel right, and understanding the power and the strength that you have that you can advocate for yourself in order to get, you know, the equitable care that you deserve and you should have."

– Mona, Taos Pueblo of Taos Pueblo, New Mexico

Trivia, Miniconjou Lakota Tribe of Cheyenne Rivers, South Dakota

Trivia's providers threw away her placenta against her wishes. She mourned the loss of her placenta, which is sacred in her culture. Then, she returned to the hospital to treat an infection and was told she could not nurse her child while on antibiotics. Trivia subsequently experienced urgent maternal warning signs associated with postpartum depression. Trivia shared: "My second child I had about a year later. I went into the second pregnancy with a mission. I was like a mama bear. I was in protective mode. The new doctor that I was working with not only heard me, he validated me. He let me know that he understood Lakota women's cultural practices when it came to packaging up the placenta. I felt relaxed and safe. I was really mindful and need to advocate myself choosing a safe primary care provider has been like at the top of my list."

"If you're uncomfortable that first visit change, you do not have to keep that person as your primary. If you feel that there is something wrong. Talk to your aunt, your mom, your best friend, your nurse. Your nurse should tell you that it's okay to call whenever they feel that they need to call. Go in, have it checked. Never discount your gut feeling. Always talk to somebody about how you're feeling if you're feeling depressed. If you're feeling that you're not good enough. If you're feeling that you can't go through with the birth. If you're having anxiety. If you're having fear. Reach out to someone. Don't do it alone. Voice how you feel."

– Trivia, Miniconjou Lakota Tribe of Cheyenne Rivers, South Dakota

WE LOSE TOO MANY AMERICAN INDIAN AND ALASKA NATIVE PEOPLE

Unfortunately, stories of pregnancy-related complications are all too common in our American Indian and Alaska Native communities. Losing someone during or after their pregnancy is traumatizing for families and communities. American Indian and Alaska Native (AI/AN) populations face a disproportionate maternal morbidity and mortality burden. AI/AN women have disproportionately high rates of maternal mortality. For every 100,000 live births to AI/AN women, there were 32 deaths related to pregnancy from 2017 to 2019. AI/AN women were nearly 2.3 times more likely to die from a pregnancy-related cause than non-Hispanic White women. While there is data in this area, we know that gathering and accessing accurate data presents a substantial challenge: racial misclassification and the relatively small sample size of AI/AN pregnant and postpartum people. Protecting AI/AN pregnant and postpartum people, their families, and Tribal communities in ways that uphold Tribal values and practices is essential for preventing maternal mortality in Indian Country. Urgent Maternal Warning Signs to Prevent Maternal Mortality

Nearly two-thirds of pregnancy-related deaths are preventable. One strategy to reduce maternal mortality is to support pregnant and postpartum people in recognizing urgent maternal warning signs and communicating these signs to family, caregivers, and providers to ensure they receive appropriate, affirming care. Pregnancy-related complications can occur up to a year after the end of pregnancy, with most maternal deaths

Continued on page 16

occurring in the postpartum period. Urgent maternal warning signs can include dizziness or fainting, extreme swelling, trouble breathing, or thoughts of harming themselves or their baby, among others. These signs or symptoms require immediate care, which can be negatively impacted by distance to a healthcare facility and limited access to culturally competent providers. Pregnant and postpartum people are often aware when something is wrong with their bodies, so it is important we listen to and uplift their voices.

HEAR HER CAMPAIGN FOR AI/AN COMMUNITIES

CDC, in partnership with the HHS Office of Minority Health and CDC Foundation, with support from Merck for Mothers, released a segment of the Hear Her™ campaign to amplify the voices of American Indian and Alaska Native people and work to improve maternal health outcomes by sharing culturally appropriate materials. NIHB worked with CDC to ensure Tribal voices and perspectives were reflected in the campaign. In November 2022, CDC released videos sharing the stories of five AI women affected by pregnancy-related complications, available at https://www.cdc.gov/hearher/personal-stories/index.html.

Each story is a powerful testament to AI/AN resilience and the sacred tradition of birth. These stories highlight the importance of listening to pregnant and postpartum people and their needs for culturally responsive, trauma-informed perinatal care providers, particularly AI/AN providers with shared cultural knowledge and experiences. The Hear Her campaign highlights the urgent maternal warning signs with posters, talking cards, and social media graphics.

HOW TO IMPLEMENT THE HEAR HER CAMPAIGN

To raise awareness of the urgent maternal warning signs and make sure pregnant and postpartum people are heard, we need help from all Tribes, Tribal organizations, and Tribal citizens to share resources from the Hear Her campaign. Methods to move the campaign forward may include, but are certainly not limited to, the following:

Listen and Respond – If a person who is pregnant or postpartum experiences an urgent maternal warning sign, they need to share their concerns. Everyone needs to listen and support them in getting the care they need. Since those conversations can be challenging, Hear Her has resources to help. The Hear Her palm cards (*see below*) are to help pregnant and postpartum people, or their support people, have difficult conversations about challenges they may be experiencing in their pregnancy and access care right away. For more resources, visit cdc.gov/hearher/aian.

Ordering Free Printed Materials – Your clinic or community organization can order Hear Her materials for free through the CDC Hear Her campaign. Posters, palm cards, and flyers can spread the Hear Her messaging. They are also available for download.

Social Media – Hear Her materials are available online and printed to distribute to pregnant and postpartum people, their families, and healthcare providers. Tribes and Tribal organizations can co-brand the urgent maternal warning signs materials with their Tribal logo and disseminate them broadly in their communities.

NIHB Activities – This summer, NIHB will host a virtual 2023 Maternal Mortality Prevention Institute (MMPI). We invite you to participate in the 2023 MMPI and connect with other perinatal and public health professionals working to prevent AI/AN maternal mortality. If you are unable to join us, consider listening to past webinars and follow our Maternal Mortality Prevention webpage for upcoming events and opportunities. For more information, email Elisha Sneddy at ESneddy@nihb.org.

Birth Storytelling and Talking Circles – To build awareness of maternal mortality in your community, consider starting talking circles regarding the Hear Her video stories and your own pregnancy, birth, and postpartum stories. Healthcare providers should consider discussion groups about listening to AI/AN patients and confronting discrimination in pregnancy care.

Sharing Your Story – There are many ways to open the conversation about maternal mortality prevention and the urgent maternal warning signs. You are also invited to reach out to the Hear Her campaign at **HearHer@cdc.gov** to share your pregnancy and postpartum stories if, when, and how you feel.

Writing Your Story – You can help others find resources to process and share their birth and postpartum stories. Some questions to consider when writing birth and postpartum stories include:

- ***How did I feel during my pregnancy and birth journeys?***
- ***Who was in my birth space?***
- ***How did my perinatal providers make me feel?***
- ***How did my care team communicate with me?***
- ***What did decision-making look like?***

NIHB Strong Systems, Strong Communities Grant Helps Pascua Yaqui Tribe Receive National Public Health Accreditation

"Lios Enchim Ania Vu, the Pascua Yaqui Tribe is extremely honored to receive the Health Department Accreditation designation from the Public Health Accreditation Board. Our staff worked long, hard hours to achieve this goal.

We are grateful for the fact that going through the accreditation process prepared us to quickly respond to the Covid-19 epidemic by encouraging us to examine and update our Public Health Codes and internal processes regarding infectious disease.

This accreditation would not have been possible without the support and guidance of our Tribal leadership and the voices of the Tribal members we serve. Thank you.

In closing, we'd like to extend our appreciation to NIHB for their financial and technical support during this challenging process and we enthusiastically encourage other Tribal Health Programs to pursue this designation. We support the Accreditation process, and our staff is very willing to assist other Tribes who may want to pursue it."

— Reuben Howard, PYT Health Department Director

The Pascua Yaqui Tribe received national public health accreditation status in August of 2021 with assistance from the National Indian Health Board's (NIHB) Technical Assistance and the Strong Systems, Strong Communities (SSSC) grant program. This success is Performance Improvement and Systems Improvement (PISI) in action.

The Pascua Yaqui Tribe's Health Services Division (PYHSD) developed and implemented community emergency response training and operations plans, evaluated their data systems, and developed tools to assess their performance management and quality improvement. PYHSD also provided staff emergency preparedness training, allowing the department to improve its response to public health emergencies. PYHSD invested in access and training in performance management software for cross-departmental staff. They also developed "train the trainer" tools that can be updated and used as needed.

Since achieving accreditation, PYHSD has partnered with and supported NIHB efforts to expand public health capacity in Indian Country by contributing to webinars, providing technical assistance to other Tribes, and contributing to national accreditation efforts to advance Tribal accreditation resources and inclusiveness as a part of the Tribal Public Health Accreditation Advisory Board (TPHAAB). Their demonstrated partnership has not only helped NIHB improve the resources available to Tribes but increased the spirit of comradery through peer-to-peer engagement.

NIHB EFFORTS TO SUPPORT PISI

NIHB has supported Tribes' PISI activities in various capacities, including providing technical assistance, bridging gaps in networking, and funding PISI projects through the Strong Systems, Strong Communities (SSSC) grant program. This funding opportunity, provided by NIHB and supported by the Centers for Disease Control and Prevention (CDC), offers support and technical assistance specifically to Tribes as they complete projects to improve their performance, meet national public health accreditation standards, and promote interconnection across the public health system to improve population health.

MORE INFORMATION ON PERFORMANCE IMPROVEMENT AND SYSTEMS IMPROVEMENT (PISI)

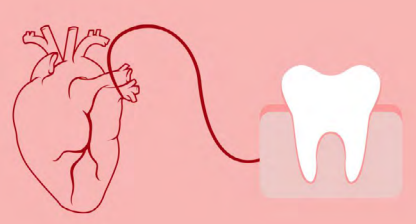
An essential part of ensuring efficient public health services for Tribes includes conducting organized and intentional performance and systems improvement efforts. Performance improvement involves formal activities addressing how Tribal public health departments plan, monitor, and improve their activities and programs. Systems improvements in public health engage the coordination and support of organizational and multi-sector personnel and resources. PISI is woven throughout the path to public health accreditation as it measures a department's performance against national standards. Both contribute to program-specific and overall department capacity to provide services leading to better health outcomes. Examples of PISI in action include many common public health department activities, including:

- Assessing community health needs through community health assessments
- Development of community health improvement plans
- Development of workforce development plans
- Tracking and evaluating progress of public health services
- Convening of coalitions and partners to inform and guide public health efforts

Systems improvements also leverage stakeholder engagement through relationship building and offer opportunities to emphasize equity-focused efforts and systems-level improvements by integrating resources, such as space, data, or personnel.

TAKE ACTION!

As NIHB works to find the most effective ways to support Tribes in their public health capacity building, our work would not be possible without the many Tribes who share their experiences and expertise with us and others. To learn more about SSSC funding and other PISI opportunities, please contact Jessica Dean, Public Health Policy and Programs Project Coordinator, at jdean@nihb.org. More information on the PYHSD can be found at PYTHEALTH.ORG.

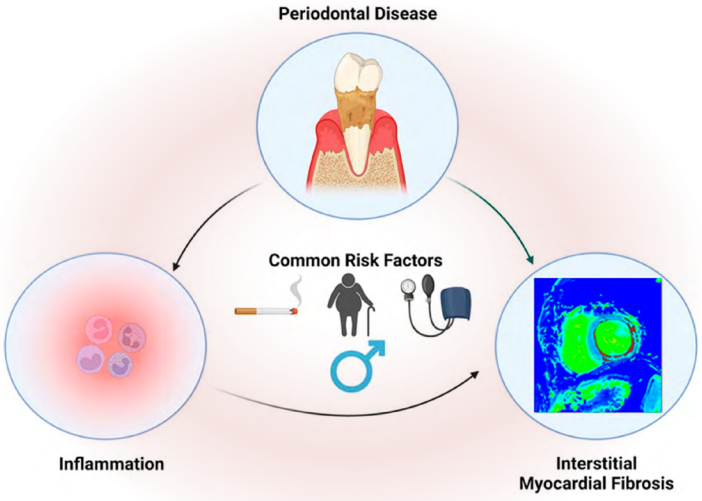


ORAL HEALTH AND HEART DISEASE: Establishing Access for Oral Health Care in Prevention of Cardiovascular Disease

The prevalence of cardiovascular disease (CVD) has increased in American Indian/Alaska Native (AI/AN) populations due to historical health inequities, such as broken treaties, exclusionary governmental policies, and structural discrimination. Because of this, AI/AN communities are at a higher risk of developing cardiovascular disease than non-Native populations.[3] Other contributing factors to CVD, such as diabetes, obesity, mental health, poor nutrition, and lack of physical activity, also pose a challenge in Tribal communities.

National Indian Health Board
Tribal Oral Health Initiative

We know that having a healthy heart is related to physical activity and a nutritious diet, but rarely do we consider that proper oral hygiene can influence our heart health as well. Research has shown that poor oral health is connected to cardiovascular disease and can lead to higher mortality rates[2]. Oral health conditions, such as periodontal disease, are a factor in the degradation of the teeth and overall oral health status.[9] Inflammation-causing bacteria in the oral cavity causes periodontal disease, as well as other infections that occur in untreated teeth and in individuals with caries or cavities, possibly leading to tooth loss and systemic inflammation.[9, 11] Periodontal disease develops from a lack of proper oral hygiene, such as brushing, flossing, and obtaining dental exams to address any issues with the teeth. Many Tribal communities are in rural areas which lack considerable dental care access, which, in turn, contributes to higher rates of cavities and other oral health conditions, and, ultimately, cardiovascular disease. Increasing oral health access in Tribal communities, regardless of their location, is vital if we want to decrease AI/AN rates of cardiovascular disease.



Currently, dental therapy is authorized in thirteen states with only four authorizing dental therapists to practice on Tribal land.[5] The Indian Health Service (IHS) and the Special Diabetes Program for Indians (SDPI) established a Healthy Heart Toolkit, which integrates interventions for tribes in CVD risk reduction programs that can help reduce CVD risk, both in individuals with and without diabetes.[8] Allowing dental health aide therapists to practice in Tribal communities can contribute to the decrease in not only oral health diseases but to the overall health and well-being of AI/AN people.[5] Establishing optimum, equitable, and accessible care in oral health to AI/AN communities would not only help to decrease rates of Native cardiovascular disease but would help to decrease mortality rates as well.

Resources

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NIHB Outreach and Education Team Using New Avenues to Make Impact in Tribal Health

The onset of the COVID-19 pandemic brought revolutionary new ways of delivering, accessing, and providing health care worldwide. Particularly within the American Indian and Alaska Native (AI/AN) community, new barriers to care created challenges. More than ever, outreach and education on new policies, procedures, and techniques related to the disease were vital to Tribal communities. The National Indian Health Board (NIHB) works diligently to provide outreach and education on every new emerging topic related to the COVID-19 pandemic.

NIHB's outreach and education team began creating and disseminating new and emerging information to ensure broad distribution across Indian country. Specifically, NIHB helped to alleviate many of the barriers that Tribal Enrollment Assisters and Certified Application Counselors (CACs) had when communicating important health care provisions. Before the pandemic, many Tribal clinics and hospitals were primarily rudimentary. Individuals would come into the clinic and personally see their CACs and Tribal Enrolment Assisters for guidance on health care issues. Because of the social distancing requirements, getting information out became an essential task for NIHB to help CACs and Tribal Enrollment Assisters.

NIHB's outreach and education department utilized its website and social media platforms to provide relevant information related to the COVID-19 pandemic and other guidance Tribal Enrollment Assisters, and CACs would have shared personally with their members. Examples include NIHB's Enrollment Assister Toolkit, the Affordable Care Act Toolkit for Tribal Youth, and a Story Banking Campaign related to health care coverage through the Centers for Medicare and Medicaid Services. Additionally, NIHB recognized the need to outreach to the youth. Through a youth website, NIHB helped Tribal youth learn about best practices in health care related to the COVID-19 pandemic for themselves and their families. To become even more inclusive of other forms of media that can be used throughout Indian Country, NIHB created its Hope and Healing Podcast. This podcast allowed NIHB to connect to Tribal members and Tribal entities who were eager to learn more about Tribal health care policies and special protections.

NIHB remains diligent in providing outreach and education to federal agency departments and leaders on AI/AN healthcare-specific privileges and needs concerning COVID19 and third-party reimbursement. During this time, the Biden Administration also increased outreach and education efforts to help AI/AN learn about the increased benefits.

Overall, outreach and education has become one of the most critical ways for Tribal members to understand better health care, health care coverage, and the benefits they are entitled to within the healthcare system. Similarly, outreach and education has also remained a valuable tool in breaking barriers related to the federal government's lack of understanding of the health care needs of Tribal communities and members.

Tribal Perspectives on Health Equity

In 2021, the Biden-Harris Administration announced health equity as a cornerstone of Administration policy. This priority came at a critical time: health equity is a crisis in Indian Country. As the Centers for Disease Control and Prevention (CDC) recently reported, life expectancy for American Indians and Alaska Natives (AI/AN) has dropped in recent years, falling to nearly 11 years less than for the general U.S. population. But as health professionals and policymakers made plans to advance health equity, AI/AN voices were missing from the conversation.

Over the past year, the National Indian Health Board (NIHB) convened Native health leaders from across the country to fill that gap. Through three major health equity events with a total of over 600 participants, NIHB investigated two critical questions:

- **What are the key drivers of health inequities for AI/AN?**
- **What does health equity mean from a Tribal perspective?**

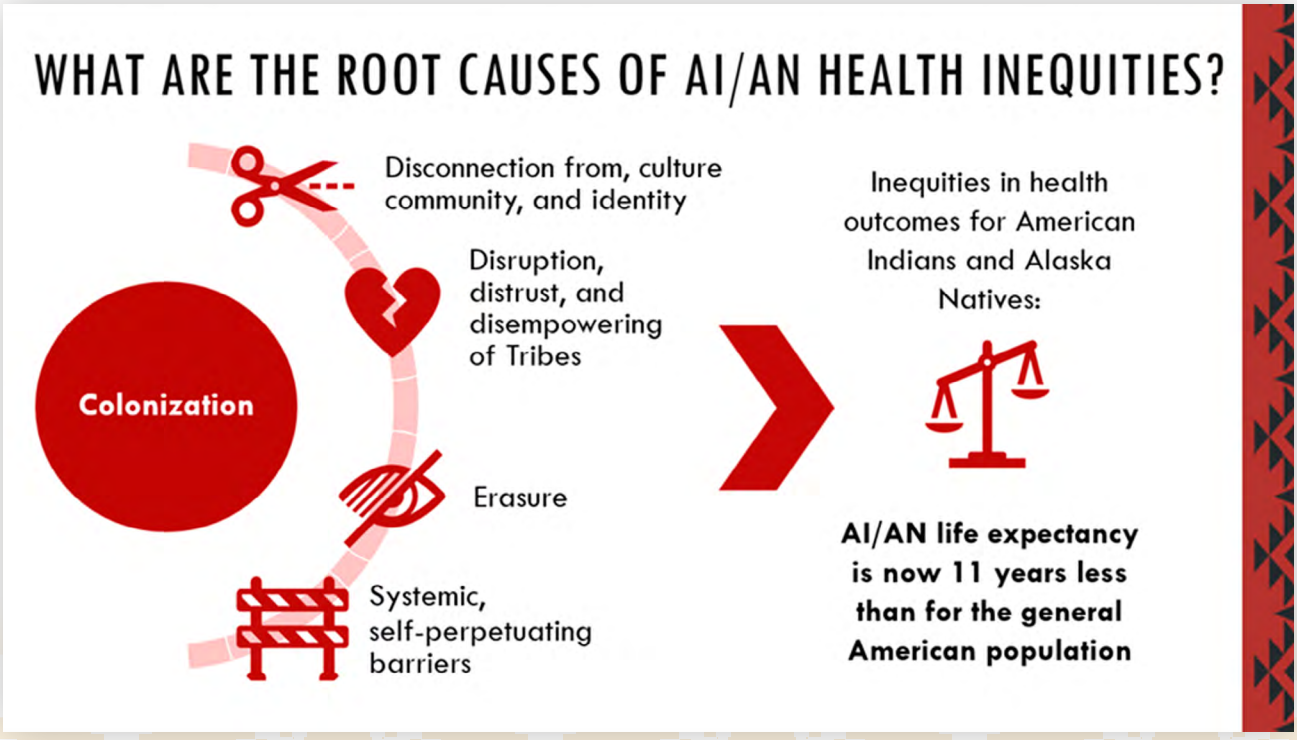
Several key themes consistently emerged as fundamental to any health equity work in Indian Country.

KEY DRIVERS OF AI/AN HEALTH INEQUITIES

A core focus of health equity work in the United States has been on social determinants of health: the role played by factors like housing, economic security, access to healthy food, education, and other aspects of daily life. These social determinants – the conditions in which we live, learn, work, play, and worship – are powerful forces in shaping health outcomes. But underlying those social determinants are structural factors that influence the distribution of power and resources and shape the social determinants of health. For American Indians and Alaska Natives, colonization is by far the most influential structural determinant driving the health inequities we see in Tribal communities.

The systemic issues which give rise to AI/AN health inequities are rooted in the long history of harmful federal Indian policies: genocide; uprooting AI/ANs from homelands and Tribal community structures; bans on cultural practices and language; forced relocation to reservations; abusive boarding schools; and other destructive polices. These colonialist policies resulted in disconnection from community, identity, and culture. Colonization disrupted traditional governance and societal structures, and fostered distrust between tribes and state and federal governments. Colonialist policies intentionally erased AI/AN people from the national consciousness and created the systemic, self-perpetuating barriers our Tribal communities continue to face – like generational poverty and barriers to education and job opportunities. These are the key drivers of the health inequities we are experiencing now.

Maintaining a clear vision of these drivers is important for two reasons. First, these root causes are the reason we use the language of "health inequities" and not just "health disparities" – these differences in health outcomes are not coincidence. They are instead the result of a long history of societal injustices. Second, once we understand where the root causes of inequities lie, we know where to focus to work for health equity. Each of these drivers becomes an opportunity for meaningful change.



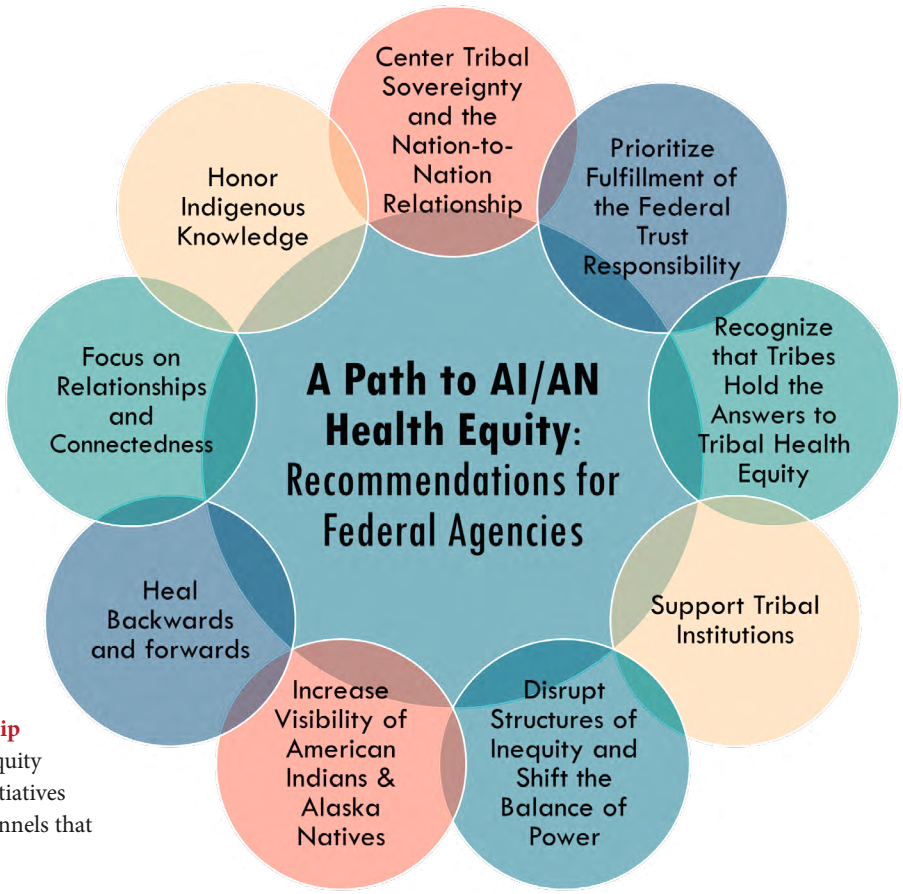
FOUNDATIONS OF HEALTH EQUITY IN INDIAN COUNTRY

Participants consistently agreed on the core concepts of health equity in Indian Country; they also commonly cited these foundational pieces as the parts most often missing from federal health equity initiatives. Any federal work on health equity for AI/ANs must be grounded in thorough comprehension and respect for **Tribal sovereignty** and the **federal trust responsibility**. This starts with four key aspects:

- "American Indian and Alaska Native" is first and foremost a **unique political status**, and is only secondarily, and in specific contexts, a racial identity.
- **Respect for the Nation-to-Nation relationship** must be the foundation of any federal health equity initiatives in Tribal communities. Health equity initiatives must flow through the appropriate diplomatic channels that respect the authority of Tribal governments.
- **Timely, meaningful, and robust Tribal consultation** is critical to ensuring policies and health equity plans are appropriate and effective for Indian Country.
- Health equity initiatives for Indian Country must always be Tribally led to **uphold Tribal self-determination**. Tribes should control the resources, plans, policies, and goals intended to achieve health equity for their people. Tribes know their people, communities, social and historical contexts, needs, and strengths best.

Finally, health equity initiatives for Indian Country must remain **rooted in strengths, resilience, and Native identity**. Colonization and the worldviews and values introduced by the colonizers have led to the devastating health inequities Tribal communities are experiencing – but leaning into traditional Indigenous values and worldviews opens new pathways forward. Indigenous knowledge, connection to community and culture, and traditional healing are essential to advancing health equity. We can only achieve health equity for Indian Country when we approach it through a Native lens.

As the Biden-Harris Administration raises health equity to a government-wide priority, moving forward will require both a nuanced understanding of the unique context of Tribal health equity and a commitment to action. Health equity can be difficult, messy work. It sets out a vision for the future of justice and wellness for all, and then



holds that vision up next to our current ugly reality. Nothing is neat or tidy about untangling the lingering lines of colonization's legacy within government systems and policies. Advancing health equity, therefore, requires a commitment to honesty, integrity, and a persevering hope that this vision is possible, and we will make it a reality. With sufficient federal commitment, we could eliminate the health inequities in life expectancy for AI/AN in one generation. It is only a question of willpower and values.

The federal government is most effective in working towards health equity when it puts its resources behind supporting the leadership of Tribal communities. Tribes have the answers. We know what needs to be done. Health equity in Indian Country cannot wait. **It's time to act.**

Read NIHB's report on Health Equity in Indian Country here.

Follow this QR code for more Tribal Health Equity resources from NIHB.

ENVIRONMENTAL HEALTH: Water Safety, Sanitation and Education for Tribal Youth

Environmental health is the branch of public health focusing on how the environment affects human health, particularly in regard to water safety, sanitation, and education. The goal of environmental health is to promote and protect public health by addressing environmental factors that impact human health, and to create sustainable solutions that can benefit both current and future generations. Environmental health professionals work to do this by monitoring and assessing environmental conditions, developing and implementing policies and regulations, educating individuals and communities about proper hygiene and sanitation practices, and collaborating with other sectors to ensure a healthy environment that supports human well-being and sustainable development.

Household water insecurity is a global threat to human health and development, yet existing metrics lack a systematic consideration of geographic inequality and spatial variation. Plumbing poverty, or households that do not have running water, an indoor bathtub or shower, and/or are lacking a toilet, is understood in a dual sense: first, as a material and infrastructural condition produced by social relations that fundamentally vary through space and, second, as a methodology that operationalizes the spatial exploration of social inequality. Plumbing incompleteness is spatially clustered in certain regions of the country and is clearly racialized: Living in an American Indian or Alaskan Native, Black, or Hispanic household increases the odds of being plumbing poor, and these predictors change the health outcome drastically. Fifty-eight out of every 1,000 Native American households lack plumbing, compared with three out of every 1,000 white households, according to a report by the U.S. Water Alliance[1]. This disparity has implications for public health - Native Americans experience more deaths, poverty, and higher unemployment rates.

As the National Indian Health Board (NIHB) builds out the environmental health resources available to Tribes, an identified need revolves around community education. NIHB is creating an interactive learning module series on water, air, and land, starting with water. The module will train participants in recognizing the risks of water pollution and go over safety precautions and materials that can be used to provide clean, accessible drinking water throughout Indian Country. These modules will contain interactive activities demonstrating water salination practices and how they can be used in a Tribal healthcare setting. The module is scheduled for release this fall.

Environmental health plays a crucial role in safeguarding public health and promoting sustainable development by addressing environmental factors that can impact human health and well-being, especially within Tribal communities. This underscores the importance of a multidisciplinary approach to public health that considers not only individual behavior and biological factors, but also environmental determinants of health. By implementing evidence-based interventions and working alongside Tribes, NIHB is ready to help reduce the burden of disease caused by environmental factors and create healthier, more resilient communities for generations to come.

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Preparing for the Next Pandemic

Our lives were forever changed three years ago. The pandemic began in late 2019 when a novel coronavirus called SARS-CoV-2 emerged in Wuhan, China. Since then, the virus has spread rapidly around the world, causing millions of deaths and disrupting economies, societies, and healthcare systems on a global scale. Whether the virus came from a lab leak or a wet market, COVID-19 turned our lives upside down. A worldwide pandemic was declared, and we were shut down. In-person work, for those not considered "essential," was put on hold; in-person school, travel, visiting, healthcare appointments, entertainment, etc., all stopped. Hospitals were overwhelmed with patients suffering from the virus, and people seeking medical care for non-COVID illnesses or injuries had no place to go. Since then, vaccines have been developed and continue to be available to reduce the chance of sickness, hospitalization, or death from COVID-19. Through several variants of COVID-19, we have all learned some things:

- **Pandemics happen, and we need to be prepared for the future.** Emerging infectious diseases have been discovered over the last several years worldwide, including Ebola, Zika, Middle East respiratory syndrome coronavirus (MERS-CoV) and Chikungunya, in addition to COVID-19. Being prepared means having the plans, resources, and capacity to prevent, detect, and respond to any infectious disease threats.

- **Collaboration, cooperation, and communication are necessary to be successful in any challenging journey.** Creating or joining a team helps prevent isolation and can really be helpful in times of trouble. Seeking out information from credible, trusted resources can prevent misinformation and confusion.

- **Science and innovation are important in any public health emergency.** Tests, medication, and vaccines to detect, treat and prevent devastating diseases like COVID-19 are life-saving strategies. Ongoing research and technology can change lives for the better.

- **Taking care of ourselves with nutrition, hydration, and exercise can reduce the chances of poor outcomes with any disease or injury.** Engaging in physical activity every day can strengthen the body and improve mental health.

While SARS-CoV-2 is not gone from our lives, we may be able to at last take a deep breath and think about what people have been telling us for a while: Be prepared. What does it look like to be prepared for the next pandemic? Some opportunities for improving our responses to epidemiologically concerning events include having an emergency preparedness plan.

An emergency preparedness plan for an individual could include the following:

1. **Stay informed:** stay up to date with the latest guidelines and recommendations from public health authorities, like the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO).
2. **Prepare a supply kit:** prepare a kit that includes essential items such as nonperishable food, water, medication, and personal hygiene items. The kit should be sufficient for at least three days.
3. **Develop a family emergency plan:** develop a family emergency plan that includes a communication plan, an evacuation plan, and a plan for meeting up in case of separation.

Celena Ghost Dog (Left) and Tommy Ghost Dog Jr. (Right) from the Northwest Portland Area Indian Health Board presented during a session at NIHB's 2023 Spring Infectious Disease Institute in Seattle, Washington.

At NIHB's 2023 Spring Infectious Disease Institute, attendees had the opportunity to strategize the application of infection control principles to protect their communities while participating in workshops, discussions, and other interactive activities aimed at fostering peer-to-peer networks and building disaster resilience across Indian Country.

4. **Practice good hygiene:** practice good hygiene habits such as washing hands regularly, covering coughs and sneezes, and avoiding close contact with sick individuals.
5. **Get vaccinated:** give vaccinated against diseases that are preventable through vaccination, such as the flu.
6. **Follow public health guidance:** follow public health guidance, such as wearing masks and practicing physical distancing, to help prevent the spread of infectious diseases.
7. **Seek medical attention when needed:** seek medical attention when experiencing symptoms of an infectious disease or if you have been in close contact with someone who has an infectious disease.

By taking these steps, individuals can be better prepared for public health emergencies and help prevent the spread of infectious diseases.

Continued on page 24

Tommy Ghost Dog Jr. from the Northwest Portland Area Indian Health Board presented on WeRNative's strategies to increase COVID-19 vaccine confidence through social media during NIHB's 2023 Spring Infectious Disease Institute.

An emergency plan for an organization or community could include the following:

1. **Assess potential risks:** the first step in developing an emergency preparedness plan is to assess potential risks. This can include identifying the types of emergencies that are most likely to occur in your area, such as pandemics, natural disasters, or terrorist attacks.
2. **Develop an emergency response team:** identify key stakeholders who will be involved in emergency response efforts, such as healthcare professionals, emergency responders, and community leaders. Develop a plan for how these stakeholders will communicate and coordinate with each other during emergencies.
3. **Develop communication protocols:** develop a plan for how emergency information will be disseminated to stakeholders and the public. This can include developing communication protocols for social media, traditional media, and other channels.
4. **Develop a plan for resource allocation:** develop a plan for how resources, such as medical supplies and personnel, will be allocated during emergencies. This can include developing protocols for prioritizing patients and allocating resources based on need.
5. **Develop a plan for continuity of operations:** develop a plan for how organizations will continue to operate during emergencies. This plan should include developing protocols for remote work and developing contingency plans for how to maintain critical operations if key personnel are unavailable.
6. **Train and educate stakeholders:** train and educate stakeholders on emergency response protocols and procedures. This can include providing training on how to use personal protective equipment, how to administer vaccines and treatments, and how to provide mental health support to individuals affected by emergencies.
7. **Review and update the plan regularly:** emergency preparedness plans should be reviewed and updated regularly to ensure that they remain current and effective. This can include conducting regular training exercises and simulations to test emergency response protocols and procedures.

By taking these steps, individuals, communities, and organizations can develop effective emergency preparedness plans that enable them to respond quickly and effectively to pandemics and other emergencies.

Preparing for the Next Pandemic ▪ *continued*

Some other considerations in emergency preparedness include:

1. **Investing in public health infrastructure:** governments should invest in building and maintaining strong public health infrastructure, including a robust surveillance, and reporting systems, effective Disease Control measures, and sufficient funding for research and development of new treatments and vaccines.
2. **Strengthening healthcare workforce:** there is a need to train and equip healthcare workers to better respond to pandemics, including providing access to adequate personal protective equipment (PPE) and training on how to use it safely. There is also a need to ensure adequate staffing levels and resources to prevent burnout and maintain high-quality care.
3. **Developing technologies:** there is a need to invest in the development of new technologies that can help identify, track, and respond to pandemics more effectively, such as telemedicine and digital health tools.
4. **Improving collaboration and coordination:** collaborative collaboration and coordination across local, national, and international levels are essential to ensure timely and effective responses to pandemics. Countries and organizations must share data and best practices and work together to develop and distribute vaccines and other essential medical supplies.
5. **Addressing underlying social determinants of health:** pandemics disproportionately affect vulnerable populations, including those with underlying health conditions and those in low-income and marginalized communities.
6. **Addressing the underlying social determinants of health:** such as poverty, housing insecurity, and access to healthcare, is essential to prevent and mitigate the impacts of pandemics.

By taking these steps, we can build a more resilient and responsive healthcare system that can better withstand and manage the impact of pandemics. Improving public awareness and education includes providing accurate and timely information, encouraging behavior change, empowering communities, providing access to mental health resources, and investing in health literacy. Delivering communication in a culturally appropriate manner can help prevent misunderstandings and disregard of information and enhance healthcare outcomes.

References:

- Centers for Disease Control and Prevention (CDC) https://emergency.cdc.gov/planning/
- Ready https://www.ready.gov/
- World Health Organization (WHO) https://www.who.int/publications/i/item/a-strategic-framework-for-emergency-preparedness
- American Red Cross https://www.redcross.org/get-help/how-to-prepare-for-emergencies.html

ACT OF LOVE

ACT OF LOVE PROMOTION:

The Act of Love campaign, launched by the National Indian Health Board in 2020, originally started to depoliticize wearing a face mask at the beginning of the COVID-19 pandemic. Since then, it has shifted into a way to encourage American Indians and Alaska Natives across the country to roll up their sleeves and get their COVID-19 vaccine to show their **Act of Love** to their community. We further encourage other Acts of Love such as hand washing, wearing a face mask, and social distancing. NIHB is committed to reinforcing that these measures are not political, rather, they are healthy, caring measures, and therefore, an Act of Love to our communities.

With the end of the COVID-19 Public Health Emergency on the horizon, it's important to start thinking of ways to keep yourself and your loved ones safe. Don't worry, though – there are still several ways to show your Act of Love! Access to COVID-19 vaccines and many treatments will not be affected, so we recommend keeping your protection up-to-date by getting boosted. We also recommend other Acts of Love like wearing a facemask if you're not feeling well and washing your hands often. You can also order your *free* Act of Love kit at https://www.nihb.org/covid-19/act-of-love/.

Save the Date

NIHB Maternal Health Webinars
May 23, 2023
June 27, 2023
via Zoom

11th Annual National Native Harm Reduction Summit
July 11-12, 2023
Shooting Star Casino
Mahnomen, MN

Infectious Disease Institute
July 19-20, 2023
Albuquerque, NM

The National Tribal Opioid Summit
August 22-24, 2023
Tulalip, WA

Infection Control Bootcamp
September 19-21, 2023
Vancouver, Washington

Health Equity Data Symposium
September 26-27, 2023
Washington, DC

VACCINATION EVENT FUNDING:

Are you planning a vaccination event in your community? We want to help you fund it! NIHB is happy to announce a funding opportunity for Tribal governments, Tribal health departments, Tribal health care facilities/health systems, and organizations that work with Tribes hosting COVID-19 vaccination clinics, vaccine drives, back-to-school events, etc. These events must feature COVID-19 vaccines or boosters, but other vaccines may also be offered and promoted. To learn more about this funding, please contact Moones Akbaran, Public Health Project Coordinator, at makbaran@nihb.org.

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Health Reporter

SPRING 2023

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