SEE INSIDE FOR OUR MATERNAL HEALTH UPDATE

STORIES *of* HEALING, POLICY, *and* PARTNERSHIP

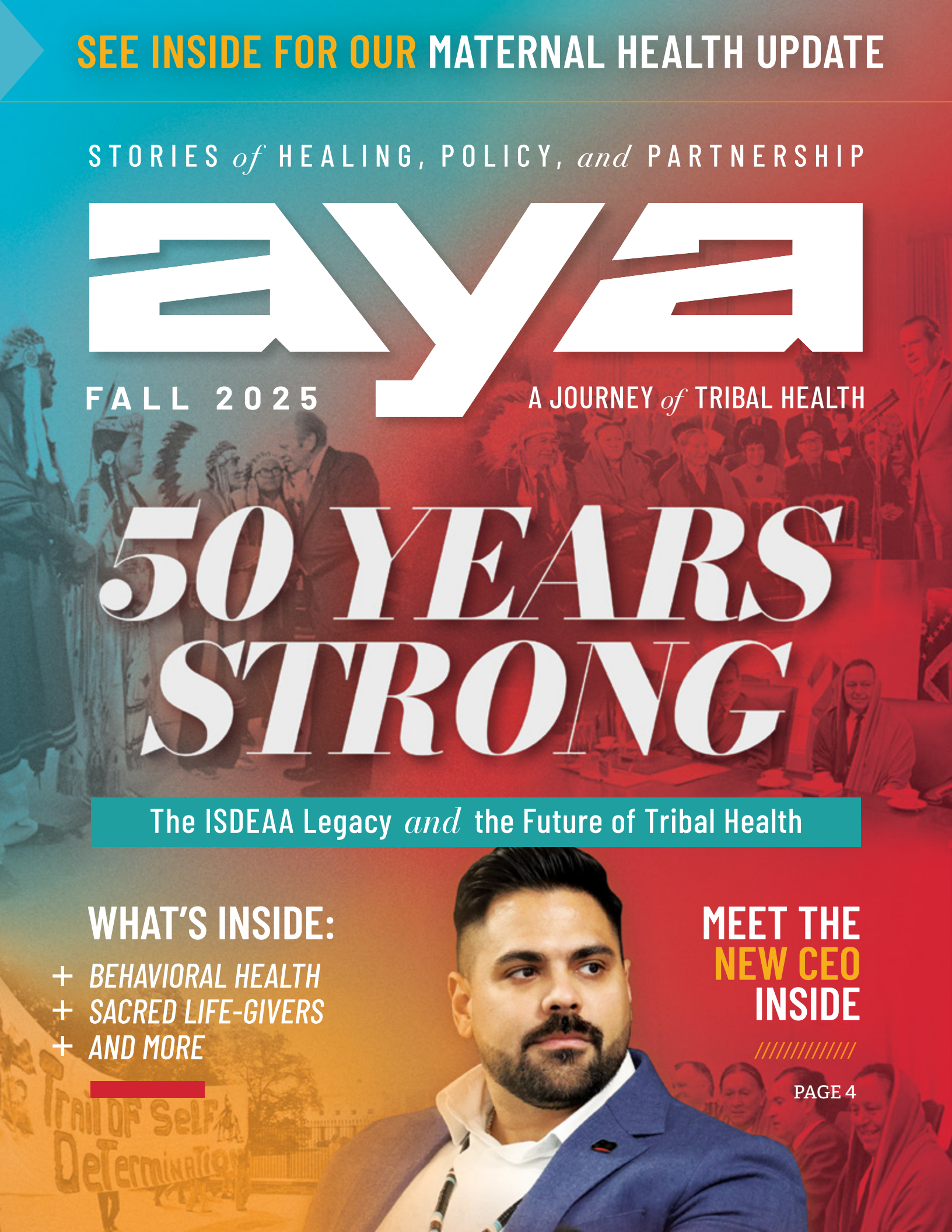
aya

FALL 2025

A JOURNEY *of* TRIBAL HEALTH

50 YEARS STRONG

The ISDEAA Legacy *and* the Future of Tribal Health



WHAT'S INSIDE:

+ *BEHAVIORAL HEALTH*
+ *SACRED LIFE-GIVERS*
+ *AND MORE*

MEET THE NEW CEO INSIDE

PAGE 4

National Indian Health Board

50 F ST NW SUITE 600 | WASHINGTON, D.C. 20001 | 202-507-4070 | NIHB.ORG

NIHB BOARD OF DIRECTORS

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*
- *Public Health Policy and Programs*
- *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.

TRIBAL PUBLIC HEALTH

NIHB is committed to improving Tribal Public Health through capacity building programs, technical assistance, research, and more. Healthier Native communities will come with an improvement in Public Health resources and infrastructure. Incorporating the Indigenous Determinants of Health is an important part of this work to ensure that agencies and organizations take a culturally appropriate approach to healing.

STORIES *of* HEALING, POLICY, *and* PARTNERSHIP

aya

FALL 2025

A JOURNEY *of* TRIBAL HEALTH

50 YEARS OF THE ISDEAA IN TRIBAL HEALTH
p. 38

In This Issue:

CEO INTERVIEW

National Indian Health Board

ABOUT A.C.

An Interview with the CEO of NIHB

THE WALLS OF A.C. LOCKLEAR'S OFFICE tell their own story — woven baskets, beadwork, and artwork from across Indian Country, each piece a reminder of the people he serves as CEO of the National Indian Health Board. A proud two-time University of North Carolina at Chapel Hill alumnus, Locklear wears a striking wampum necklace with a boar's tooth pendant that was gifted to him by his father, a piece that keeps him connected to his family, his Lumbee heritage, and the generations who came before him. Originally from Pembroke, North Carolina, he brings the same presence whether he's in deep conversation with Tribal leaders or across the table from federal officials — always thinking, always planning, always pushing for what Indian Country needs next.

We sat down with Locklear to talk about his roots, his passion for the work, and his vision for NIHB's future.

"SURVIVAL IS STRATEGIC, SACRED, **AND** GENERATIONAL."

Q: Let's start with your story. Where did you grow up, and how did that shape the person you are today?

A.C. LOCKLEAR: I grew up in Pembroke, North Carolina — the heart of the Lumbee Tribe. It's a small town in Robeson County, the poorest county in the state, but it's rich in culture, kinship, and resilience. I didn't know anything other than the Native world I was raised in. My schools were mostly Lumbee. My community was Lumbee. I was surrounded by family, by history, and by a deep tie to land and place.

But like many Native communities, we weren't immune to hardship. That contrast — deep pride alongside deep struggle — taught me that survival in Indian Country is never accidental. It's strategic, sacred, and generational.

Q: What moments or people in your life put you on the path toward public health and advocacy?

A.C. LOCKLEAR: My grandparents were some of the first to show me the power of education and service. Three of my four grandparents were college educated — and at the university that was founded by us, for us — the University of North Carolina at Pembroke, formally Croatan Indian Normal School. They were all UNCP grads. So were my parents. I grew up hearing the stories of my ancestors — how they broke barriers, survived disenfranchisement and Jim Crow policies, and built institutions for our people. That shaped my worldview: your education, your gifts, they're not just for you. They're for your community.

I've also had powerful mentors like Dr. Marcus Collins, Dr. Amy Locklear Hertel, and my high school guidance counselor Karen Stickney — who pushed me to go after things no one else thought possible. They lit the fire, and it's never gone out.

Q: Before you ever stepped into this role — who were you?

A.C. LOCKLEAR: I've always been a community-rooted policy nerd. I started my career as a Udall intern in the Office of the Assistant Secretary for Indian Affairs, thinking

I'd go into federal Indian law. But I took a different path — first working at UNC Chapel Hill as Director of Student Engagement, then joining the Center for Native American Youth at the Aspen Institute to work with young Native advocates. That's where I learned: you can use policy to create pipelines, open doors, and shift systems. My "why" has always been the same—how can I improve the lives of our people?

Q: How did you first come to know the National Indian Health Board? Was it love at first sight — or did the relationship build over time?

A.C. LOCKLEAR: I first encountered NIHB during COVID. I saw them doing real-time advocacy to protect our people, and I thought, "This is where the fight is." Then someone from NIHB reached out and asked if I'd consider applying. It was one of those moments where your personal values and the moment in history line up. I knew I had to be part of it.

Q: What do people misunderstand most about you?

A.C. LOCKLEAR: That I'm just polished and political. That because I come from a state-recognized Tribe, I don't feel the weight of what I carry. The truth is, I carry a lot — my own lived experience, the stories of Tribal communities across the country, the expectations that come with being one of the few.

But I don't see that as a burden — I see it as sacred. And I've learned how to hold all of that without letting it crush me. Sometimes I laugh too loud or speak too plainly — but that's just me being real.

CONTINUED ON PAGE 6

RIGHT: Locklear grew up in Pembroke, North Carolina, "the heart of the Lumbee Tribe," and later attended the University of North Carolina at Chapel Hill.

"SERVICE ISN'T A METAPHOR — IT'S MEASURABLE."

Q: You talk often about service. What does that word mean to you in the context of Tribal health?

A.C. LOCKLEAR: Service means putting the needs of your people before your own. It means honoring the responsibility to those who came before you and those who'll come after. In public health, that's not metaphor — it's measurable. Service is making sure our babies are born healthy, our elders have access to life-saving medicine, and our systems reflect our values.

Q: What's the moment that cemented this work as a calling, not just a career?

A.C. LOCKLEAR: It's never been just a job. As a two-spirit Native person, this work is personal — it's survival. Every decision we make at NIHB impacts the health, wellbeing, and sovereignty of our Nations. That kind of responsibility doesn't clock out at 5 p.m.

Q: Where does your fire come from — what keeps you motivated in hard times?

A.C. LOCKLEAR: I think about the elders who can now access medication without driving for hours. I think about the kids born into communities that fought tooth and nail to make sure they had a clinic nearby. I think of my own grandmother, my great-grandfather, and my great-great-grandfather — how they sacrificed so that I could be here. Every generation made it a little better. I want to be the link that makes it a lot better.

And honestly? I think about the Native kids learning their languages, learning their culture, proud of who they are, knowing they belong. That's what keeps me going.

Q: You lead a national organization, but at the heart of it all are people, families, and Nations. How do you stay grounded in that truth?

A.C. LOCKLEAR: You can't lead from behind a desk in D.C. You have to be in community — listening, learning, showing up. I've been to clinics in remote Alaska, rural Arizona, and across Turtle Island. I've heard firsthand how policies fail or succeed on the ground. That's the only way to lead — by relationship, not by assumption.

At NIHB, we talk a lot about "carrying the stories." That's a sacred responsibility. We don't just represent data — we represent people. And I take that seriously.

"You can't lead from behind a desk in D.C. You have to be in community."

Q: When the work feels heavy — and it often does — what pulls you back to center?

A.C. LOCKLEAR: I turn to the land and the water. That's where the noise quiets. I also find strength in ceremony and in our staff's Eagle Staff — it was gifted to NIHB and has become a source of spiritual grounding for us during hard times. Also, family always centers me, no one can help calm me the way my husband and mother can. They are my biggest support system and always help remind me of why I do what I do.

And sometimes? It's a big bowl of food and a Netflix binge. Or cooking something my grandma used to make. Our foods are medicine, too. They reconnect me to home.

Q: You've taken the reins of an organization with a long legacy. What parts of NIHB's history do you carry with you every day?

A.C. LOCKLEAR: NIHB was created by Indian Country, for Indian Country. It's not mine, it's not the Board's, and it's not the staff's — it belongs to the people we serve. We've always been a warrior for Indian health. We've refused to let our issues be an afterthought. And we've stood in the halls of power demanding — not begging — for what our communities are owed.

That legacy runs deep in me. We carry the weight of our ancestors' prayers, their dreams, and their battles. Our job is to protect that legacy while evolving it for the next seven generations.

"NIHB BELONGS TO THE PEOPLE WE SERVE."

Q: We're in a transformative moment in Indian health. What do you believe NIHB's role should be right now?

A.C. LOCKLEAR: We're in a time of chaos and uncertainty — federal shifts, funding threats, workforce crises. It's easy to get lost in the fire drill. But NIHB can't just respond to the moment — we have to help shape what's next.

That means being strategic while staying grounded. It means holding the line while also pushing forward. NIHB has to be both shield and spear. And most importantly, we have to be a trusted partner to every Tribe — big or small, rural or urban — because that's who we work for.

Q: You've called NIHB a convener, a champion, and a warrior. What does that mean in action?

A.C. LOCKLEAR: One example? When this administration threatened to terminate probationary federal employees, thousands of IHS jobs were suddenly at risk. These were Native people hired through Indian preference, people serving their own communities. NIHB acted immediately — we opened our doors and brought together organizations like NCAI, NIEA, and AIHEC to build a rapid response team. In less than 48 hours, we turned the tide. The Secretary exempted IHS from the terminations. That's what happens when we convene, when we champion, when we act like warriors for our people.

"We're in a time of chaos and uncertainty," says Locklear, pointing to federal changes, threats to funding, and workforce crises. But Locklear believes NIHB can help shape what comes next.

Another? Advance appropriations for IHS. That's a fight NIHB helped lead for over a decade. And we won. Now, if the federal government shuts down, our emergency rooms and clinics don't have to close with it.

CONTINUED ON PAGE 8

FROM SURVIVAL MODE TO SOVEREIGNTY MODE.

Locklear would like to overhaul how the federal government engages with Tribes. Right now, the NIHB CEO says, outdated laws limit real-time collaboration between Tribal leaders, technical advisors, and federal agencies. He envisions NIHB serving as a hub for Tribal innovation, a launchpad for Native talent, and a protector of health sovereignty.

Q: Behind every policy win are people. Can you share a story from your time at NIHB that reminds you why this work matters?

A.C. LOCKLEAR: I think about NIHB Chairman Chief Bill Smith, who talks about growing up in Alaska without dental care — about enduring traumatic procedures that scarred him for life. Today, because of the work of Tribal leaders and advocates, there are state-of-the-art dental facilities in his region. That's healing in action.

And every time I walk into a Tribal health facility — where providers are from the community and care is delivered in culturally grounded ways — I'm reminded of what's possible. We're not just fighting for systems. We're fighting for sovereignty, dignity, and health.

Q: Let's talk future. What's your vision for where NIHB is headed in the next 3 to 5 years?

A.C. LOCKLEAR: We're building something sacred. NIHB will be stronger, more strategic, and unapologetically rooted in service to all of Indian Country. That means every Tribal leader — every citizen — knows who we are, what we do, and that we work for them.

We'll be a hub for Tribal innovation, a launchpad for Native talent, and a protector of health sovereignty. We'll have the infrastructure to respond in real time and the vision to push bold ideas forward.

And we'll do it all with transparency, reciprocity, and respect. Because that's what our people deserve.

Q: If you could change one thing about the federal health system today for Tribes, what would it be — and why?

A.C. LOCKLEAR: I'd overhaul how the federal government engages with Tribes. Right now, outdated laws like FACA limit real-time collaboration between Tribal leaders, technical advisors, and federal agencies. It's paternalistic and inefficient.

Tribal governments are governments. Period. We should be able to sit at the table with our federal partners — not as stakeholders, but as sovereigns. If we remove those barriers, we can co-create solutions that actually work.

Q: How do you see NIHB pushing the envelope — on equity, on sovereignty, on power — in the years ahead?

A.C. LOCKLEAR: We're done playing by the old rules. The systems we've relied on for decades don't work the way

they should — and maybe never did. NIHB has to reimagine what Indigenous health can be.

That means shifting from survival mode to sovereignty mode. It means asking, "What does Native health look like seven generations from now?" and building backward from that vision. Our self-governance Tribes are already showing us what's possible — we just need the political will and the resources to scale it.

Q: You've talked about NIHB being good partners. What does that look like to you?

A.C. LOCKLEAR: Being a good partner means honoring two core Native values: respect and reciprocity. It means showing up with humility and leaving ego at the door. Whether it's a Tribe, a federal agency, or a philanthropic partner — our mission stays the same: to serve Indian Country, not ourselves. Everything we do is in service of that sacred responsibility.

"I want people to feel that NIHB is stronger, more grounded, and more visionary."

"I WON'T WASTE A SINGLE PRAYER, A SINGLE TEAR, A SINGLE DREAM."

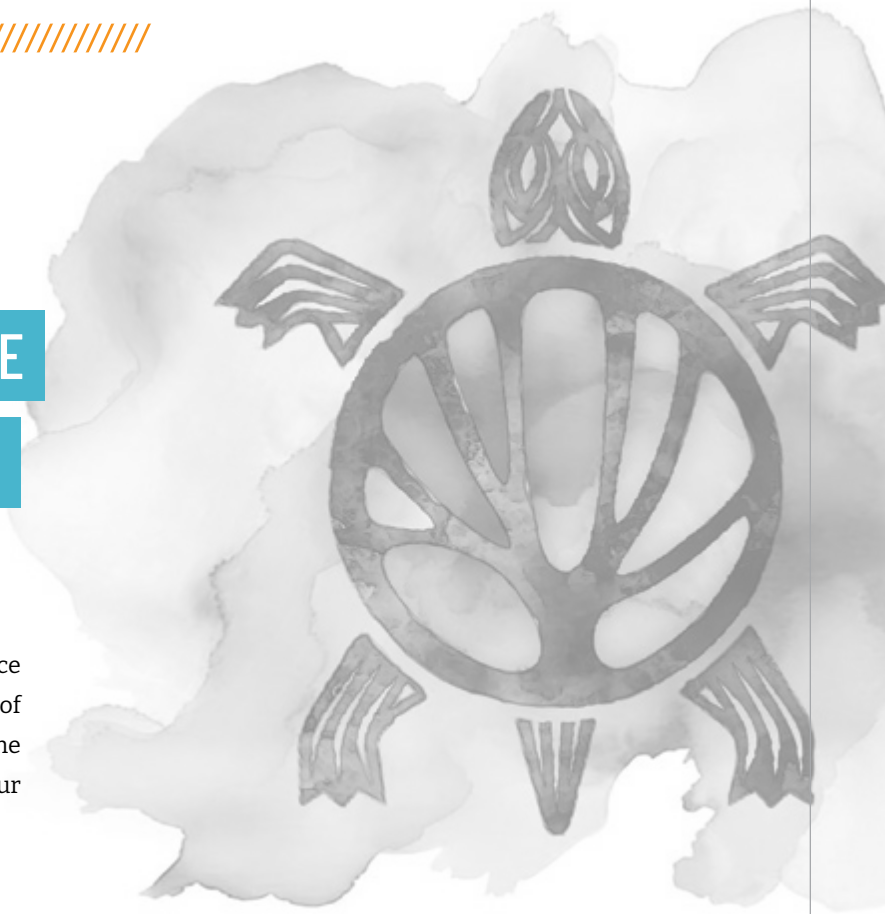
Q: What kind of legacy do you hope to leave at NIHB? Not the résumé stuff, but the soul stuff.

A.C. LOCKLEAR: That I led with heart. That I made space for others. That every decision we made was in service of our people — and that our communities, especially the ones often left out, saw themselves at the center of our work.

I want people to feel that NIHB is stronger, more grounded, and more visionary because we honored the past while building for the future.

Q: Finish this sentence: If you really want to understand who I am and why I do this work, you need to know ...

A.C. LOCKLEAR: ... I was never supposed to be here. I know what it means for someone from a state-recognized Tribe to hold this kind of sacred responsibility — to fight for the health of every Native person on Turtle Island. But my ancestors, and all of our ancestors, dreamed me into existence. I won't waste a single prayer, a single tear, a single dream. My job is to carry that forward — and to make sure I'm not the last.



STRONG BEGINNINGS

A Reflection on the Second Convening on Tribal Maternal Mortality Review

FROM JUNE 2-4, 2025, the National Indian Health Board, in partnership with the CDC Maternal Mortality Prevention Team, hosted the **SECOND CONVENING ON TRIBAL MATERNAL MORTALITY REVIEW** in Denver, Colorado. Building on the vision set in 2023, the event brought together American Indian and Alaska Native (AI/AN) maternal health leaders, Tribal Epidemiology Centers, Birthworkers, public health professionals, and community advocates to advance Indigenous-led solutions to maternal mortality.

Rooted in community and guided by culture, the convening served as a powerful space for connection, reflection, and collective action. Participants described feelings of recognition, pride, and belonging – many naming the profound impact of being in a space built intentionally for Indigenous voices.

Discussions centered on foundational values: data sovereignty, meaningful representation on review committees, and the importance of long-term investment in Native-led efforts. Sessions also explored traditional birthing knowledge, the role of inclusive care for Two Spirit and LGBTQ+ relatives, and the importance of healing practices rooted in cultural continuity.

A highlight of the convening was a panel of Tribal representatives sharing on-the-ground progress: the creation of Tribal maternal mortality subcommittees, strategies for overcoming state-level barriers, and innovative approaches to securing sustainable funding. These stories made clear that community-led review processes, when supported and resourced, can create real change.

ONE RESOUNDING MESSAGE EMERGED: Tribal leadership is essential. When Tribal governments support maternal health initiatives, they bring the cultural authority, political power, and deep community knowledge needed to shift systems. Their engagement – through policy support, appointments to review bodies, and advocacy for Tribal data access – ensures this work stays rooted in sovereignty and reflects the realities of Native families.

Tribal leaders are invited to join maternal health workers, Birthworkers, and grassroots advocates in this movement. Their presence affirms that the health of Native mothers, birthing people, and children is not only a health issue – it's a matter of self-determination, cultural survival, and generational healing.

The 2025 Strong Beginnings convening affirmed that Native-led maternal health work is growing – steadily, powerfully, and with purpose. These efforts are grounded in tradition, fueled by community, and sustained by a shared vision: health and justice for the next seven g enerations and beyond.

HEALING HAPPENS WHEN WE DO THIS WORK TOGETHER. AND IT'S ALREADY UNDERWAY.

The 2025 Strong Beginnings convening affirmed that Native-led maternal health work is growing.

BIRTH

RESTORING SACRED CARE

Indigenous Birthworkers and the Future of Maternal Health in Tribal Nations

ACROSS INDIAN COUNTRY, Indigenous Birthworkers are restoring sacred traditions that have long supported Native families during pregnancy, birth, and postpartum. Their work is about more than care — it's about reclaiming practices that connect generations, protect sovereignty, and uphold the dignity of Native mothers and birthing people.

CONTINUED ON PAGE 14

THE TERM BIRTHWORKER HONORS a wide range of roles — doulas, midwives, peer support specialists, recovery coaches, and community health workers — who walk alongside families through some of life's most profound moments. Whether trained clinically or through community-rooted pathways, Indigenous Birthworkers are healers, advocates, teachers, and protectors. They offer relational, culturally grounded care in a world where Native voices are often overlooked or marginalized.

involvement, meeting people where they are with non-judgmental care, traditional healing, and advocacy. In many cases, they serve as trusted bridges between families and larger health or social systems, making sure that Native voices are heard and respected.

This movement is not going unnoticed. In 2025, several states passed legislation to support the integration and reimbursement of doula care through Medicaid:

MONTANA passed Senate Bill 319, creating licensure for doulas with a focus on access in rural & Tribal communities.

Birthworkers can serve as bridges between families and larger health or social systems, making sure that Native voices are heard.

Across the country, Native-led organizations are building maternal health systems by and for their communities.

IN MINNESOTA, the Indigenous Peoples Task Force offers doula and midwifery training grounded in Anishinaabe teachings.

IN ARIZONA, the Tribal Council of Arizona Maternal Health Innovation Center strengthens Tribal knowledge and resources across the state.

IN WASHINGTON, the Hummingbird Indigenous Doula Collective and Seattle Indian Health Board elevate Indigenous leadership in the maternal health space.

IN ALASKA, the Alaska Native Birthworkers Community offers advocacy, education, and support rooted in traditional knowledge systems.

These programs ensure that care remains relational, respectful, and responsive to the cultural and lived experiences of Native families.

Indigenous Birthworkers are also leading critical harm reduction work. Birthworkers support families navigating substance use, housing instability, and child welfare

WASHINGTON began reimbursing doula services under Medicaid in January 2025.

ILLINOIS expanded Medicaid coverage to include perinatal doula and lactation services without requiring physician referral.

ADDITIONAL STATES — including Arizona, Colorado, Delaware, Kansas, Massachusetts, Missouri, and New York — have also implemented similar Medicaid doula benefits.

These policy wins reflect a growing recognition of the essential role that Indigenous Birthworkers play in addressing maternal health disparities. Yet, significant barriers remain.

American Indian and Alaska Native mothers and infants continue to face disproportionately poor health outcomes stemming from historical trauma, structural racism, and the chronic underfunding of Tribal health systems. The shortage of culturally aligned maternal health professionals, coupled with limited data collection and funding access, continues to hinder the development of sustainable, Tribal-led maternal and infant health programs.

And still, Native communities lead. With resilience and vision, Indigenous Birthworkers, midwives, and grassroots

organizations are creating whole-person care models rooted in tradition and trust. These innovations are improving outcomes in communities long underserved — and proving that culturally aligned care works.

But these efforts cannot grow without sustained investment.

Tribal Nations and Native organizations must be supported in expanding maternal health infrastructure, securing Medicaid reimbursement, building culturally grounded training pathways, and integrating Birthworkers into Tribal and urban Indian health systems. Indigenous knowledge must be recognized as clinical expertise, and Indigenous Birthworkers must be compensated and protected as the vital public health force they are.

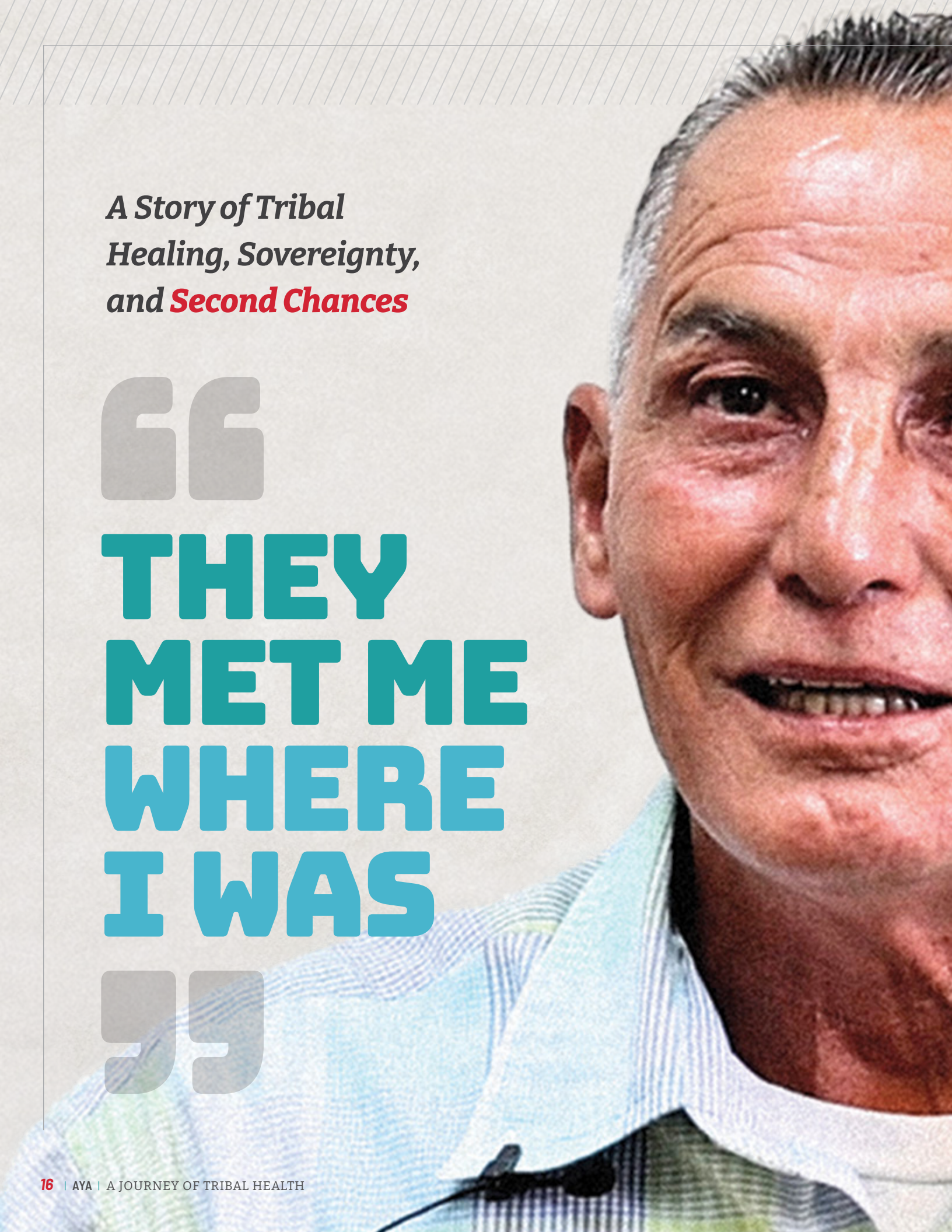
The National Indian Health Board remains committed to advocating for these priorities — so that every Native mother, birthing person, and baby can be welcomed into this world with care that is sacred, sovereign, and strong.

REFERENCES

- **Alaska Native Birthworkers Community. (2021).** Our Work. Retrieved from https://www.nativebirthworkers.org/
- **Seattle Indian Health Board. (2023).** Maternal and Child Health Programs. Retrieved from https://www.sihb.org
- **Indigenous Peoples Task Force. (2022).** Doula and Midwifery Programs. Retrieved from https://www.indigenouspeoplestf.org
- **Inter Tribal Council of Arizona (2025).** Maternal health Innovation Resources. Retrieved from https://itcaonline.com/maternal-mental-health-resources/
- **National Indian Health Board (NIHB). (2022).** Tribal Maternal, Infant, and Early Childhood Health Innovations. Retrieved from https://www.nihb.org
- **Washington State Health Care Authority (2025).** Doulas; Program Information for Providers. Retrieved from https://www.hca.wa.gov/billers-providers-partners/program-information-providers/doulas
- **Montana Free Press. (2025, May 14).** Governor signs new law professionalizing doula care. Retrieved from https://montanafreepress.org/2025/05/14/governor-signs-new-law-professionalizing-doula-care
- **Montana Free Press. (2025, March 25).** Montana bill would increase access to doula care. Retrieved from https://montanafreepress.org/2025/03/25/montana-bill-would-increase-access-to-doula-care
- **Prenatal-to-3 Policy Impact Center. (2024).** State Policy Roadmap: Community-Based Doulas. Retrieved from https://pn3policy.org/pn-3-state-policy-roadmap-2024/us/community-based-doulas
- **MyJournalCourier. (2024, December 20).** Illinois Medicaid to cover doula, lactation support services. Retrieved from https://www.myjournalcourier.com/news/article/illinois-medicaid-cover-doula-lactation-support-19991519.php
- **National Health Law Program. (n.d.).** Doula Medicaid Project. Retrieved from https://healthlaw.org/doulamedicaidproject

A Story of Tribal Healing, Sovereignty, and ***Second Chances***

“THEY MET ME WHERE I WAS”



MICHAEL FARIAS TOLD HIS STORY with tears in his eyes — and everyone in the room. "I was just miserable," he said, sitting in the clinic that helped save his life. "Laying in bed, wondering what I was going to do to go get what I was used to."

Michael was in Houston, Texas, caught in a decades-long battle with addiction. "I struggled with drugs and alcohol for a lot of years. Dysfunctional family. Prison time. I'd put a lot of people through the wringer — especially my wife."

One day, at the end of her rope, his wife made a phone call that changed everything. She reached out to the Tunica-Biloxi Tribe in Alexandria, Louisiana — the Tribe Michael belonged to by birth, but hadn't connected with in years. "She asked if there were any resources that could help me," he recalled. "I didn't even know she had called. But I'm grateful for it now."

That same day, someone from the Tribe's health department called him. "They asked if I wanted to come to treatment in Louisiana," Farias said. "I didn't know anything about it — just that I was a Tribal member. But I said yes."

CONTINUED ON PAGE 18

LEFT: Michael Farias faced a decades-long battle with addiction. But one phone call to the Tunica-Biloxi Tribe in Louisiana, the Tribe Michael belonged to by birth, changed everything.

WITHIN AN HOUR, the health staff had found him a bed. By the time his wife got home from work, she had a bus ticket in hand. "Next thing I know, I was on the next thing smoking out of Houston," he said. "It happened so fast. I'm glad it did. If it hadn't, I probably would've changed my mind."

When he arrived in Louisiana, staff from the Tribal health department were waiting at the bus station. "They took me straight to the facility. Covered everything. Not just 28 days — they extended it to 90. That's what saved me."

That kind of care doesn't come from a hotline or a one-size-fits-all program. It comes from Tribal sovereignty — the power to design and deliver care rooted in culture, connection, and compassion.

"BEFORE WE MERGED SERVICES, WE WERE LOSING PEOPLE."

Cameron Chase, the Tunica-Biloxi Health Director, helped lead the transformation that saved Michael's life — and many others.

When Cameron stepped into his role five years ago, behavioral health services were fragmented and reactive. "There were no clinicians. No real-time case management. If someone was in crisis, they might bounce through ten agencies before getting the help they needed," he said. "We were losing people."

One of the first cases that tested the system was a Tribal citizen whose home was condemned due to mental illness. "We had to interdict them through tribal court," Chase said quietly. "They've been in care now for three and a half years. Last week, we were finally able to reduce that to a partial interdiction. That's healing. That's progress."

Seeing the gaps firsthand, Cameron and housing director Stephanie Stiles decided to do something most systems struggle with: work as one. They merged departments, broke down silos, and built what they a wrap-around case management model. Health, housing, police, reentry services, and social supports now communicate constantly, making sure no one falls through the cracks.

Cameron Chase, the Tunica-Biloxi Health Director, and Stephanie Stiles, the housing director, were among those who **helped lead the transformation that saved Michael's life** — and many others.

"Every Monday morning, we sit down and go over every case," Chase said. "We ask: Who's at risk? What do they need? Who's stepping in?" ***No referrals lost in the shuffle. No phone tag. Just real-time support.***

THE LIFE CENTER: SHELTER, SAFETY, AND STABILITY

During the COVID-19 pandemic, the Tribe converted an old motel into a Life Center — a transitional housing facility that does more than provide a bed.

"It has a community room, laundry, on-site victim services, wellness programs, and evening check-ins," Stiles explained. "It's not just a place to sleep. It's a place to heal."

They also built reentry housing for citizens returning from incarceration or domestic violence situations. Instead of shuffling people through temporary shelters and handoffs, the Tribe created pathways to permanent

housing and independent living — all with case management, transportation, and therapy layered in.

"We're not just treating addiction or diabetes," Chase said. "We're helping people feel seen, get stable, and believe in themselves again. That's public health. That's sovereignty in action."

The Tunica-Biloxi model works because it's flexible & forgiving.

"EVEN IF YOU WEREN'T READY THE FIRST TIME..."

The Tunica-Biloxi model works because it's flexible and forgiving. As Stephanie puts it, "We don't do cookie-cutter help. Each case gets its own plan. And we tell folks: even if you weren't ready the first time, the door is still open when you are."

The Tribe doesn't wait for people to ask for help. Sometimes it's the school resource officer who calls. Sometimes it's an elder worried about a neighbor. And sometimes, it's a woman with a bus ticket in her hand — like Michael's wife — who sets a miracle in motion.

"We've had success because we talk," Chase said. "Health, housing, police, social services — we sit down together and ask, 'What does this person need to thrive?' Not just survive. Thrive."

FROM ROCK BOTTOM TO ROLE MODEL

Michael didn't just survive. He rebuilt. After completing his 90-day program, he stayed in Louisiana. He now lives on the reservation. He owns a landscaping business with several Tribal contracts. He's part of a church; part of the community; part of the healing.

"I have a church family. I have a Tribal family. I'm 65 and living my best years yet," he said. "I used to take everybody's stuff. People used to rather see me going than coming. I'm welcomed everywhere now."

Michael knows the resources that saved him weren't an accident — they were the product of vision, investment, and love.

"Without God — first of all — and the Tribe's resources, I don't know where I'd be. They paid for my care. They covered my treatment. They showed up for me."

He paused. His voice caught.

"What was so freely given to me, I have to give back," he said. "That's what recovery is about. That's what the Tribe gave me. A second chance. A real life."

MICHAEL FARIAS DIDN'T JUST SURVIVE. HE REBUILT.

STRENGTHENING SOVEREIGNTY AND PUBLIC HEALTH SYSTEMS

Reflections on Progress Since PHICCS II

IN THE YEARS SINCE THE SECOND *Public Health in Indian Country Capacity Scan (PHICCS)*, Tribal Nations have continued to demonstrate what self-determined, sovereign public health leadership looks like in action. Conducted by the National Indian Health Board (NIHB) in partnership with the Centers for Disease Control and Prevention (CDC), PHICCS is a national assessment that offers an unprecedented snapshot of Tribal public health infrastructure, capacity, and needs.

THIS DATA TELLS A POWERFUL STORY: Tribal Health Organizations (THOs) are leading public health efforts across Indian Country, often in the face of underfunding, workforce shortages, and limited access to data. Yet even with these challenges, Tribes are designing systems rooted in culture, community priorities, and sovereignty.

A SNAPSHOT OF SOVEREIGNTY IN PRACTICE

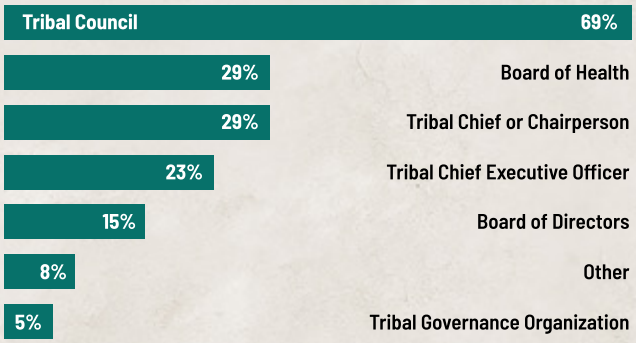
PHICCS findings reaffirm that Tribal public health systems are deeply embedded in Tribal governance structures. The majority of THOs are governed directly by Tribal Councils, underscoring the political authority Tribes bring to health service delivery and systems development (Fig.10).

Beyond governance, THOs are actively engaging in strategic planning and quality improvement:

- **72% OF THOS** have initiated a Community Health Assessment (CHA) (Fig. 25)
- **57%** have begun or completed a Community Health Improvement Plan (CHIP) (Fig. 26)

These efforts reflect a commitment to intentional, community-driven planning grounded in the specific needs and strengths of each Tribal Nation.

Governance Structure of THOS by Percent of THO (n=130)



A RESILIENT WORKFORCE — DESPITE GAPS

The PHICCS report also highlighted the role of Tribal Health Organizations during the COVID-19 pandemic. THOs led the way in testing, vaccination, contact tracing, and community education - often with small, overstretched teams and a reliance on volunteers. PHICCS estimates that an additional 1,238 public health personnel are needed to meet full service capacity across Indian Country (Fig. 48).

Despite these gaps, Tribes have shown remarkable leadership, resilience, and innovation. The work continues, even without the full resources to match the need.

PHICCS IN ACTION: REAL CHANGE ACROSS INDIAN COUNTRY

Perhaps most importantly, PHICCS data is being used. Tribal public health departments are leveraging their individual results to advocate for expanded funding, develop department priorities, and strengthen cross-sector partnerships. At the national level, PHICCS data has been used to inform:

- Federal and state collaboration models
- Capacity-building efforts across Tribal regions
- Tailored technical assistance and programming from NIHB

As shared by the Ho-Chunk Nation Public Health Director, "The PHICCS tool helped us identify gaps in capacity and guided updates to job descriptions so they better reflect the work of our Tribal public health program. It also helped justify areas for growth and investment. Being able to compare our capacity with other Tribes and Tribal entities across the country helped us identify what we're doing well and where we may need to grow."

Conversations sparked by PHICCS are shaping how state agencies understand and engage with Tribes. They're also creating space for Tribal public health professionals to exchange best practices, tools, and lessons learned.

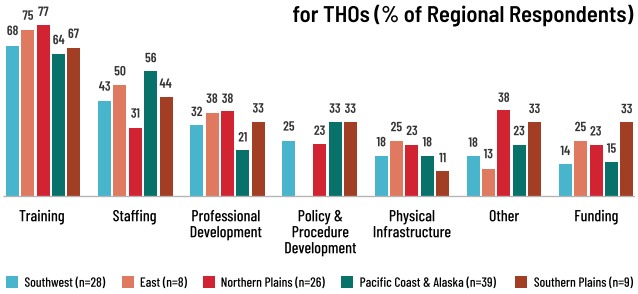
NIHB'S ROLE: TURNING DATA INTO ACTION

As a national Tribal organization, NIHB uses PHICCS data to shape its services, policy priorities, and training opportunities. The most recent scan directly informed the creation of NIHB's Best Practices Learning Community, a peer-to-peer space where Tribal public health staff can collaborate and learn on topics such as:

Status of Community Health Assessment by Percent of THOs (n=122)

Status of Community Health Improvement Plan by Percent of THOs (n=122)

Top Public Health Workforce Development Needs for THOs (% of Regional Respondents)



- Leveraging data for grant writing and proposals
- Workforce development
- Evaluating Tribal public health programming
- Conducting Tribal needs assessments.

PHICCS is more than a report – it's a roadmap to building sovereign, sustainable, and culturally grounded public health systems.

LOOKING AHEAD

The second PHICCS didn't just update a national snapshot - it realigned collective purpose. By centering Tribal values and lived realities, the scan provides both quantitative and qualitative evidence to guide investments and strengthen Tribal public health systems. It also affirms a central truth: Tribal Nations are leading the way in defining what Indigenous public health looks like — holistic, community-driven, and sovereign.

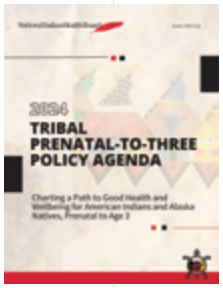
NIHB remains committed to supporting that vision.

For more info about current and upcoming PHICCS events, please email PHI@nihb.org

2024 TRIBAL PRENATAL-TO-THREE POLICY AGENDA

"Our women are our life givers. When we protect them, we protect the heartbeat of our Nations."

Our sovereignty is only as strong as the safety of our women and families. The Protect Native Women and Families (PN3) Policy Agenda is a powerful call to action that centers the strength of Native women and the rights of our sovereign Nations. This agenda is not just words on paper. It is a blueprint for healing and justice, crafted by Indigenous leaders, families, and advocates who know firsthand what our communities have endured — and what it will take to change it.



The PN3 Policy Agenda lays out Indigenous-led solutions rooted in our sovereignty and our knowledge. It demands full, long-term funding for Tribal programs to prevent and respond to domestic and sexual violence. It recognizes that safety is a basic right our women and families have been denied for far too long. It insists on restoring and enforcing Tribal jurisdiction over crimes committed on our lands, so our Nations have the power to protect our people without interference or delay.

The Agenda calls for investment in culturally based healing programs and services. It makes clear that western approaches alone cannot address the deep wounds of violence, historical trauma, and intergenerational harm. Our people need access to programs that are grounded in our cultures, languages, and ways of knowing. These are the paths to true healing and prevention.

Another critical piece of the PN3 Policy Agenda is the demand for Indigenous-led research and data sovereignty. Too often, research is done on us instead of with us, and our communities are left out of decisions about how data is collected, shared, and used. The agenda insists that Tribes lead research efforts so we can define what safety and healing mean for our people, measure what matters, and hold systems accountable for results that align with our values.

Amy Stiffarm (Aaniiih, Apsáalooke, Chippewa Cree; DrPH, MPH) and Janelle Palacios (Apsáalooke; PhD, CNM, RN) have shared powerful testimony lifting up this agenda. They are not only experts in public health and maternal health — they are Indigenous women who know the weight of these issues in their own lives and communities.

Their courage and leadership remind us that Indigenous women are not passive victims. They are fierce, knowledgeable protectors of our Nations who carry solutions forward.

THE PN3 POLICY AGENDA ALSO HIGHLIGHTS THE NEED FOR:

- **INCREASED FUNDING** for Tribal victim services programs, including shelters, advocacy, and transitional housing, so survivors have real options to escape violence and rebuild their lives.
- **EXPANSION OF TRIBAL AUTHORITY** to issue and enforce protective orders that are recognized across jurisdictions, ensuring the safety of victims even when they travel or relocate.
- **RESOURCES FOR PREVENTION EDUCATION** that addresses the root causes of violence, including substance use, poverty, and historical trauma, and that empowers Native youth with cultural identity and resilience.
- **SUPPORT** for Tribal coalitions and advocacy organizations, which are essential for coordinating local responses, building capacity, and amplifying Native voices at state and federal levels.

This agenda is a chance to transform how our country responds to violence against Native women and families — but it will only happen if we stand together and demand action. Our sovereignty means we have the inherent right to protect our people, and our survival depends on it. We cannot let another generation grow up believing violence is normal or that justice is out of reach.

This is not a time to wait for someone else to fix broken systems. It is a time to act. We need every Tribal leader, every health worker, every advocate, every family member, and every ally to get behind the Protect Native Women and Families Policy Agenda. Contact your members of Congress and tell them you support the PN3 Policy Agenda. Join with Tribal organizations and community groups working on these issues. Share the agenda in your networks. Speak up for the safety of our women and the future of our Nations.

Our women are the heartbeat of our communities. When they are safe, our cultures, languages, and children thrive. Our sovereignty is real when we use it to protect our life givers. Together, we can make sure that the generations yet to come inherit a world where Native women and families are safe, strong, and thriving.

Scan the QR code to read more

ADVANCING DATA SOVEREIGNTY

NIHB's Electronic Case Reporting Roadmap for Tribes & TECs

For Tribal Nations and Tribal Epidemiology Centers (TECs), access to real-time, accurate health data is essential. Yet too often, data needed for effective public health responses remains out of reach—trapped in state systems that are not designed to serve Tribal communities. The National Indian Health Board (NIHB), in partnership with the Centers for Disease Control and Prevention (CDC), is working to change that.

Electronic Case Reporting (eCR) offers one promising pathway.

WHAT IS ECR?

Electronic Case Reporting is the automated, real-time exchange of health information from electronic health records (EHRs) to public health authorities. It helps streamline the reporting of disease cases, enabling timely response activities like contact tracing, case management, and outbreak detection. For Tribal Nations and TECs, eCR offers a route to receive public health data directly - rather than relying on delayed or filtered state-level systems.

While eCR is not a perfect solution, it presents a significant opportunity: one where Tribes can exercise greater control over their own data, inform public health decisions with real-time information, and strengthen their sovereign health systems.

NIHB'S TRIBAL ECR ROADMAP: SUPPORTING TRIBAL READINESS AND ACTION

To help Tribes and TECs navigate the eCR landscape, NIHB developed the Tribal eCR Roadmap — a guide informed by direct pilot projects, community feedback, and lessons learned from early adopters. The Roadmap was created with three core goals:

MAKE ECR CONNECTIONS MORE ACCESSIBLE to Tribes and Tribal Epidemiology Centers (TECs) by outlining clear steps to achieving a direct eCR connection

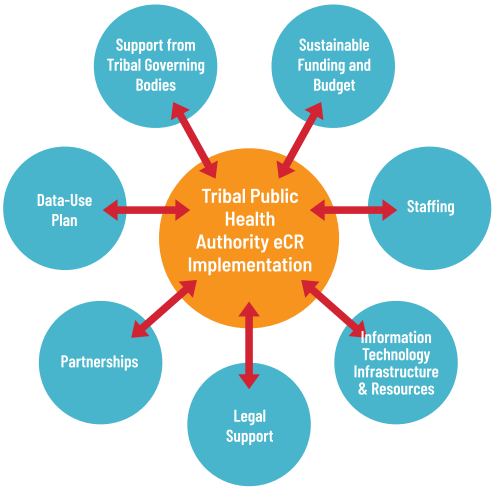
OUTLINE CHALLENGES Tribes and TECs may face in connecting to eCR and share resources and best practices for overcoming these challenges

PROVIDE RESOURCES AND LANGUAGE for Tribes and TECs to advocate for their own legal right to access public health data

PILOT PROJECTS AND GROUNDWORK

The Roadmap builds on foundational efforts by NIHB and partners, including:

DIRECT FUNDING AND TECHNICAL ASSISTANCE for pilot Tribes and TECs to establish eCR connections.

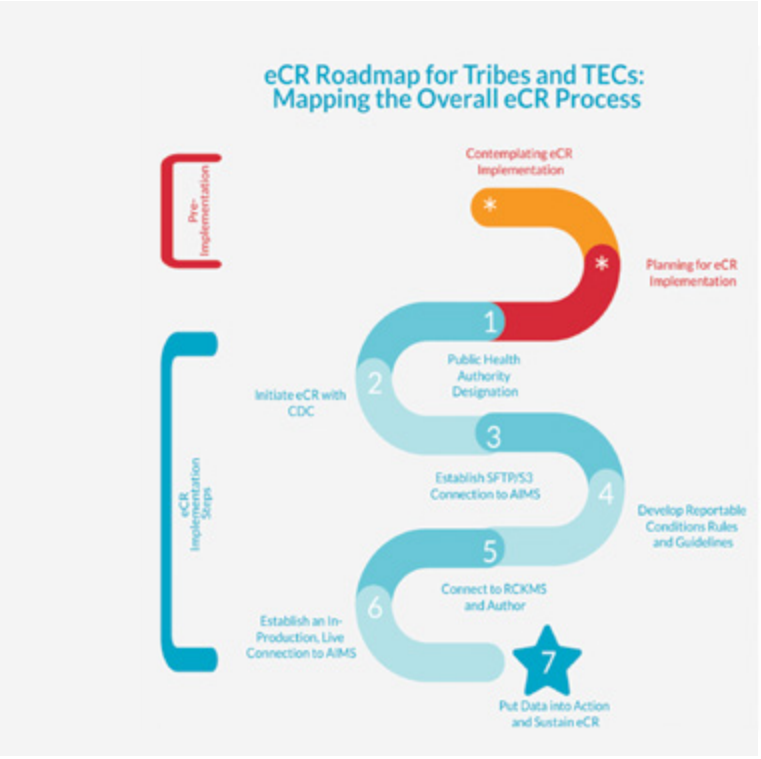


EVALUATION OF ECR IMPLEMENTATION EXPERIENCES, captured through interviews with Tribal public health staff.

ROADMAP DEVELOPMENT, shaped by on-the-ground realities, strengths, and systemic challenges faced by Tribal implementers.

THE ROADMAP: A STEP-BY-STEP GUIDE TO ECR IMPLEMENTATION

The Roadmap outlines key phases for Tribes and TECs considering eCR.



CONTEMPLATING ECR IMPLEMENTATION:

Before moving forward, Tribal public health organizations should assess:

01 Their purpose in connecting to eCR,

02 Their capacity to connect to eCR,

03 Their capacity to use the data they receive for public health activities, and

04 The alternatives to a direct connection to the AIMS platform for eCR that may be available.

PLANNING FOR ECR IMPLEMENTATION

Once readiness is established, organizations should develop internal plans to guide a successful rollout. Outlined below are the key factors to be considered in the planning phase for eCR implementation.

ECR IMPLEMENTATION STEPS:

STEP 1 Public Health Authority Designation

STEP 2 Initiate eCR Process with CDC

STEP 3 Establish SFTP/S3 Connection to AIMS

STEP 4 Develop Reportable Conditions Rules and Guidelines

STEP 5 Connect to RCKMS and Author

STEP 6 Establish an In-Production, Live Connection to AIMS

STEP 7 Put Data into Action and Sustain eCR

NEXT STEPS: EXPANDING ACCESS AND BUILDING CAPACITY

With continued support from CDC, NIHB is actively expanding its work to support:

- Tribes connecting directly to eCR,
- Tribes forming formal partnerships with state and local agencies to receive indirect data feeds, and
- Urban Indian Organizations (UIOs) working to make their health systems eCR-capable, in partnership with the National Council of Urban Indian Health (NCUIH).

NIHB is also developing supplements to the eCR Roadmap, including new guidance on establishing indirect connections when direct options are limited.

RECLAIMING OUR DATA, PROTECTING OUR COMMUNITIES

For generations, public health data systems have been built without Native input, often excluding Tribal priorities and voices. The eCR Roadmap is one tool in a growing movement to change that. By reclaiming control of health data, Tribes and TECs are taking powerful steps toward self-determination, equity, and stronger public health systems.

As this work grows, NIHB remains committed to walking alongside Tribal partners - supporting their leadership, strengthening data sovereignty, and building a healthier future for all Native communities.

Scan the QR code to access the eCR Roadmap for Tribes & TECs

CHANGING LIVES & BUILDING THRIVING TRIBAL COMMUNITIES

Celebrating The Special Diabetes Program For Indians

SDPI PROGRAMS HAVE REPEATEDLY been some of the most successful public health intervention programs in Indian Country, and in diabetes treatment and prevention overall. Tribal and Urban programs are able to leverage SDPI funds to meet the core needs of their communities, offering culturally grounded programs and services in nutrition, physical activity, eye health, foot health, and more. This has led to an 11% decrease in A1Cs and a 25% reduction in cholesterol (IHS, 2022).

SDPI programs not only reduce diabetes in Tribal communities, but also target other related chronic illnesses, including preventing heart disease, diabetic retinopathy, dementia, and certain types of cancers, and reducing the risk of serious complications from infectious diseases such as COVID-19. For example, programs have reduced commercial tobacco use by 28%- tobacco use is tied to many chronic diseases including lung disease, heart disease, and cancer. Programs are successful because they are locally driven- each program designs their services based on evidence, traditional knowledge, and the deeply held values of the Tribe they serve.

For the first time since 2004, SDPI received funding increases in 2024 brining the level to approximately $160 million. This allows over 300 grantees to continue to implement their life-saving programs nationwide and strengthens the sustainability of the program, which has lost significant buying power over 20 years due to medical inflation.

The Rosebud Wellness Center (RWC) uses SDPI to support diabetes education, fitness activities, summer walks and runs, and their Buffalo Harvest

Tribes are gearing up to share the important of SDPI with lawmakers again this month. SDPI is set to expire on September 30, 2025. Tribes would like to see another increase in funding to meet the needs of Tribes in diabetes prevention, and they have long advocated for $250 million for the program. Tribes are also pursing changes to the program which would give an option for SDPI funding to come through Indian Self-Determination and Education Assistance Act contracts and compacts, allowing Tribes to choose how they receive funding. It is important to note the important contributions of direct service Tribes, who would continue to receive funds through the existing grant process.

SDPI SPOTLIGHT: ROSEBUD WELLNESS PROGRAM/DIABETES PREVENTION

The Rosebud Wellness Center (RWC) uses SDPI to support diabetes education, fitness activities, summer walks and runs, and their Buffalo Harvest. RWC fosters a culturally-centered and holistic approach to fitness and nutrition which helps prevent, reduce, and improve diabetes and pre-diabetes for the community. The Center offers facilities and classes to support Tribal citizens to engage at the right level for them and foster a positive community to support growth and improvement. The facility is also home to a mobile medical unit, which travels out to remote parts of the reservation to promote diabetes education, screening, and prevention to residents that have limited access to care. As a primarily Direct Service Tribe, the RWC also has a strong relationship with the IHS to help connect Tribal citizens with nutritionists who can help them with specialized treatment plans.

STRENGTHENING

TRIBAL PUBLIC HEALTH PREPAREDNESS

The CDC's PHEP Program and the Response Readiness Framework

The Centers for Disease Control and Prevention (CDC) is key in protecting the public from health emergencies. Within the CDC, the Office of Readiness and Response (ORR) leads efforts to prepare for and respond to crises like natural disasters and disease outbreaks (CDC, 2023).

One of ORR's most important programs is the Public Health Emergency Preparedness (PHEP) program, which has supported communities across the country since 2002. With over $15 billion invested, PHEP helps health departments build emergency response capabilities through planning, training, and resources (CDC, 2024). A major focus of the program is supporting Tribes and Tribal organizations in strengthening their public health systems.

Recognizing the unique needs of Tribal communities, the CDC partners with them to improve preparedness through tailored technical assistance, funding opportunities, and culturally relevant training (CDC, 2024).

Within the CDC, the Office of Readiness and Response (ORR) leads efforts to prepare for and respond to crises like natural disasters and disease outbreaks.

These partnerships help Tribal health departments develop and update emergency plans that reflect local priorities and challenges.

To guide preparedness efforts, the CDC introduced the Response Readiness Framework (RRF) — a set of ten essential priorities that serve as a foundation for effective public health response. The RRF emphasizes community engagement, data-driven decision-making, and workforce readiness. Using the RRF, Tribes and other jurisdictions can review and update their written guidance and operational plans to ensure they're ready for future emergencies (CDC, 2024).

The CDC also uses tools like the Incident Management System (IMS) and a 24/7 Watch Desk to manage emergency responses. These systems help coordinate resources and communication quickly during a crisis (Mielke et al, 2014). Meanwhile, training programs such as the Incident Manager Training Program (IMTDP) and the Public Health Emergency Management Fellowship (PHEM) prepare leaders and public health professionals to respond effectively (CDC, 2023).

The CDC is helping create a more resilient & prepared public health system

The ORR is committed to continuous improvement, using lessons learned from past responses to strengthen future preparedness. By combining strategic guidance from the RRF with strong partnerships through the PHEP program, the CDC is helping create a more resilient and prepared public health system, especially in communities that face the greatest risks.

In conclusion, the CDC's PHEP program and Response Readiness Framework help Tribes and Tribal organizations build stronger, more responsive public health plans. Together, these efforts support a healthier, safer future for all communities.

REFERENCES

- **1. Emergency operations.** (2024, February 21). Office of Readiness and Response. https://www.cdc.gov/orr/deo/index.html
- **2. Mielke, J., Winchell, D., Murphy, A.,** Colorado State University, North Dakota State University, South Dakota State University, University of Colorado Denver, University of Denver, University of Utah, Utah State University, University of Wyoming, U.S. Department of Transportation, Mountain-Plains Consortium, Eastern Washington University, Upper Great Plains Transportation Institute, Northwest Tribal Technical Assistance Program, Rolland Associates, Federal Highway Administration, & Northern Plains Tribal Technical Assistance Program. (2014). Emergency Preparedness Handbook for Tribal Governments. https://www.ugpti.org/resources/reports/downloads/mpc14-276.pdf
- **3. Noelte, K. C., Kosmos, C., & McWhorter, A. (2023).** New challenges, Evolved approach: The Public Health Response Readiness Framework. Health Security, 21(S1), S89–S94. https://doi.org/10.1089/hs.2023.0056
- **4. Office of Readiness and Response. (2023).** Readiness report. In Readiness Report (pp. 1–23) [Report]. https://www.cdc.gov/orr/media/pdfs/ORR_2023_Readiness_Report_508.pdf
- **5. Public Health Emergency Preparedness (PHEP) program and guidance. (2024, August 16).** State and Local Readiness. https://www.cdc.gov/readiness/php/phep/index.html
- **6. Tribal Emergency Preparedness Law. (2024, May 16).** Public Health Law. https://www.cdc.gov/phlp/php/tribal-public-health/tribal-emergency-preparedness-law.html

SACRED LIFE-GIVERS

Efforts like those of the National Indigenous Women's Resource Center are helping Native women reclaim **what has always been theirs.**

Honoring the Power of Indigenous Women

INDIGENOUS WOMEN are our sacred life-givers. They carry our languages, our traditions, our futures. From the moment they take their first breath, they hold within them the strength of our ancestors and the possibility of generations yet to come. It is through them that our Peoples continue. It is through them that our Nations stand. Yet, Native women face some of the highest rates of violence in the United States today: more than 84% of Native women experience violence in their lifetime, and Native women are murdered at rates up to 10 times higher than the national average in some Tribal communities.[1,2] ***These are not just statistics — they are the lived realities of our mothers, sisters, aunties, daughters, and grandmothers.***

CONTINUED ON PAGE 32

THIS VIOLENCE DIDN'T START WITH US. It came from colonization, forced assimilation, and policies meant to destroy our ways and silence our women. But the truth is: the violence inflicted on our women is violence against the very heart of our communities. When a Native woman is hurt, it echoes through her children, her family, and her Nation. And when a Native woman is lifted up, her power brings healing and hope to everyone around her.

Our ways have always taught that women are sacred. They are not only life-givers but also knowledge keepers, protectors of the land, and the first teachers of our children. Colonization tried to erase this, but our teachings remain. We are remembering. We are returning to our ways.

Today, efforts like those of the National Indigenous Women's Resource Center (NIWRC) are helping us reclaim what has always been ours. NIWRC is leading the work to restore respect for Native women through powerful national advocacy, community-based trainings, and resources that honor our traditional teachings.

They have launched the Restoration Magazine, a publication sharing stories of resistance and healing from Native women across Turtle Island, reminding us that we are not alone.[3] They offer webinars and toolkits on topics like traditional advocacy, the role of Native women in sovereignty, and the connections between violence and land theft, grounding every resource in our cultures.[4]

NIWRC also works with Native youth to teach them about healthy relationships rooted in Indigenous values, making sure our girls grow up knowing they are sacred and powerful, and that our boys and men grow up understanding that women are life-givers who must always be held up as sacred. Our boys and men need to know deep in their hearts that women are not just to be protected but honored, because when they honor women, they honor life itself, and they honor who we are as Indigenous Peoples.

We are the descendants of women who endured boarding schools, forced sterilizations, relocation, and every attempt to take away their power. Still, we are here.

Today, we remember who we are. We remember that our women are sacred life-givers. We honor them by speaking their names with respect, by lifting their voices, and by carrying forward the teachings they have guarded for us since time began.

When a Native woman is lifted up, her power brings healing & hope to everyone around her.

As the NIWRC says, "Safety for Native women is inextricably linked to restoring the sovereignty of our Nations." This is how we heal. This is how we rise.

REFERENCES

- [1] **National Institute of Justice. (2016).** Violence Against American Indian and Alaska Native Women and Men. https://nij.ojp.gov/library/publications/violence-against-american-indian-and-alaska-native-women-and-men-2010-findings
- [2] **Urban Indian Health Institute. (2018).** Missing and Murdered Indigenous Women & Girls Report. https://www.uihi.org/resources/missing-and-murdered-indigenous-women-girls/
- [3] **National Indigenous Women's Resource Center. (2024).** Restoration Magazine. https://www.niwrc.org/restoration-magazine
- [4] **National Indigenous Women's Resource Center. (2024).** Training & Resources on Culturally Based Advocacy. https://www.niwrc.org/

Scan the QR code to learn more by visiting **NIWRC.ORG**

MEET THE FUTURE

Highlighting Our Inaugural Cohort of Tribal Scholars for Health & Sustainability

NIHB'S TRIBAL SCHOLARS FOR HEALTH AND SUSTAINABILITY PROGRAM

The National Indian Health Board, in partnership with the Centers for Disease Control and Prevention, is excited to announce the launch of the Tribal Scholars for Health & Sustainability (TSHS) Program. TSHS seeks to provide students and recent graduates with hands-on experience in Tribal public health and policy while working closely with Tribal communities. Over the course of 10-weeks, our scholars had the opportunity to contribute to national public health initiatives, meet inspiring Tribal health professionals and leaders working in careers across Indian Country, and join NIHB for an in-person week in Washington, DC, where they visited Capitol Hill and engaged directly with federal leaders.

The TSHS program is an important reflection of NIHB's commitment to build pipelines for a stronger Tribal public health workforce. We are committed to investing in our communities, and our scholars are the future of Tribal public health. Throughout the program, NIHB staff provided mentorship, skill-building, and cultural awareness. TSHS equipped our inaugural cohort of Scholars to lead with confidence and purpose so that the future of Tribal public health is shaped by those who know their communities best.

MEET THE 2025 SCHOLARS

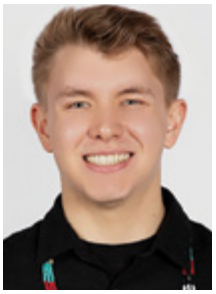
This year we are proud to support our first three Scholars who represent different Tribal Nations and are committed to improving the health and well-being of their Tribal communities.

LUKE LAYMAN (YU'PIK AND ATHABASCAN)

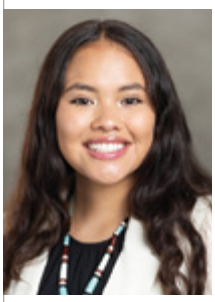
HOMETOWN: Anchorage, AK | **SCHOOL:** Alaska Pacific University | **MAJOR:** Health Sciences with a concentration in Healthcare Management

FUTURE SCHOOL: In the fall, I will begin my MPH at University of Colorado Anschutz

GOAL: *I am especially interested in the ability to work with Tribal health systems in my community to strengthen data systems. These data systems play an important role in population health trends, targeting specific needs, and guiding public health strategies. Data sets can be divided into sets with benchmarks that can eventually reach the goals of an analyst. Essentially for Indigenous people and our healthcare systems, data systems are vital to us already under resourced systems of care.*



PROJECT AT NIHB: Luke worked with NIHB's surveillance and data modernization team on the development of a report and guidance document aimed at developing recommendations to improve syndromic surveillance data sharing with Tribes and Tribal Epidemiology Centers (TECs). The project, which was supported by the Council of State and Territorial Epidemiologists, had the goal of assessing current syndromic surveillance practices, successes, and barriers for Tribes and TECs. Luke conducted key informant interviews around data sharing and syndromic surveillance with Tribal health organizations, conducted a qualitative analysis on interview transcripts, and reviewed background literature and legal documents on Tribal syndromic surveillance and data sharing. Luke also assisted in drafting sections of the final report and guidance document, which is intended to strengthen the ability for Tribes and TECs to receive data and participate in syndromic surveillance. Luke's work set up a strong foundation for NIHB's continued expansion of projects to strengthen Tribal data sovereignty and increase data sharing with Tribes.



LARISSA SCOTT (NAVAJO AND WINNEBAGO NATIONS)

HOMETOWN: Santa Fe, NM

SCHOOL: Stanford University

MAJOR: Human Biology w/ concentration in Epidemiology and Community Health

FUTURE SCHOOL: In the fall, I will begin my MPH at Dartmouth College

GOAL: *I'm interested in an infectious disease project because of its intersection and connection to broader public health challenges in Native communities. Many infectious diseases like hepatitis C, HIV, and even the COVID-19 pandemic disproportionately affect Indigenous populations. These are often in connection with structural issues such as lack of access to care or housing insecurity. My interest lies in how these determinants intersect these diseases in a Native population. I am also focused on the topics of substance use and mental health. For example, the rise in hepatitis C and HIV among Native people is closely linked to injection drug use and gaps in harm reduction services. Exploring these issues through an infectious disease lens allows for a syndemic approach to understanding how co-occurring epidemics affect one another. I want to use this lens to develop community-informed, culturally grounded responses that address these overlapping public health concerns.*

PROJECT AT NIHB: Larissa created an educational toolkit about measles that is culturally relevant for American Indian and Alaska Native (AI/AN) youth. This toolkit has a student workbook, a detailed lesson plan, and a PowerPoint presentation that can be used in elementary or middle school science classes. The lesson plan features pre- and post-tests to assess students' knowledge and attitudes toward measles and vaccination.

As part of the curriculum, Larissa plans to adapt the educational game You Make Me Sick to explore the immune system and the MMR (measles, mumps, rubella) vaccine. Her version incorporates the Native language and culturally relevant context to enhance engagement and accessibility. Together, these tools aim to increase awareness and understanding of measles while promoting vaccine confidence within AI/AN communities.

CHEYENNE MARTINEZ (HOPI NATION)

HOMETOWN: Village of Kykotsmovi on the Hopi Reservation in AZ

SCHOOL: Arizona State University
Current degree program: Master's in Social Work

GOAL: *My work and goals are directly tied to workforce infrastructure because behavioral health is critical and often underserved in Tribal communities. By becoming a licensed therapist and eventually striving to open a substance abuse treatment center on the Hopi Reservation, I aim to strengthen and expand the behavioral health workforce where it's needed most. Not only will this provide essential services to individuals facing addiction and incarceration, but it will also create jobs and training opportunities within the community. Investing in mental health professionals and treatment resources is a key part of building sustainable, responsive workforce infrastructure, particularly in rural and Indigenous communities that have long faced barriers to care.*

PROJECT AT NIHB: Cheyenne completed a Tribal workforce development project using the PHICCS as a reference to assess the capacity & role of behavioral health specialists that support individuals facing challenges related to substance & alcohol use. With the goal of improving Tribal public health infrastructure & developing skills that will contribute to her preparedness to implement similar programs in her own community, Cheyenne identified key leaders & organizations that contribute to the public health system that supports this work. From there, she was introduced to various Tribal public health & behavioral health professionals where she was able to learn more about what they do & ask questions to shape her understanding of the topic. Through research & hands-on skill development, she identified key strategies for effective partnership & relationship sustainability & was able to generate example questions that can assist with identifying existing resources & assessing workforce challenges related to behavioral health services. Cheyenne also built performance improvement skills by identifying key areas & challenges where process mapping may aid in addressing programmatic barriers that impact Tribal behavioral health workforce.

CULTURE IS MEDICINE

Building Tribal Behavioral Health Workforce Through Sovereignty

ACROSS INDIAN COUNTRY, Tribes and Native organizations are leading the way in tackling the behavioral health workforce crisis by investing in people right in our communities. By training Behavioral Health Aides, Peer Support Specialists, and other paraprofessionals who already know our languages, traditions, and realities, we're reclaiming what healing should look like — and keeping care rooted in sovereignty.

We know culture is medicine, and when we grow our own workforce, we keep that medicine in our communities. These roles don't just fill gaps; they create trusted relationships, support our people through healing, and offer stepping stones into long-term careers in health.

PROGRAMS TAKING ACTION

IN ALASKA, the Behavioral Health Aide (BHA) Program continues today through the Alaska Native Tribal Health Consortium (ANTHC) and Tribal health partners, providing local behavioral health services in villages where providers are scarce (ANTHC, 2024).

SEATTLE INDIAN HEALTH BOARD (SIHB) employs Native peer specialists as part of its integrated care team, weaving cultural connection into mental health and substance use support in urban Native communities (SIHB, 2023).

IN SOUTH DAKOTA, the Great Plains Tribal Leaders Health Board has trained Tribal members as Peer Support Specialists, helping bridge people to care with cultural humility and lived experience (GPTLHB, 2023).

These programs show that embedding workforce within Tribal communities builds trust and keeps dollars and talent local. They are examples of what's possible when Tribes design systems for their own people.

OPPORTUNITIES AND ADVOCACY

Looking forward, Tribal Colleges and Universities (TCUs) have the potential to expand behavioral health training programs, including certificates and associate degrees for paraprofessionals. By creating accessible education pathways, we can develop a workforce that stays in Tribal communities and advances into higher-level careers over time.

Additionally, Medicaid Section 1115 waivers have been used by some states and Tribes to cover traditional healing or innovative care models. Exploring these waivers as part of workforce efforts could support paraprofessionals who integrate cultural practices into behavioral health, further centering sovereignty in our solutions (CMS, 2023).

SOVEREIGNTY IS THE FOUNDATION

We need policies that respect Tribal sovereignty to define what care looks like, support for Tribal training programs, and investment in our people as the workforce of the future. Behavioral health aides and peers aren't just stopgaps; they are critical pieces of a trusted, culturally grounded system. They prove that when we say culture is medicine, we mean it — and we're ready to build the pipelines to make it real.

REFERENCES

- **Alaska Native Tribal Health Consortium (ANTHC). (2024).** Behavioral Health Aide Program. Retrieved from ANTHC website.
- **Seattle Indian Health Board (SIHB). (2023).** Peer Support Services. Retrieved from SIHB website.
- **Great Plains Tribal Leaders Health Board (GPTLHB). (2023).** Peer Support Specialist Training. Retrieved from GPTLHB website.
- **Centers for Medicare & Medicaid Services (CMS). (2023).** Section 1115 Demonstrations. Retrieved from CMS website.

SUPPORT TRIBAL PUBLIC HEALTH **The TSHS Program shows what's possible when we invest in Native people. Our Scholars are not just preparing for the future; they are shaping it, grounded in cultural knowledge, & driven by purpose, & committed to their Tribal communities. Still, programs like ours cannot thrive without support. And we cannot do this work alone. To grow & sustain a strong Tribal public health workforce, programs like ours need ongoing support from public & private funders, allies, advocates, & partners who believe in us. Your support contributes to a more equitable & diverse public health workforce where Native voices are heard, trusted, & leading change.**

Upholding the Political Status of Tribal Nations and Tribal Citizens

THE NATIONAL INDIAN HEALTH BOARD continues to actively engage with federal agencies, Congress, and the administration to uphold the United States' trust and treaty responsibilities owed to Tribal Nations — responsibilities rooted in a legally recognized political relationship.

THESE OBLIGATIONS arise from the sovereign status of Tribal Nations and the political status of their Tribal citizens. These are not discretionary actions, they are binding duties affirmed through treaties, the U.S. Constitution, federal statutes, court decisions, and administrative law.

In recognition of the distinct political status of Tribal Nations and Tribal citizens, federal agencies have a legal obligation to provide quality healthcare to Tribal Nations and Tribal citizens.

One of the United States' obligations under its trust and treaty responsibilities is the provision of health care to Tribal people. The Indian Health Care Improvement Act (IHCIA) affirms that:

"[I]t is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." 25 U.S.C. § 1602(1).

Moreover, the IHCIA established that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1).

The federal government's responsibility to deliver healthcare to AI/AN people is an **ongoing, legally binding obligation**.

In February 2025, the U.S. Department of Health and Human Services (HHS) Office of General Counsel (OGC) issued an Advisory Opinion clarifying that recent Executive Orders (EOs) related to Diversity, Equity, Inclusion, and Accessibility programs do not affect the federal government's legal obligations to provide healthcare for Tribal Nations and Tribal citizens. The OGC stated that:

"The three recent EOs addressed below do not apply to the Department's legal obligation to provide healthcare for Indian Tribes and their citizens or the government-to-government relationship that underlies those obligations, which are distinct from the DEI programs targeted in the EOs."

CONGRESSIONAL ACTION IS URGENTLY NEEDED FOR MATERNAL & INFANT HEALTH PROGRAMS

Although not a final agency action, the Advisory Opinion is consistent with Department of the Interior Secretarial Order No. 3416, which similarly clarifies that EO 14151 does not alter or diminish the federal trust and treaty obligations to Tribal Nations. A related HHS memorandum also confirms that programs and services for AI/AN people are exempt from these EOs, based on the political status of Tribal Nations and their citizens.

This obligation flows down into specific policies adopted by Congress and the Administration. One such example is the recognition of the role Medicaid and Medicare play in meeting the trust and treaty obligations for health. Congress, in the recent One Big, Beautiful Bill Act, provided a number of exemptions for American Indian and Alaska Native beneficiaries, such as for Medicaid community engagement and work requirements. The Administration has also committed to engage with Tribal Leaders on the Reorganization of the Department of Health and Human Services. This is critical to protect the programs and resources which support Tribal Nations.

The federal government's responsibility to deliver healthcare to AI/AN people is an ongoing, legally binding obligation. Direct federal investment in the Indian health system, including Indian Health Service (IHS), Tribal, and Urban Indian health programs is required to support the health and well-being of Tribal Nations. The responsibility must remain intact and uncompromised, during any Administration.

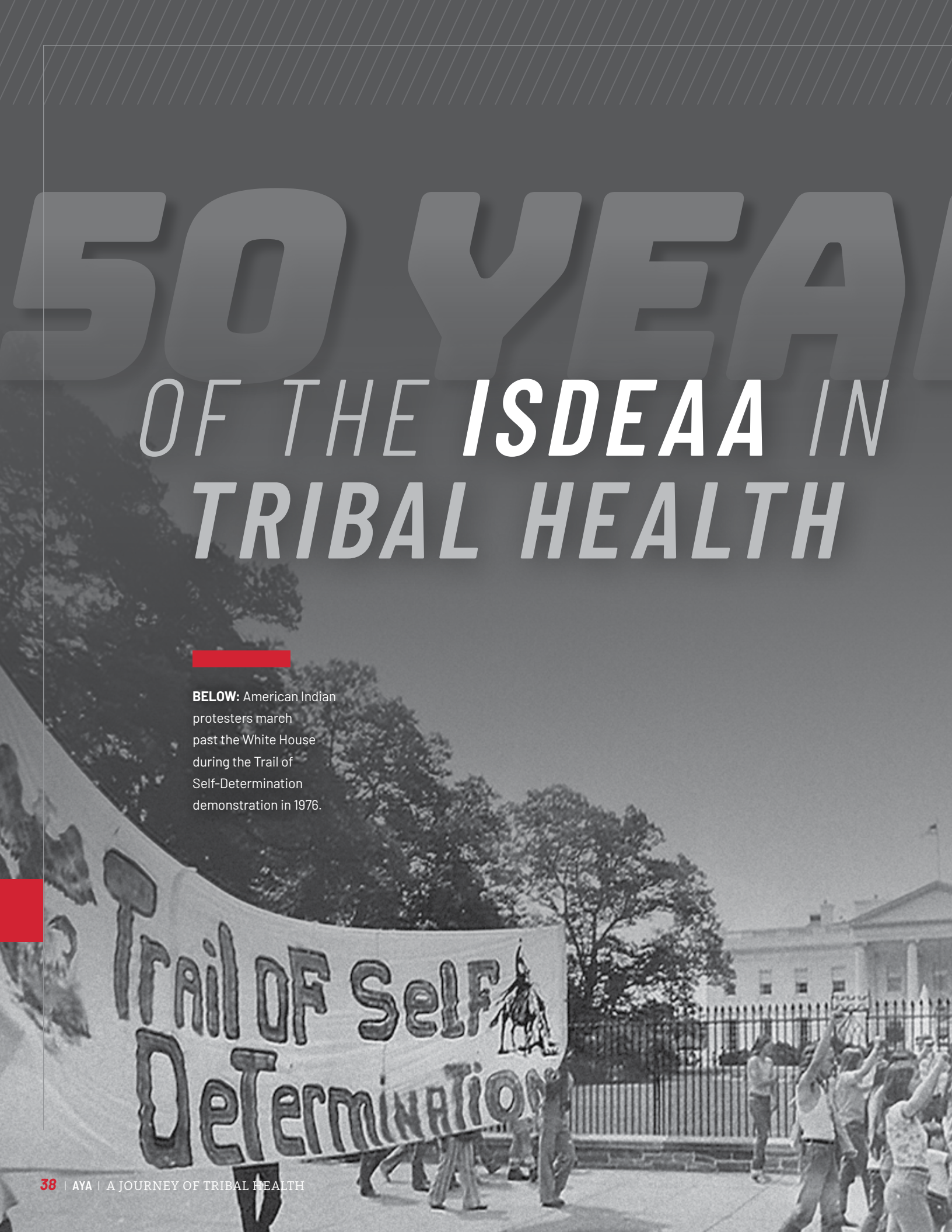
AI/AN mothers and infants continue to experience disproportionately poor health outcomes due to the compounded effects of historical trauma and persistent social, economic, political, and environmental inequities. These systemic barriers — combined with chronic underinvestment in Tribal health systems, a lack of culturally appropriate maternal health professionals, and inadequate data collection — have severely limited the ability of Tribal Nations to implement effective and sustainable maternal and infant health programming.

Despite these challenges, Native-led organizations have demonstrated innovation and resilience by centering cultural values and traditional practices in maternal care. Initiatives such as whole-person care models, access to Indigenous doulas and midwives, and culturally relevant prenatal and postnatal education programs have shown promise in improving outcomes for AI/AN mothers and infants.

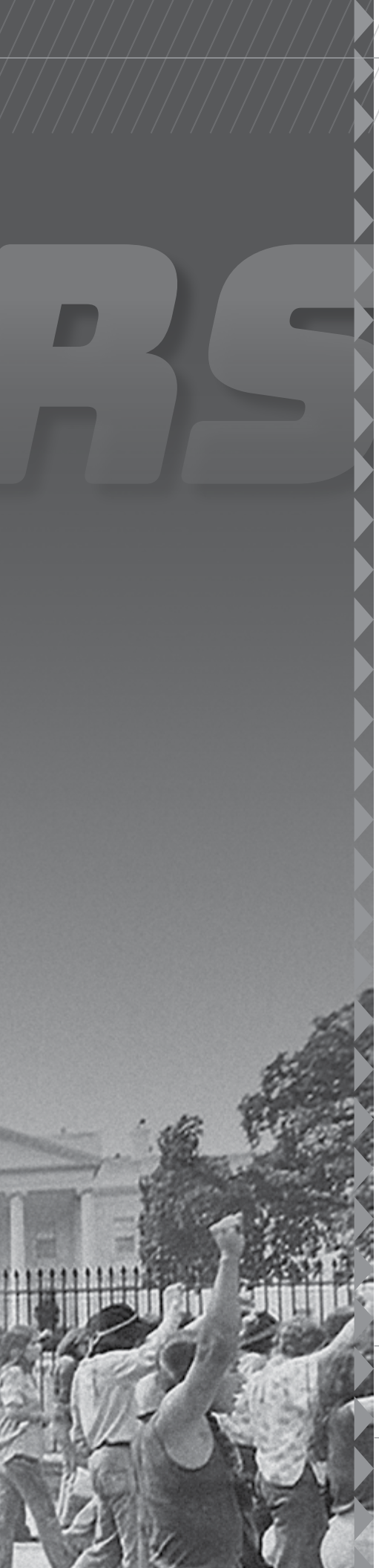
However, these promising community-based efforts cannot fully meet the scale of need without targeted legislative action. Congressional legislation is urgently needed to ensure sustained and adequate federal funding specifically for AI/AN maternal and infant health programs.

The National Indian Health Board (NIHB) will continue to advocate for legislative and policy changes that address this crisis and protect our future generations.

50 YEARS OF THE ISDEAA IN TRIBAL HEALTH



BELOW: American Indian protesters march past the White House during the Trail of Self-Determination demonstration in 1976.



The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA) **marked a watershed moment in U.S.–tribal relations**, granting American Indian and Alaska Native (AI/AN) Tribes greater autonomy over federally funded services such as education, health care, and law enforcement.

THE WORK OF TRIBAL NATIONS AND TRIBAL ADVOCATES helped secure ISDEAA, ending the period of Tribal termination and bringing forward self-determination and self-governance. The Act enabled Tribes to contract directly with federal agencies and eventually negotiate self-governance compacts, empowering Tribal communities to shape their own futures. ***Tribal Nations are rightfully celebrating the 50th anniversary of ISDEAA*** and its impact on Tribal communities now and into the future.

In healthcare, Tribal assumption of their sovereign rights to provide healthcare for their people has resulted in significant benefits. ISDEAA's self-governance authority has allowed Tribes to pursue a variety of innovative solutions to healthcare management and delivery improving outcomes for our communities. Many Tribes now lead in the healthcare space adopting and pioneering integrated care settings, combining primary care, dental, behavioral health, and even opioid treatment programs. Tribal facilities are also major economic drivers in their communities, regions, and states, bringing strong job and career opportunities that support healthy communities.

Throughout Indian Country, Tribes have proven time and time again that Self-Governance is the most effective use of funding and resources to serve each Tribes' specific needs best.

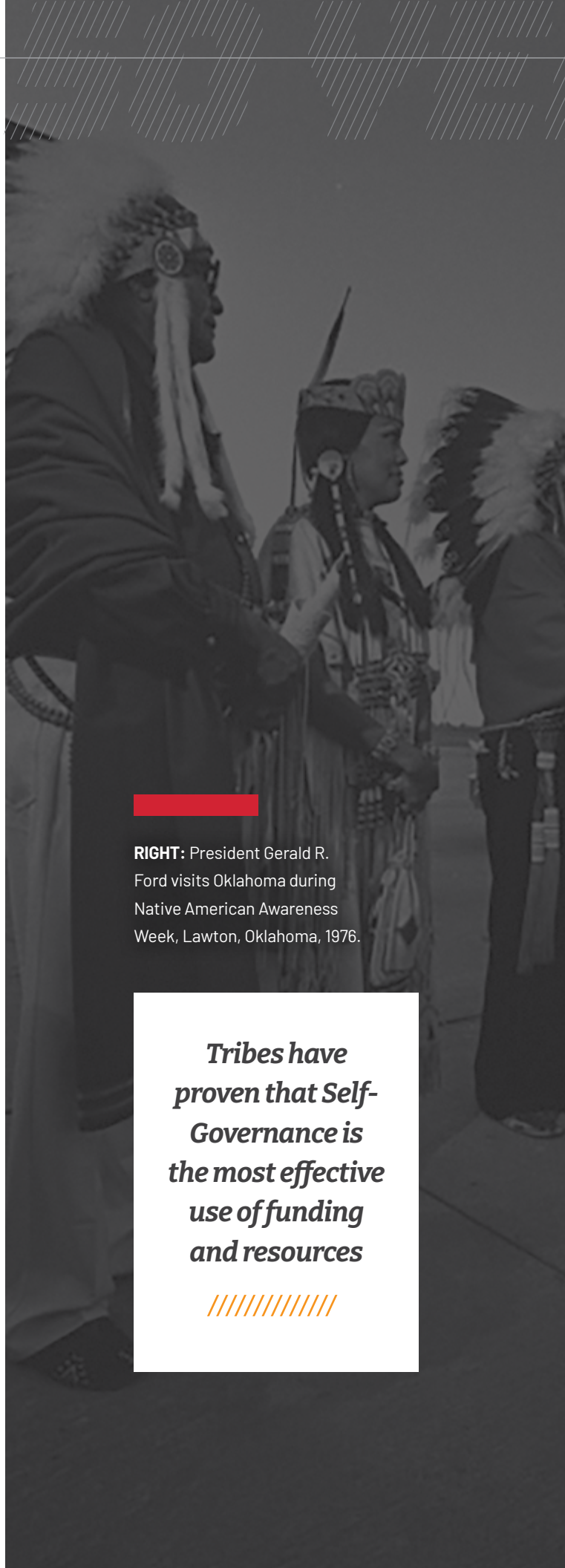
CONTINUED ON PAGE 40

This article is a collaboration between the National Indian Health Board (NIHB) and the Self-Governance Tribal Consortium

Tribes are award-winning employers demonstrating their excellence in delivering and improving healthcare to our People. In Ada, Oklahoma, the Chickasaw Nation's Department of Health is the first Tribal Nation to win the Malcolm Baldrige National Quality Award, which is the highest presidential honor for organizational performance excellence in the United States. In Anchorage, Alaska, Southcentral Foundation, a two-time Malcolm Baldrige National Quality Award winner, pioneered its Nuka System of Care integrating unique Alaska Native cultural approaches that have strengthened its healthcare delivery model. These examples show how Tribes have been able to better tailor their care to improve patient satisfaction with more responsive and culturally informed services, including the use of traditional healing practices.

Now 50 years later, nearly all Tribes are engaging in some type of self-governance or self-determination within the Indian Health Service. In fact, more than 388 of the 574 federally recognized Tribes participate in some form of Self-Governance within the IHS. The rapid successful expansion of "638" programs (as they are also called) under the IHS lead to discussion of expanding self-governance at the IHS and other health programs Tribes accessed within the Department of Health and Human Services. Starting in 2000, Congress adopted ISDEAA amendments which formally adopted Title V creating the Tribal Self-Governance program within IHS and further directed the HHS Secretary under a new Title VI to conduct a feasibility study on self-governance for HHS programs outside the IHS. In a statement of US Government policy adopted as part of the amendments, Congress made clear, "It is the policy of Congress to permanently establish and implement tribal self-governance within the Department of Health and Human Services."[1] In response to Congress, a 2003 study was conducted by a joint HHS/Tribal Workgroup, which determined that expansion at HHS was feasible. The study identified eleven HHS programs that could be integrated into Tribal Self-Governance. They also recommended that Congress pass legislation authorizing a demonstration project to expand Self-Governance at HHS.

In 2004, Senator Ben Nighthorse-Campbell introduced legislation to the Senate to extend Tribal Self-Governance



RIGHT: President Gerald R. Ford visits Oklahoma during Native American Awareness Week, Lawton, Oklahoma, 1976.

Tribes have proven that Self-Governance is the most effective use of funding and resources

ABOVE: President Richard Nixon meets with Tribal leaders at the White House to discuss self-determination, 1970.

to other HHS programs by authorizing a five-year demonstration project based on the HHS/Tribal Workgroup findings. Congress noted in its report on the bill that one of the key components of Self-Governance was the streamlining bureaucracy,[2] echoing previous statements by Congress on the value of Tribal self-governance. Even over 20 years ago, Congress recognized the great potential for cost savings and efficiency the Tribal self-governance and the value of empowering Tribal Nations. Unfortunately, that bill did not make it out of the 108th Congress and another bill like it has not yet been reintroduced. Since then Tribal leaders and experts have worked on additional reports and bill language in hopes of expanding the success of Tribal Self Governance to other HHS programs.

WHAT'S NEXT?

It's time to extend Tribal Self-Governance beyond Indian programs, including to other HHS programs serving Tribes. The trust and treaty responsibility does not sit isolated within IHS, BIA, and BIE; it extends to all of the services and programs the government delivers to Tribal Nations and our citizens. The Administration can use existing statutory authority to expand some grant and programs now empowering Tribes with flexibilities, and Congress can enact new authorizing legislation that will open these programs up to Self-Governance as is the US Government's stated policy and commitment. Tribal self-governance is feasible within HHS; it creates efficiency; and it empowers Tribes to improve our communities. ***Fifty years into this Era of Self-Determination, there has never been a better time to expand self-governance beyond programs.***

REFERENCES

- [1] P.L. 106-260
- [2] https://www.congress.gov/108/crpt/srpt412/CRPT-108srpt412.pdf

One Year with the New NIHB Branding

REFLECTING ON A MILESTONE

Nearly a year ago, the National Indian Health Board (NIHB) revealed a redesigned logo and visual identity — **a bold step that both honored our roots and embraced the future of Tribal health.**

THIS WASN'T JUST A DESIGN UPDATE, it was storytelling made visible. In collaboration with Native-owned creative agency Nativ3, our trusted partners during the 2024 National Tribal Health Conference, we developed a modern design that pays homage to our heritage. Every element of the logo was chosen with care: the colors, the movement, the symbolism all reflect the vibrancy, resilience, and individuality of our people.

To bring even deeper meaning to the design, we partnered with artist Evans Flammond (Rosebud Sioux) to create a painted buffalo hide depicting NIHB's origin story - from our founding in the 1970s in Colorado to our present-day leadership in Washington, DC. This hide now hangs in our office, a daily reminder of where we've been, and where we're going. It also directly influenced parts of the logo and has since become a cornerstone of our visual storytelling.

Over the past year, we've been proud to see this new identity carried across our materials, events, and communications. But more importantly, we've been proud to see how it's resonated with Tribal leaders, health advocates, partners, and community members across the country.

It's more than a logo. It's a reflection of our shared mission: to advance the health and well-being of all American Indian and Alaska Native people through policy, advocacy, and partnership.

As we look ahead, we remain we remain guided by our core values — sovereignty, wellness, unity, and cultural strength — and deeply grateful to each of you who walks this path with us. Thank you for your trust, your support, and your vision for a healthier future.

Together, we build a stronger, healthier future for all American Indian and Alaska Native communities.

CONTINUED ON PAGE 44

ARTIST PROFILE: EVANS FLAMMOND SR. AND THE BUFFALO HIDE

TRIBAL AFFILIATION & ROOTS

- Evans Flammond Sr. is an enrolled member of the Sicangu (Rosebud Sioux) and Oglala Lakota Tribes. Born in Rosebud, SD and raised on the Rosebud and Pine Ridge Reservations, he now resides in Oglala, SD, where he works with family to preserve and evolve Lakota art traditions.

ARTISTIC JOURNEY & VISION

- Inspired by Northern Plains Indian art from age seven and mentored by his uncle Maynard Barker, Flammond remained largely self-taught. His work spans ledger art, hide painting, beading, metalwork, canvas, and ceremonial pieces — all infused with ancestral designs and contemporary color palettes.

BUFFALO HIDE STORYTELLING

- The painted hide created for NIHB memorializes our founding and growth. Using a chisel brush and acrylics on premium buffalo hide, Flammond honored the buffalo's cultural and spiritual significance while depicting scenes of journey, community, and collective resilience. The artwork directly informed elements of NIHB's logo and continues to shape our visual storytelling.

CULTURAL SIGNIFICANCE OF PAINTED BUFFALO HIDES

- Painted buffalo Plains Tribes traditionally used hides to record history, honor leaders, celebrate accomplishments, and tell stories. Often created by community historians or warriors, these hides served as living documents, chronicling events, and preserving cultural memory for future generations. Today, artists like Flammond carry forward this tradition - revitalizing its meaning through contemporary expression.

LEGACY & RECOGNITION

- Flammond's artwork is featured in museums, galleries, and public and private collections, including the Red Cloud Heritage Center, Minnesota Historical Society, and the South Dakota State Capitol. His pieces have been exhibited at the Sioux Indian Museum, All My Relations Gallery, and the Red Cloud Art Show, underscoring his dedication to growing Native art across generations.

PARTNER PROFILE: THE NATIV3 TEAM

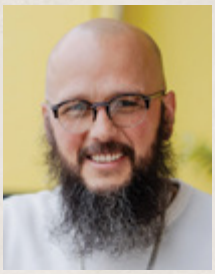
WHO THEY ARE

- NATIV3 is a Native-owned, full-service digital agency based in the Twin Cities. Founded in 2016, the agency blends technical expertise with cultural insight to create human-centered digital solutions that honor story, heritage, and identity. With clients ranging from federal

agencies to Tribal governments, NATIV3 is driven by the values of human integrity, thoughtful excellence, and proactive resilience.

CONNECTION TO NIHB

- After a successful collaboration on the 2024 National Tribal Health Conference, NIHB partnered with NATIV3 again to reimagine our visual identity. Their team brought deep respect, creative clarity, and cultural sensitivity to the project, helping us develop a logo that reflects the vibrancy, resilience, and sovereignty of the Tribal Nations we serve.



ABOUT JON CRAPPEL, CEO & FOUNDER

- Jon Crappel (United Houma Nation) is a strategist, storyteller, and advocate whose work bridges the digital and human worlds. As the founder and CEO of NATIV3, he leads with an openhanded philosophy rooted in cultural thoughtfulness and a belief in mutual empowerment. His vision for the agency is guided by lagniappe - the act of giving "a little something extra" - which he infuses into every relationship and project.

PERSONAL MISSION

- A dedicated foster parent alongside his wife Teri, Jon is raising seven children and advocating fiercely for those in the child protection system. His commitment to family, heritage, and faith informs his leadership at NATIV3, and inspires the team's approach to storytelling that is both inclusive and impactful.

CULTURAL THOUGHTFULNESS IN ACTION

- With a professional background in both theology and computer science, Jon brings a unique lens to digital work — one that is as reflective as it is technical. Whether leading digital campaigns or developing tools for identity preservation in the child welfare system, his work always centers dignity, community, and healing. Jon views change not as disruption, but as restoration. His work is about honoring what is essential while creating room for growth. That perspective is especially reflected in the design process with NIHB, where tradition and modernity came together to tell a story of continuity and transformation.

"THE ENROLLMENT ASSISTER MADE THE DIFFERENCE"

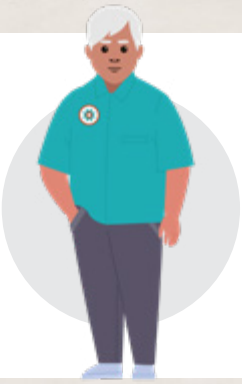
Real Tribal Stories Behind Health Coverage Access

ACROSS INDIAN COUNTRY, the journey to health care is not just about access — it's about survival, sovereignty, and resilience. The National Indian Health Board (NIHB), in collaboration with Tribal Enrollment Assisters, has gathered powerful, real-life stories of Native individuals and families navigating health insurance coverage. These stories, part of the CMS Storyboard Project, illustrate how federal programs like Medicaid, Medicare, CHIP, and the Health Insurance Marketplace are making a tangible difference in Native lives.

Each story shares a deeply human moment — when an illness, injury, or unexpected cost threatened stability — and how Tribal support helped people find their way forward.

One story follows a mother from the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians. When a modest income increase pushed her family out of Medicaid eligibility, she fell into a dangerous coverage gap. Her children qualified for CHIP, and her husband had employer insurance, but she was left uninsured. Through the Health Insurance Marketplace and the guidance of an Enrollment Assister, she secured affordable coverage — protecting her health while preserving critical Purchased/Referred Care (PRC) dollars for others in need.

ANOTHER NARRATIVE highlights a silversmith from the Navajo Nation whose vision — and livelihood — was at risk due to untreated cataracts. Unable to afford Medicare Part B, he had no way to pay for surgery. With help from a Patient Benefits Coordinator, he enrolled in Medicaid and qualified for the Qualified Medicare Beneficiary (QMB) program, which eliminated his out-of-pocket costs. His restored vision allowed him to continue his art and pass his skills to his grandchildren.



STORIES LIKE THESE AREN'T UNIQUE — THEY ARE **HAPPENING EVERY DAY** IN TRIBAL COMMUNITIES.

A MOTHER from the Mescalero Apache Tribe gained coverage for her entire family through Medicaid support of employer-sponsored premiums.

A CHOCTAW COUPLE found affordable coverage through the ACA just in time for four critical surgeries.

A YOUNG APACHE man received emergency surgery for appendicitis thanks to rapid action by his Tribal clinic.

A DINÉ MAINTENANCE WORKER avoided disability and homelessness by accessing low-cost coverage after a horse-riding injury.

IN EACH CASE, the key difference was clear: a knowledgeable, trusted Enrollment Assister or Patient Benefits Coordinator who stepped in at the right time.

These stories are more than testimonials. They are tools for advocacy, visibility, and education. Inspired by Native traditions of storytelling, they reflect how shared experiences can teach, heal, and mobilize communities. They also highlight systemic gaps — where eligibility cliffs and affordability challenges still jeopardize Native health — and the solutions that exist when resources and relationships align.

Through these accounts, NIHB underscores a vital truth: health insurance is more than a policy; it's a promise. A promise rooted in the federal Trust and Treaty responsibility to American Indian and Alaska Native peoples. A promise that, when fulfilled, leads to stronger families, sustainable clinics, and vibrant communities.

In Indian Country, stories are medicine. And these stories affirm what we already know — when Tribal communities are supported and empowered, health equity becomes possible.

Reclaiming Warrior Wellness Through Indigenous Social Determinants of Health

THEY CARRIED THE BURDEN FOR US

AT A NATIONAL GATHERING hosted by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Veterans Affairs (VA), Carrie Field, Senior Policy Analyst at the National Indian Health Board (NIHB), and Lacey Wind, Vice President of Tribal Health Programs at NIHB, delivered a message rooted in cultural truth: suicide prevention for Native veterans must be grounded in Tribal knowledge, identity, and healing. NIHB was invited to speak on Tribal Social Determinants of Health (TSDOH), bringing a perspective shaped by community, ceremony, and sovereignty.

American Indian and Alaska Native (AI/AN) people serve in the U.S. military at the highest rates per capita. But when they return, too many face disconnection, racism in care, underfunded systems, and the lasting impact of historical trauma. From 2020 to 2021, suicide among AI/AN veterans rose by 51.8% — the highest increase across all racial and ethnic groups[1].

Lacey and Carrie framed their message through Indigenous Social Determinants of Health (ISDH) — a framework that includes more than upstream drivers of health. ISDH speaks to the deep interwoven elements of Native life that support wellness: connection to traditional land, language, cultural roles, community belonging, and spiritual practice[2].

A core message from the session was that land-based healing must happen on a veteran's own traditional Tribal

American Indian and Alaska Native people have a long and storied history of service in the U.S. Armed Forces. Despite their service, too many AI/AN people face disconnection, racism and underfunding when they return to civilian life.

lands. Healing is not interchangeable. It is specific. For Native veterans, going back to their own land — where their ancestors walked, where they know the plants, animals, medicines, and stories — is what brings meaning and restoration. The land holds memory, connection, and identity[3].

Language was also lifted up, not as bilingualism, but as ceremony. Language is how warriors speak to their ancestors. It is how they pray. It is how they call their spirit back. For many veterans, that call is necessary after trauma and separation. Language is part of identity, and identity is suicide prevention[4].

Tribal belonging, too, is a critical protective factor. Knowing who you are, what Nation you belong to, and where you fit in your community keeps people grounded. Warrior identity and Tribal identity must be upheld — not only to honor service, but to sustain life[5].

One audience member offered a reflection that stuck with everyone in the room: that both men and women warriors must be welcomed home. Veterans of all genders deserve ceremony, healing, and the full recognition of their role. The entire community carries that responsibility — to uplift, restore, and walk beside those who carried the burden for us.

The presentation called for preparation on both ends — before and after service. Cultural grounding, ceremony, and mentorship should start before enlistment and continue through return. This transition must be whole, intentional, and community-held.

Field and Wind also highlighted examples of Tribal approaches that work:

- **CEREMONIAL HEALING:** Sweats, naming, storytelling, spiritual guidance
- **ELDERS AND TRADITIONAL HEALERS:** Guiding warriors back to themselves
- **LAND-BASED HEALING:** On the veteran's own homelands, not just any land
- **MENTORSHIP AND BELONGING:** Veteran-to-youth connections that build purpose
- **TRIBAL CONTROL OF SERVICES:** Systems created by and for Native people
- **CULTURAL SAFETY:** Providers trained in historical trauma and Indigenous worldviews

Lacey reminded the audience that programs alone are not enough. "This is about sacred responsibility," she said. "Restoring warriors to their rightful place in the community — that's the medicine."

The session closed with the words of Chief Leonard Crow Dog (Sicangu Lakota):

"It is not the job of a warrior to fight alone. It is the job of a warrior to fight for the people, to heal the people, and to build the people up."

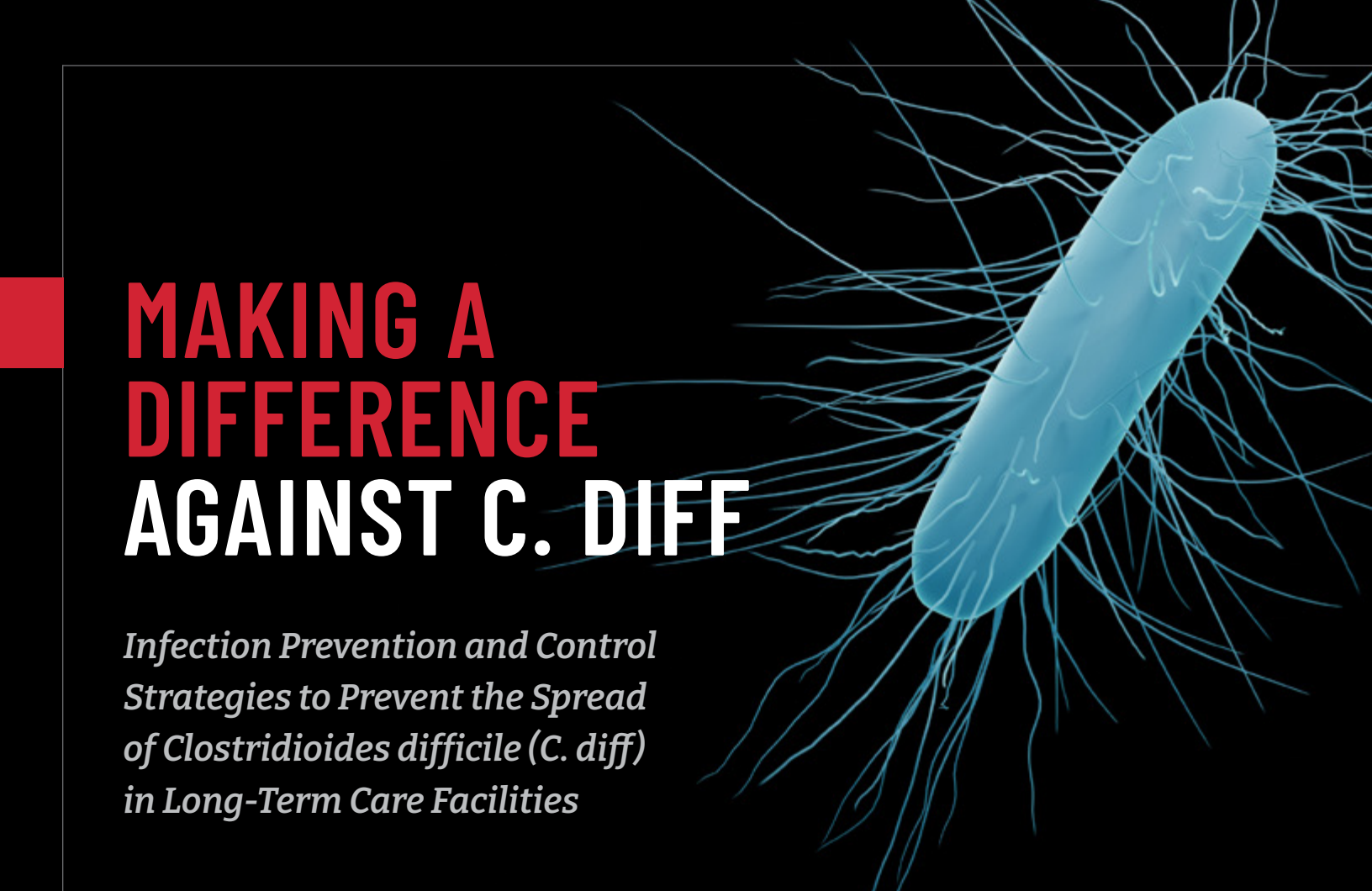
When we welcome our warriors home with land, language, ceremony, and love — we don't just prevent suicide. We restore life, connection, and honor.

REFERENCES

- **1. U.S. Department of Veterans Affairs. (2022).** 2022 National Veteran Suicide Prevention Annual Report. https://www.mentalhealth.va.gov/suicide_prevention/data.asp
- **2. Warne, D., & Lajimodiere, D. (2015).** American Indian health disparities: Psychosocial influences. Social and Personality Psychology Compass, 9(10), 567–579. https://doi.org/10.1111/spc3.12231
- **3. Smithsonian National Museum of the American Indian. (2020, Fall).** Returning Home: Traditional Healing and Modern Warriors. American Indian Magazine. https://www.americanindianmagazine.org/story/returning-home
- **4. Gone, J.P., & Trimble, J.E. (2012).** American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. Annual Review of Clinical Psychology, 8, 131–160. https://doi.org/10.1146/annurev-clinpsy-032511-143127
- **5. Walters, K.L., Beltran, R., Huh, D., & Evans-Campbell, T. (2011).** Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives. Du Bois Review: Social Science Research on Race, 8(1), 179–189. https://doi.org/10.1017/S1742058X1100018X
- **6. Native American Rights Fund. (2018).** Healing the Warrior: Veterans, Ceremonies, and the Quest for Balance. https://www.narf.org/healing-warrior/
- **7. Gone, J.P. (2013).** Redressing First Nations Historical Trauma: Theorizing Mechanisms for Indigenous Culture as Mental Health Treatment. Transcultural Psychiatry, 50(5), 683–706. https://doi.org/10.1177/1363461513487669

MAKING A DIFFERENCE AGAINST C. DIFF

Infection Prevention and Control Strategies to Prevent the Spread of Clostridioides difficile (C. diff) in Long-Term Care Facilities



CLOSTRIDIOIDES DIFFICILE INFECTIONS (often called CDI, *C. diff*, or *C. difficile*) is a spore-forming bacterium that can cause diarrhea and more severe intestinal conditions, such as colitis. *C. difficile* spreads from person-to-person through the fecal-oral route. CDI often arises after the use of antibiotics that change the normal bacteria in the gut. Symptoms of *C. diff* include watery diarrhea, fever, and abdominal pain. Residents in long-term care facilities are at greater risk because of their age, underlying disease / comorbidities and frequent hospitalizations. In long-term care settings, following infection control practices and taking precautions can reduce or prevent the chance of spreading CDI.

Recommended Infection Prevention and Control Strategies

HAND HYGIENE: Healthcare workers should use alcohol-based hand sanitizers with 60% to 90% alcohol content to clean their hands. If hands become soiled, wash with soap and water after caring for a resident with CDI during outbreaks.

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE): Wear a gown and gloves when entering a resident's room and properly discard before exiting the patient's room. This protects staff and limits the spread of

C. DIFF IS ESTIMATED TO CAUSE ALMOST HALF A MILLION INFECTIONS IN THE U.S. EACH YEAR

LEFT: A *Clostridioides difficile* spore. CDI often arises after the use of antibiotics that change the normal bacteria in the gut. Symptoms of *C. diff* include watery diarrhea, fever, and abdominal pain.

C. diff spores. Proper donning and doffing of PPE should be followed to prevent cross-contamination .

ENVIRONMENTAL CLEANING: EVS (Environmental Services) staff should regularly use a *C. difficile* sporicidal agent (EPA List K agent) to clean and disinfect high-touch surfaces. This includes cleaning resident bedrails, doorknobs, and toilet seats, with particular attention to terminal cleaning upon patient discharge or transfer. Shared equipment items should be cleaned before use with another resident.

MONITOR USE OF ANTIBIOTICS in the facility to reduce the number of CDI cases. A good antibiotic stewardship program can help prevent *C.diff* outbreaks by minimizing unnecessary prescribing.

EDUCATE AND TRAIN STAFF on *C. difficile* transmission prevention and proper PPE use.

ISOLATION PROTOCOLS:

- Place residents with suspected or confirmed CDI in private rooms, when possible, with a dedicated toilet. Contact and standard precautions should be continued if a patient with CDI has diarrhea or muddy stools .
- Use dedicated patient-care equipment such as blood pressure cuffs and stethoscopes.

Conclusion

Long-term care facilities can reduce the risk of outbreaks by prioritizing hand hygiene, proper use of PPE, effective cleaning, isolation protocols, and antibiotic stewardship. Continuing education and updated policies help keep infection control standards high. To keep our vulnerable people safe from C. diff, all the staff in long-term care need to work together and be committed.

REFERENCES

- **Appendix A:** Type and duration of precautions recommended for selected infections and conditions. (2024, September 20). Infection Control. https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html#:~:text=Hand%20hygiene:%20Handwashing%20for%2030,against%20spores%20%5B983%5D.
- **C. diff: Facts for Clinicians. (2024, March 5).** https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html
- **Centers for Disease Control and Prevention. (2014, October).** Sequence for putting on personal protective equipment (PPE) [Instructions]. https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-figure.html
- **Clinical Guidance for C. diff Prevention in Acute Care Facilities. (2024, March 8).** C. Diff (Clostridioides Difficile). https://www.cdc.gov-/c-diff/hcp/clinical-guidance/index.html
- **Contact Precautions.** (n.d.). https://www.cdc.gov/infectioncontrol/pdf/contact-precautions-sign-P.pdf
- **EPA's Registered Antimicrobial Products Effective Against Clostridioides difficile (C. diff) Spores [List K] |US EPA. (2024, June 3).** US EPA. https://www.epa.gov/pesticide-registration/epas-registered-antimicrobial-products-effective-against-clostridioides#for
- **IHSgov. (2024, July 9).** Advancing antimicrobial stewardship: Navigating the latest Joint Commission updates [Video]. YouTube. https://www.youtube.com/watch?v=iP8vZ5Y-cG0
- Sukhlall, D., PharmD, BCPS, Sims, J. G., PharmD, BCPS, Adams, M., PharmD, BCPS, Kern, R., PharmD, BCPS, Phoenix Indian Medical Center, Crow/Northern Cheyenne Hospital, Northern Navajo Medical Center, & Claremore Indian Hospital. Practical application & implementation of the core elements of hospital antibiotic stewardship Programs.
- https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/asp/Core-Elements-of-Antimicrobial-Stewardship.pdf

National Indian Health Board

NIHB.ORG

SOVEREIGNTY. STRENGTH. EQUITY.