

SPRING

2024

# HEALTH REPORTER

## TRADITIONAL HEALING: THE PATH FORWARD

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### FEATURED INSIDE

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- + **IDH REPORTS 'GAMECHANGING' FOR NATIVE HEALTH**
- + **USING LAW AS A TOOL FOR EQUITY**



National Indian  
Health Board



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**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 orga-  
 nizations, 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 Indi-  
 an 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 rec-  
 ognized American Indian/Alaska Native (AI/AN)  
 Tribes through the fulfillment of the trust respon-  
 sibility to deliver health and public health services.  
 Since 1972, NIHB has advised the United States  
 Congress, IHS federal agencies, and private founda-  
 tions 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 Associa-  
 tion of State Medicaid directors to the IHS Leader-  
 ship Council.

**TRIBAL PUBLIC HEALTH**

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



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**HEALTH REPORTER**

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COVER STORY

**WHERE WE ARE AND THE PATH FORWARD**

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## Toiyabe Indian Health Project

The impact of the COVID-19 pandemic was felt around the world. During the course of the pandemic, American Indians and Alaska Natives (AI/ANs) experienced a disproportionate disease burden compared to other populations in the United States. In 2020, among young adults and middle-aged range AI/ANs, the COVID-19 mortality rate was over ten times higher compared to the white population<sup>1</sup>.

However, Tribes cared for their people during the pandemic to prevent COVID-19 morbidity and mortality. This often meant that Tribes used innovative practices that weren't used by their state and local counterparts. For instance, some Tribes closed their borders or fishing waters to non-Tribal members, supplied families with personal protective equipment (PPE) such as masks, and even worked with their counties for contact tracing! Although they didn't have to prove anything to us, Tribes proved to the rest of the world that we take care of our own, even when the tides are turned against us.

To advance our mission of achieving the highest level of health and wellbeing for our people, the National Indian Health Board (NIHB) provides funding to Tribes and Tribal organizations doing work in their community. During the COVID-19 pandemic, NIHB was able to supply funding to a number of Tribes and organizations, one of which being the Toiyabe Indian Health Project (TIHP). We are incredibly grateful to TIHP for sharing the story of their pandemic experience with us. Keep reading below to learn more.

### TIHP: Leading the Way in Protecting Communities

Toiyabe Indian Health Project, Inc. (TIHP), is a Tribal, nonprofit organization in California that offers medical services and preventive health programs for seven



federally recognized Tribes and one Native American community across Inyo and Mono Counties: Antelope Valley Indian Community (Coleville), Big Pine Paiute Tribe of the Owens Valley, Bishop Paiute Tribe, Bridgeport Indian Reservation, Fort Independence Indian Reservation, Lone Pine Paiute-Shoshone Reservation, Utu Utu Gwaitu Tribe (Benton), Timbisha Shoshone Tribe (Death Valley), and surrounding non-native communities in Bishop, CA.

Schools and youth are often neglected by public health prevention and wellness activities. With funding assistance from NIHB, TIHP was able to provide the lacking education and support to students and schools in Mono and Inyo counties. TIHP served approximately 1,350 community members (including K-12 students, teachers, and staff) by providing education on COVID-19 prevention and various wellness topics to six Tribal-affiliated schools in Mono and Inyo counties!

TIHP found the most success with COVID-19 outreach and education by focusing more on wellness, health promotion, and disease prevention rather than specifically on COVID-19 infections. In addition, TIHP was able to establish stronger relationships with the Tribal schools in the region and clinic departments through collaborative efforts due to this grant. Even better than that, the communities and schools enjoyed the materials!

## Continued Challenges to Preventing Disease in Tribal Communities

The median distance for patients to TIHP is 98 miles, an obvious barrier to access to prevention programs and care. Additionally, since the beginning of the pandemic, TIHP has struggled with the closure of clinics, limited community health services offered, and vaccine hesitancy from patients. Despite these challenges, the TIHP Community Health Department has still been able to offer health education and preventative services to all of their Tribal communities!

During TIHP's efforts, they were able to address a few challenges: the environment limiting access to community outreach (rural terrain, natural disasters), staff changes that affected organization workflow, and lack of staffing that reduced the amount of work they hoped to accomplish. However, vaccine hesitancy and health-care distrust aren't uncommon in Tribal communities, so it was difficult to convince those who were adamant in their beliefs. Regionally, the vaccination rates for a completed primary series ranged from 55 to 75%, depending on zip code. However, the vaccination rate for primary series among TIHP tribal members was 45%.

Four years into the pandemic and Tribal communities still continue to face loss and grief. The challenges Tribes faced, and still face today, highlight the need for continued funding, resources, and support for Tribal communities to strengthen their ability to provide public health services. ■



**Thank you to our partner *MS. CHRISTY TONEL, MPH, RYT*, with Toiyabe Indian Health Project, Inc. organization for providing information on COVID-19 features.**

1. Goldman and Andrasfay (2022). Life Expectancy Loss among Native Americans During the COVID-19 Pandemic. medRxiv. Version 2. doi: 10.1101/2022.03.15.22272448.



## Oyate Health Center's Drive for Equitable Healthcare

In 1997, Congress took a monumental step in addressing healthcare disparities among American Indian and Alaskan Native (AIAN) Tribes by establishing the Special Diabetes Program for Indians (SDPI). Geared toward providing grants for diabetes treatments and prevention services, this initiative has been addressing the effects of diabetes in AIAN communities across the United States. With annual funding of \$150 million, the SDPI has been implementing evidence-based strategies and recommendations regarding diabetes prevention, treatment, and control for AIAN people.<sup>1</sup>

### The Oyate Health Center

Situated as an urban hub in Rapid City, South Dakota, the Oyate Health Center exemplifies the power of community-driven healthcare, offering hope and support to all who seek it. Oyate Health Center serves the local Rapid City population and neighboring Tribes such as the Rosebud Sioux Tribe, Oglala Sioux Tribe, and Cheyenne Sioux Tribe, which amounts to 25,000 people who come to the center. The center's mission is "to improve the wellness of our people by providing quality healthcare, public health services, advocacy, and support in partnership with the tribal nations of the Great Plains area."<sup>2</sup>

At its helm is Mr. Stephen Yellowhawk, the Program Director for the SDPI at Oyate Health Center, whose personal journey from health technician to program leader embodies a deep-rooted commitment to community health. "I've seen this program grow from being in a double-wide trailer to being in a three-level building." Embracing the Nuka system of care, inspired by the South-Central Foundation, the SDPI at Oyate Health Center places patients, referred to as "relatives," at the forefront and serves approximately 1,350 people.

The program offers personalized support tailored to each relative's unique needs through a multidisciplinary team comprising dietitians, educators, and lifestyle coaches. "We focus on setting goals with relatives and making sure they hit their goals," states Yellowhawk.

We do bike challenges and warrior challenges where we bike and hike in the Black Hills. We try to produce different things to motivate them to work hard."

### Expanding Reach and Impact

Access to the program requires being a beneficiary of the Indian Health Service (IHS) or proof of being enrolled in a federally recognized tribe. With primary care on the first level for consultations and the fitness center on the third level, the new building houses many services and programs in one location, creating efficiency and accessibility for all participants. The program's impact resonates across the Great Plains and draws individuals from afar to benefit from its SDPI services and fitness center. "This past April, we extended our fitness center hours from 6:00 am-7:00 pm to accommodate those who work. We are anticipating an increase in participants who use the fitness center."

With a robust outreach strategy through word of mouth, listserv reminders about Turkey or Roast Challenge incentives, and social marketing from the Great Plains Leaders Health Board, participation continues to grow steadily. Personal stories, such as that of an individual achieving significant weight loss and improved A1C levels, highlight the program's efficacy and transformative potential. "This older gentleman was preparing to have surgery and wanted to lose a certain amount of weight and work on his A1C level," states Yellowhawk, "We supported him and his journey. He lost 20 lbs. and his A1C went down 3-4 points before his surgery."



## Addressing Food Insecurity

Complimenting this initiative, another community program is making strides in providing fresh produce every week. "We have a sister program called Fight Against Diabetes: A South Dakota Produce Prescription Program (SDPPP) that provides access to fresh produce and this program helps them with their diet, especially when food is expensive. People are so grateful for this program," states Yellowhawk. Furthermore, the program offers educational resources, including recipes featuring a variety of produce, which enables relatives to explore new culinary foods. "They're being exposed to produce they haven't eaten before," states Yellowhawk. Oyate Health Center is one of the first to lead this charge.

In collaboration with IHS, the U.S. Department of Health and Human Services has allocated \$2.5 million in funding to Produce Prescription Programs for Tribal communities to alleviate food insecurity and enhance healthcare outcomes. HHS Secretary Xavier Becerra emphasized the importance of access to healthy food, stating, "Food is medicine, and nutrition is health. It is critical that all Americans have access to healthy food." IHS Director Roselyn Tso echoed this sentiment by characterizing the funding

as a commitment to addressing food insecurity in AIAN communities and said, "It is a recognition of the urgent need to empower and support tribal communities in their pursuit of food sovereignty and well-being."<sup>3</sup>

### REFERENCES:

1. *Special Diabetes Program for Indians 2020 Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress* [Internet]. Rockville (M.D.): Indian Health Service (U.S.); 2020. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK571291/>
2. *Oyate Health Center 2024*. (2024, March 29). *Our Mission, Vision, and Values*. Oyate Health Center. <https://www.oyatehealth.com/about-ohc/our-mission/>
3. *HHS Press Office*. (2023, July 31). *HHS Awards \$2.5 Million to Help Decrease Food Insecurity in Native Communities*. U.S. Department of Health and Human Services. <https://www.hhs.gov/about/news/2023/07/31/hhs-awards-2-5-million-help-decrease-food-insecurity-native-communities.html>

## Overcoming Challenges

Despite encountering obstacles such as spatial restrictions and financial constraints, Oyate's SDPI has seen success and is expanding. The fitness center is now accommodating more people, promoting discussions about the need for additional space. "Once 25-30 people are in the fitness center, it gets crowded. I have already spoken to the administration about the space. We have already outgrown our space, which is a good thing." Financial concerns persist, but the program remains optimistic, especially with a promising collaboration on the horizon with the Center of Indigenous Health at Johns Hopkins University. Tailored to the Lakota community, this initiative, named "Together Overcoming Diabetes," holds the potential to address the rising diabetes trends among young individuals.

An essential aspect of any program is its staff, and Yellowhawk proudly acknowledges his team's ability to create meaningful relationships with relatives and create a welcoming environment. "They make the relatives feel comfortable. They also reach out to relatives and support them in their journeys. They are compassionate and have invested in their craft." Yellowhawk remarks. Their firm support, coupled with compassion and dedication to their roles, highlights the importance of teamwork in achieving program success. "We laugh, we cry, and we support one another. We are a team," emphasizes Yellowhawk.

At the heart of the Oyate Health Center's SDPI lies a commitment to holistic care, community health, and cultural relevance. Led by Mr. Yellowhawk and his team, the program stands a beacon of hope for managing or preventing diabetes. As the program continues to evolve and expand, its enduring message remains clear: "We are here to help, to support, and to empower our communities toward healthier and brighter futures," states Yellowhawk. ■



# WHERE WE ARE

## *Traditional Healing Reimbursement Through 1115 Demonstration Waivers*

**A**rizona, California, Oregon, and New Mexico each submitted 1115 demonstration waivers requesting Medicaid to provide reimbursement for various traditional healing services. The Centers for Medicare and Medicaid Services (CMS) set apart the traditional healing components in each waiver for further federal review despite approving other requests in these applications. In March of this year, CMS proposed a skeleton draft framework to guide the review process of 1115 waivers, including traditional healing services. This framework will set a path for how Tribes proceed with reimbursement for traditional healing through Medicaid and will be tremendously consequential in the future relationship between Tribes and CMS. ***This report seeks to provide a primer on the current landscape of 1115 demonstration waivers and an outlook on the road ahead for reimbursement of traditional healing practices through Medicaid.***

&

# THE PATH FORWARD

*Tribes have each developed, refined, and stewarded their unique understandings and practices of health since time immemorial.*



## Traditional Healing, Sovereignty, and the Trust Responsibilities

Tribes have each developed, refined, and stewarded their unique understandings and practices of health since time immemorial. Consequentially, American Indian/Alaska Native (AI/AN) traditional healing practices possess *inherent sovereignty*.

Traditional healing services should be able to receive reimbursement from the federal government since accessing traditional medicines protects the right of AI/AN people to care for their health in its whole, traditional domain. As reaffirmed through the Indian Health Care Improvement Act (IHCIA), it is the duty of the U.S. government to “ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”<sup>1</sup> Despite this trust responsibility to provide for the highest possible health status for AI/ANs, obtaining Medicaid reimbursement to support access to traditional healing services has proven to be a long and challenging process for Tribes.

## All About 1115 Demonstration Waivers Including Traditional Healing

1115 demonstration waivers grant state Medicaid programs the flexibility to waive specific federal requirements to perform a “demonstration project.” A demonstration project intends to show how a particular approach can provide better services that improve a Medicaid program.<sup>2</sup> Tribes looking to launch a new 1115 waiver with traditional healing components must work with and through the state where they reside to

1. Indian Health Care Improvement Act, 25 U.S.C. § 1602 (2010). <https://www.govinfo.gov/content/pkg/USCODE-2022-title25/pdf/USCODE-2022-title25-chap18-other-sec1602.pdf>.

2. Centers for Medicare and Medicaid Services. (n.d.). About Section 1115 Demonstrations. *Medicaid.gov*. <https://www.medicare.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>.



LEFT: Blue Elderberry; ABOVE: White Sage

complete their application.<sup>3</sup> Each currently pending waiver application undergoing federal review provides traditional healing in unique ways.

### ARIZONA

The Arizona Health Care Cost Containment System submitted its most current 1115 demonstration requests to CMS in 2020 and seeks to provide traditional healing services included in a patient’s care plan and approved by a facility’s or Tribe’s governing body through Indian Health Service (IHS), Tribal, and Urban Indian health providers (I/T/Us).<sup>4</sup> However, Arizona included traditional healing services in its 1115 waiver for the first time in 2015. The 2015 demonstration

requested reimbursement for credentialed Traditional Practitioner services provided through a Regional Behavioral Health Authority integrated plan.<sup>5</sup>

### CALIFORNIA

The California Advancing and Innovating Medi-Cal (CalAIM) 1115 demonstration was submitted to CMS in 2021. It seeks to provide services from traditional

3. Centers for Medicare and Medicaid Services. (n.d.). 1115 Application Process. <https://www.medicare.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html>

4. Centers for Medicare and Medicaid Services. (2021). Arizona Health Care Cost Containment System. Pending Application – Extension Request. *Medicaid.gov*. <https://www.medicare.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa8.pdf>

5. Centers for Medicare and Medicaid Services. (2015). Arizona Health Care Cost Containment System. Arizona Extension Application. <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-ext-app-10152015.pdf>

6. Centers for Medicare and Medicaid Services. (2021). California Advancing and Innovating Medi-Cal (CalAIM) (formerly “Medi-Cal 2020”. Medi-Cal 2020/CAL-AIM (DHCS) Renewal Request. <https://www.medicare.gov/medicaid/section-1115-demonstrations/downloads/ca-medi-cal-2020-pending-renewal-pa9.pdf>

7. Centers for Medicare and Medicaid Services. (2022). Oregon Health Plan. Oregon Health Plan Extension Application. <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-pln-extnsion-appl-2022-2027.pdf>

healers and natural helpers within their substance use disorder treatment options through Indian health care providers.<sup>6</sup>

### OREGON

The Oregon Health Plan 1115 demonstration was submitted to CMS in 2022 and seeks to provide reimbursement for Tribal-based practices approved by the Tribal-Based Practice Review Panel, which currently includes prevention, substance use, and mental health services through claims-based reimbursement.<sup>7</sup>

### NEW MEXICO

New Mexico’s Centennial Care 2.0 demonstration is the only 1115 waiver that contains approved traditional healing components for AI/ANs. The waiver extension application was approved in 2019 and includes Traditional Healing Benefits facilitated through each Managed Care Organization and delivered as a self-directed community benefit.<sup>8</sup> This benefit is provided by community-recognized medicine men and women as healers and is subject to the \$2000 annual limit for eligible Tribal members.<sup>9</sup> The 2022 extension request expands the traditional healing benefits to all Native American members enrolled in managed care. It would annually provide each member with up to \$500 for traditional healing services provided by traditional healers.<sup>10</sup> This extension request is currently undergoing further federal review.<sup>11</sup>





CMS representatives have introduced a draft framework meant to guide the approval process of the 1115 demonstration waivers with traditional healing components.

### Where We Are Now: 1115 Demonstration Waiver Federal Review Framework

At the March Face-to-Face Meeting of the CMS Tribal Technical Advisory Group (TTAG), CMS representatives introduced a draft framework meant to guide the approval process of the 1115 demonstration waivers with traditional healing components. Medicaid representatives shared that this framework must be finalized before they will approve any 1115(a) demonstration waiver applications with traditional healing services. This newly proposed framework impacts the approval process for Arizona, California, Oregon, and New Mexico's waivers with traditional healing, which are all pending approval. This proposed framework will also impact Tribes in other states that may be currently working on an 1115(a) demonstration waiver or Tribes that are interested in submitting such a waiver in the future.

As of April 2024, CMS has shared limited details about the draft framework, which are "pre-decisional and subject to change." It is uncertain at this time how the draft framework would affect the review status of

the pending waivers. It is further unclear if CMS will release the full text of the approval framework and perform consultation on the full version before finalizing it.

Currently, the framework consists of five components: eligible beneficiaries, traditional healthcare practices, providers/practitioners, reimbursement and infrastructure, and evaluation. Notable details from this framework include the following provisions:

- The draft framework would only reimburse services provided by or through IHS or Tribally-operated facilities at 100 percent service match.<sup>12</sup>
- The practices eligible for reimbursement would be those that "align with the Indian Health Care Improvement Act, that are actively delivered by or through IHS or tribal facilities." Urban Indian Health Programs would not be eligible for reimbursement through Medicaid under this framework.<sup>13</sup>
- Providers of these services must be employed or contracted by IHS or Tribal facilities. CMS was clear that "there would be no additional state licensing, credentialing, any other requirements beyond those which IHS and tribal facilities already establish."<sup>14</sup>

### Approval and Beyond

There are several outcomes advocates hope can be supported by approving any of the pending 1115 demonstration projects. To start, approving these demonstration projects will provide additional resources for traditional medicine providers, improving access to culturally competent care for eligible Tribal citizens. Access to Medicaid funding would also represent a long-awaited acknowledgment of Tribes' sovereign right to provide health care services in alignment with their knowledges and practices of wellness.

Additionally, as 1115 waivers with traditional healing components are approved, it can encourage other states and Tribes to pursue creating and submitting their own demonstration projects. Furthermore, a series of successful demonstration projects could produce compelling evidence to advocate for legislative changes to amend the Medicaid statute to make traditional healing reimbursement possible nationally.

**For more information on traditional healing, please contact Alanna Cronk, Government Relations Coordinator, at [ACronk@nihb.org](mailto:ACronk@nihb.org)** ■

8. Centers for Medicare and Medicaid Services. (2018). *New Mexico Centennial Care 2.0 (formerly New Mexico Centennial Care). CMS Extension Approval.* <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-12142018.pdf>

9. Ibid.

10. Centers for Medicare and Medicaid Services. (2022). *New Mexico Centennial Care 2.0 (formerly New Mexico Centennial Care). Pending Application – Extension Request.* <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa5.pdf>

11. Centers for Medicare and Medicaid Services. (2023). *New Mexico Centennial Care 2.0 (formerly New Mexico Centennial Care). Demonstration Approval.* <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-appvl-12152023.pdf>

12. Centers for Medicare and Medicaid Services. (2024). *Medicaid Coverage of Traditional Health Care Practices Provided at Indian Health. [Unpublished Consultation Materials].* [https://www.nihb.org/resources/All-Tribes-Call-PowerPoint\\_508-Compliant.pdf](https://www.nihb.org/resources/All-Tribes-Call-PowerPoint_508-Compliant.pdf)

13. Ibid.

14. Ibid.



# PROTECTING NATIVE MOTHERS

American Indian/Alaska Native (AI/AN) women are pillars in Tribal communities as life givers, culture bearers, and caretakers of homelands. Holding the power to bring life into this world is a highly valued and sacred tradition in Indian Country that is surrounded by *cultural importance, knowledge, and good medicine.*

As keepers of traditions and customs in many Tribes, mothers hold distinct roles of nourishing, teaching, and leading their families as matriarchs. Native women, across all Tribal nations, have the fundamental and equal right to have healthy birth experiences and the right to quality care before, during, and after pregnancy and childbirth.

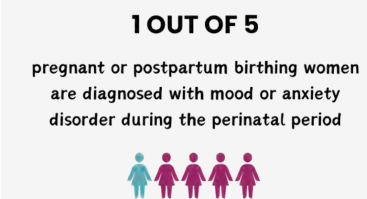
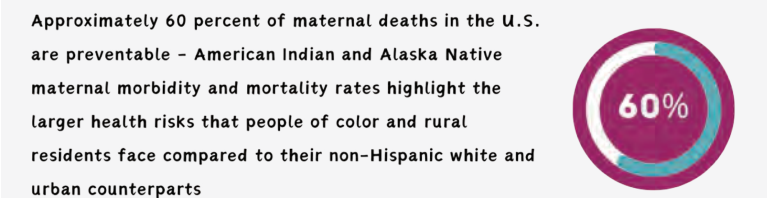
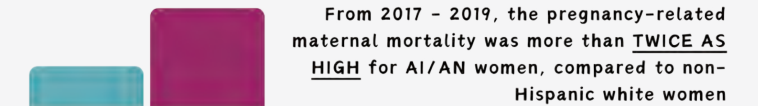


Losing a woman during or after their pregnancy is traumatizing for families and communities, and AI/AN populations face a disproportionate maternal morbidity and mortality burden. For every 100,000 live births to AI/AN women, there were 32 deaths related to pregnancy from 2017 to 2019. *AI/AN women were nearly 2.3 times more likely to die from a pregnancy-related cause than non-Hispanic White women.* Research has shown that approximately 60% of maternal deaths in the U.S. are preventable, and AI/AN maternal morbidity and mortality rates highlight the larger health risks that people of color and rural residents face compared to their non-Hispanic white and urban counterparts.

Gathering accurate data also presents a substantial challenge: Racial misclassification and the relatively small sample size of AI/AN women has prevented the issue of maternal mortality in Indian Country from gaining national attention. Protecting AI/AN mothers, their families, and Tribal communities in ways that uphold Tribal values and practices is essential for preventing maternal mortality in Indian Country.

Adverse maternal health outcomes like this are due, in part, to the ongoing trauma of inequitable access to healthcare including discrimination, racism, and OBGYN deserts, as well as the historical trauma of systemic racism, colonization, genocide, forced migration, reproductive coercion, and cultural erasure. Despite these challenges, Native women and communities continue to draw strength and resiliency from our cultures and traditions – we’ve seen incredible growth and development of birth workers, doulas, and traditional birth attendants, as well as in the realms of

## MATERNAL HEALTH IN TRIBAL COMMUNITIES



Postpartum Medicaid expansion is the first step to achieving maternal health equity, especially in Tribal communities. Postpartum people in states that do not have extended pregnancy coverage to 12 months are at a higher risk of coverage disruption

In the U.S., AI/AN people are most likely to have Certified Nurse Midwife-attended births, working towards the goal of reclaiming traditional birth practices in their communities. A 2022 report highlighted that AI/AN people have inherently protective practices embedded in their cultures that contribute to their ongoing resilience

traditional birthing practices, and even the development of traditional birthing centers!

Addressing maternal health disparities and inequities in Indian Country requires collective action and meaningful collaboration and consultation directly with Tribal communities to eliminate the systemic and structural barriers that hinder efforts to achieve maternal health and well-being now and for future generations.

Artist Credit: **MADONNA DOLPHUS** is an accomplished designer hailing from South Dakota and a member of the Otoe-Missouria Tribe. Her artwork was featured as part of the 2024 National Tribal Health Conference held in Rapid City, S.D.



The high maternal mortality rates for AI/AN women reflect the U.S. policies on maternal and reproductive health. Failure to address the social determinants of health, combined with a lack of comprehensive healthcare access, prenatal and postpartum support, and cultural humility, has led to the adverse maternal health outcomes we see today. Failing to recognize and address the health inequities in our current healthcare system stops us from achieving equitable health for AI/AN women and children.

Since 1972, the National Indian Health Board (NIHB) has not stopped working to address this health burden.

## Tribal Maternal Health Work at NIHB

### MMRCS

NIHB is proud to partner with the Centers for Disease Control and Prevention (CDC) to assist Tribes and Tribal organizations in exploring the feasibility and building capacity to implement Tribal-led Maternal Mortality Review Committees (MMRCS) as a potential model for maternal mortality prevention. Currently, there are no tribally-led MMRCS, and many states lack Tribal representation or have in their MMRCS. It is critical to establish a committee that deeply understands our people's cultural and historical context to develop equitable solutions for maternal health in Indian Country.

### HEAR HER CAMPAIGN

Our Partnership with CDC also includes our work on the Hear Her Campaign to amplify the voices of AI/AN people and to raise awareness about urgent maternal warning signs during and after pregnancy that could indicate potentially serious complications. Families and communities deserve access to culturally appropriate care rooted in their traditional practices. Through this partnership, we have offered funding opportunities, supported by the U.S. Department of

Health and Human Services, Office of Minority Health, and the Centers for Disease Control and Prevention, for Tribes and Tribal organizations to support and advance their efforts in maternal health promotion that meet the needs of their communities and speak to their perspectives of maternal mortality prevention capacity locally while utilizing the CDC Hear Her campaign materials.



### COMMUNITY GATHERINGS

From November 2-3, NIHB's Maternal Health Team, in collaboration with the CDC Maternal Mortality Prevention Team, hosted the "2023 Convening on Tribal Maternal Mortality Review" that was held on the sacred lands of the Santa Ana Pueblo at the Hyatt Regency Tamaya Resort. This gathering successfully brought together 60+ maternal health experts, Tribal partners, birth workers, and advocates from across the nation, including our partners from Area Health Boards and Tribal epidemiology centers, who are dedicated to improving the healthcare and well-being of Native communities. During this in-person convening, participants across Indian Country engaged in peer-to-peer learning to shape the future of this work.



**ABOVE:** NIHB's Maternal Health Team, in collaboration with the CDC Maternal Mortality Prevention Team, hosted the "2023 Convening on Tribal Maternal Mortality Review" that was held on the sacred lands of the Santa Ana Pueblo at the Hyatt Regency Tamaya Resort.

### MATERNAL HEALTH WEBINARS

The Maternal Health Tribal Learning Community Series is a virtual series dedicated to learning together about maternal health work in Indian Country, sharing knowledge to inform efforts going forward, and engaging with others in the field. Some of the topics covered included sovereignty from first breath, cultural competency and responsive healthcare practices, mental health and wellbeing, and advancing health equity.

### MATERNAL HEALTH WEBINARS

Each year, in partnership with CDC, NIHB hosts a virtual Maternal Mortality Prevention Institute. The goal of these institutes are to share culturally centered practices, strength-based approaches, and equitable solutions that are making a positive impact on the health and well-being of Tribal communities. Some of the topics covered in previous institutes include home visiting and the Family Spirit Program, affirming



LGBTQ2S+ clients in perinatal care, Tribally-led Maternal Mortality Review Committees, and midwifery work in Indian Country. ■





# “ GAMECHANGING ”

*The release of Indigenous Determinants of Health reports are re-shaping the **global understanding** of Native health*

**D**uring a recent Tribal Consultation with the U.S. Department of Health and Human Services, NIHIB Chairman William Smith, a Tribal leader of the Valdez Native Tribe, emphasized the importance of a holistic view of health with a poignant personal story. With tears in his eyes, Chairman Smith told the gathering of federal officials, policymakers, and Tribal leaders about why his mother had scars on her forehead all her life: it was from a coffee cup that was thrown at her face, because she dared to speak to her sister in their Native Eyak language.

Chairman Smith continued, “They said they needed to ‘kill the Indian to save the man’, and they really did a good job of killing the Indian. The boarding schools especially. At the end of her life, my mother hated that she was the last full-blooded speaker of our language, that Eyak was going to be the first Alaska Native language to go extinct.”



**ABOVE: NIHIB Chairman William Smith**

Chairman Smith and other Tribal leaders have often discussed the importance of language as an Indigenous knowledge keeper and transmitter, and how strong connections to Indigenous cultures and languages are protective to the health of American Indians and Alaska Natives (AI/AN). Tribal leaders also emphasize the destructiveness wrought by Indigenous-specific stigma, the erosion of traditional lifeways, ongoing trauma exposure, the feder-

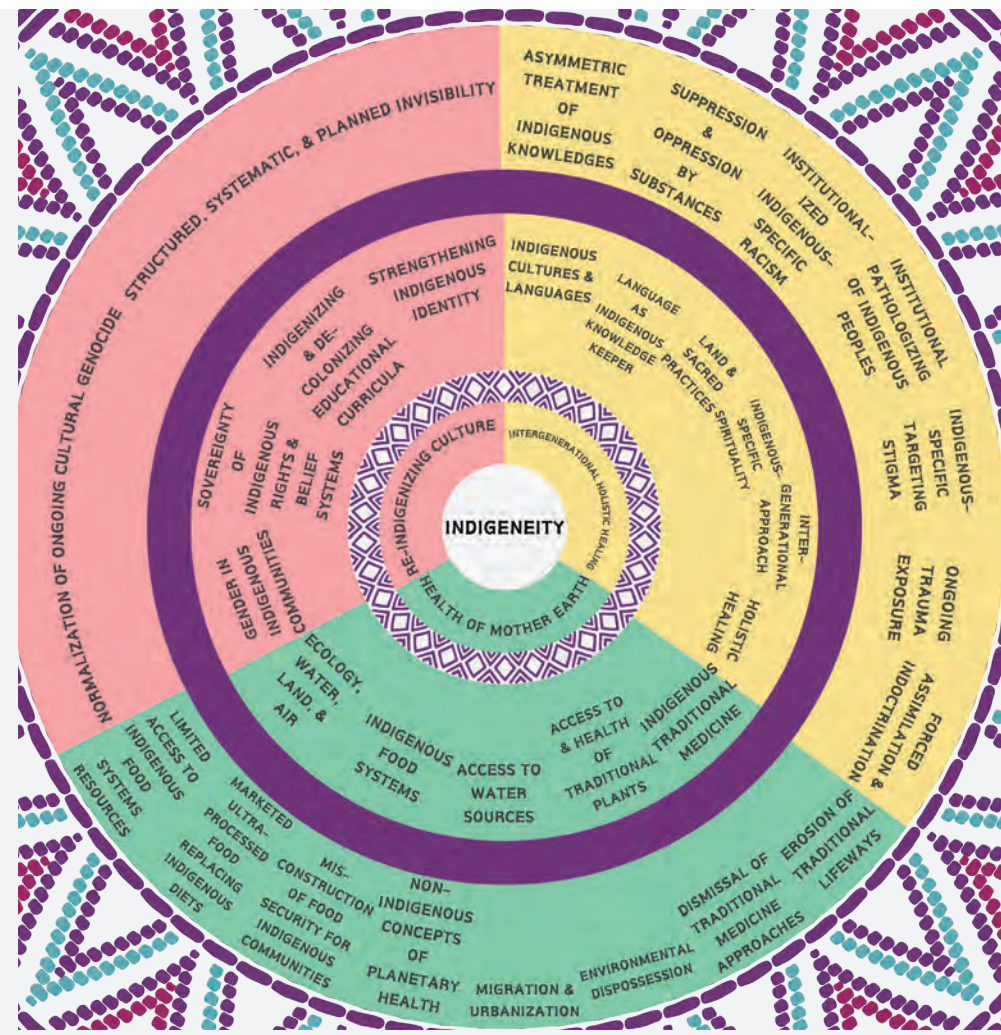
al Indian boarding schools, and other forms of forced assimilation and cultural genocide. These combined positive and negative forces – both historical and current – can powerfully influence health outcomes for Native peoples.

“NIHB’s sole commitment and focus is to the health of all American Indian and Alaska Native peoples,” said Chairman Smith at another time. “That work cannot succeed without restoration of language and culture, and healing from colonization. Our very concepts of what it is to be healthy are rooted in our cultures, languages, and in our shared and individual histories. **Without standing in the full knowledge and understanding of the impact colonization has defined in all Indigenous experience, we will not know health. We will not heal.**”

“My mother hated that she was the last full-blooded speaker of our language, that Eyak was going to be the first Alaska Native language to go extinct.”



**RIGHT: Indigenous Determinants of Health.** Indigeneity is an intersectional, overarching driver of health across sectors. Both negative (outer ring) and positive (middle ring) factors make up the 32 additional drivers of Indigenous health, grouped into three categories.



In a significant and promising step forward, the federal government has prioritized work towards health equity in recent years. Unfortunately, federal health equity initiatives have largely proceeded without attention to critical drivers specific to Native health. The most recent update to the HHS Equity Action Plan includes as a key objective: “Advance social determinants of health (SDOH) research...to better identify and address structural barriers to healthcare access and influence positive outcomes.” But this focus on “SDOH” remains too limited, and – by neglecting Tribal perspectives – risks missing the forest for the trees. While “SDOH” may focus on questions like, “How can we improve access to grocery stores?”, the more important question for many Tribal communities may be: “How can we strengthen our Indigenous food systems and pass on Indigenous food knowledges to younger generations?” In addressing behavioral health issues like depression, an “SDOH” approach may ask, “How can we increase access to mental health treatment services?”, but risks ignoring the harm caused by treatment that overly relies on Western approaches and focuses on changing an Indigenous person’s way of thinking, perceiving, or behaving, rather than changing the discriminatory and oppressive systems that create the ongoing traumas at

the root of the depression. In short, the SDOH framework is grievously insufficient to capture the upstream drivers that influence the health of Native peoples. To address this gap, NIHB is committed to advancing Indigenous perspectives of health and equity – and to transform global perceptions and efforts regarding the drivers of health for Indigenous people. Part of this critical, groundbreaking work has been NIHB’s international collaboration with Indigenous peoples from academia, Tribes and stakeholders, and other Indigenous serving organizations to develop a pair of reports on Indigenous Determinants of Health (IDH) for the United Nations Permanent Forum on Indigenous Issues. These two reports provide guidance for global, national, and local decision-makers on how to implement systemic and structural changes to equitably address Indigenous health and wellbeing. They are designed to educate government officials on practical actions to address 33 Indigenous-specific risk

and protective factors in a culturally safe way. This is a crucial step to mitigate systemic apathy towards Indigenous issues by fostering dialogue and change in critical areas.



**ABOVE: The Social Determinants of Health model examines drivers of health outside of biomedical factors, but falls short of capturing important Indigenous-specific drivers of health.**

Stacy Bohlen, CEO of the National Indian Health Board and citizen of the Sault Ste. Marie Tribe of Chippewa Indians, expressed concern for the frequent federal habit of missing the bigger picture when she said, “How can you talk about equity at all, if you don’t first ask us what equity means to us?” According to Bohlen, having a new framework that looks clearly at the drivers most important to the health of Indigenous peoples is nothing short of “game-changing.” She continued, “You won’t reach equity without understanding the importance of culture, language, traditional foods – without understanding the importance of Indigeneity itself - but these things never show up in federal plans or diagrams about ‘social determinants of health.’” According to Bohlen, the Indigenous Determinants of Health framework isn’t just a shift in perspective; it’s a paradigm shift.

Bohlen explained that this framework is the bigger picture that provides context to all the issues and priorities Tribal health advocacy has focused on for decades. “A lot of Tribal advocacy focuses on asking

for more resources. But just asking for resources isn’t enough, if the people holding the strings to that funding don’t understand who you are or what your people need,” she said. “The Indigenous Determinants of Health is a starting point for saying, ‘This is who we are, this is why you need us at the table, and this is why you need to address Tribal issues separately from the work you do on behalf of ‘minority communities.’”

NIHB has already made progress on using the IDH framework as a tool for policy change. NIHB and the National Congress of American Indians each passed resolutions supporting the IDH framework and calling on the United States to develop a national plan for AI/AN health. These resolutions also called on the United States to adopt a framework for Tribal Determinants of Health, in consultation with Tribes. Creating the Tribal Determinants of Health will be an opportunity to take the global IDH framework and apply those priorities to the specific context of American Indian and Alaska Native Tribes. Following this resolution, NIHB has used the IDH to frame many Tribal health policy priorities in daily advocacy work at the federal level. In addition, last year NIHB supported a resolution for the World Health Organization to create a global action plan for the health of Indigenous peoples. The resolution was approved by the Seventy-sixth World Health Assembly and has reinvigorated the momentum generated by Indigenous global leaders regarding the urgency of addressing Indigenous issues in a culturally safe manner.

“We add our hands to those of our brothers and sisters around the globe to carry this basket of hope, justice, healing, and restoration together,” said Bohlen. “This action is just the beginning. Now the work begins to reclaim and re-cut the trail of Indigenous health and wholeness deliberately over-planted with colonization’s bitter, thorny brambles.”

**For more information on NIHB’s work on Tribal health equity and the Indigenous Determinants of Health, see [nihb.org/health-equity](https://nihb.org/health-equity) ■**



# MOSQUITO ABATEMENT

*A shifting climate and the reproduction of disease-carrying mosquitoes poses a **distinct challenge** to Tribal communities*



**I**n Tribal communities, addressing climate change takes on a unique dimension with a focus on mosquito abatement. The interconnectedness of a shifting climate and the reproduction of disease-carrying mosquitoes poses a distinct challenge to these regions. Rising temperatures and altered precipitation patterns create conducive environments for mosquito breeding, heightening the risk of vector-borne diseases. In response, Tribal nations have implemented innovative strategies for mosquito control that align with their cultural and environmental values. *These initiatives often involve a blend of traditional knowledge, sustainable practices, and collaboration with modern scientific approaches.*



*The integration of Indigenous wisdom with contemporary solutions not only aims to mitigate the immediate health risks, but also fosters resilience within Tribal communities against the broader impacts of climate change. Some examples of these strategies include:*

### Indigenous-Led Mosquito Abatement Strategies

#### THE NAVAJO

The Navajo Nation, spanning parts of Arizona, New Mexico, and Utah, face significant challenges from mosquito-borne diseases like West Nile virus and Zika virus. To combat these threats, the Navajo Nation Department of Health initiated a program blending traditional ecological knowledge with modern science. One notable strategy involved using indigenous plants like sagebrush and yarrow, known for their mosquito-repelling properties, to create natural mosquito repellents and larvicides. Elders and traditional healers played a crucial role in identifying and utilizing these plants, emphasizing cultural significance and sustainability in mosquito abatement efforts.

### Cultural Resilience in Climate-Driven Mosquito Challenges

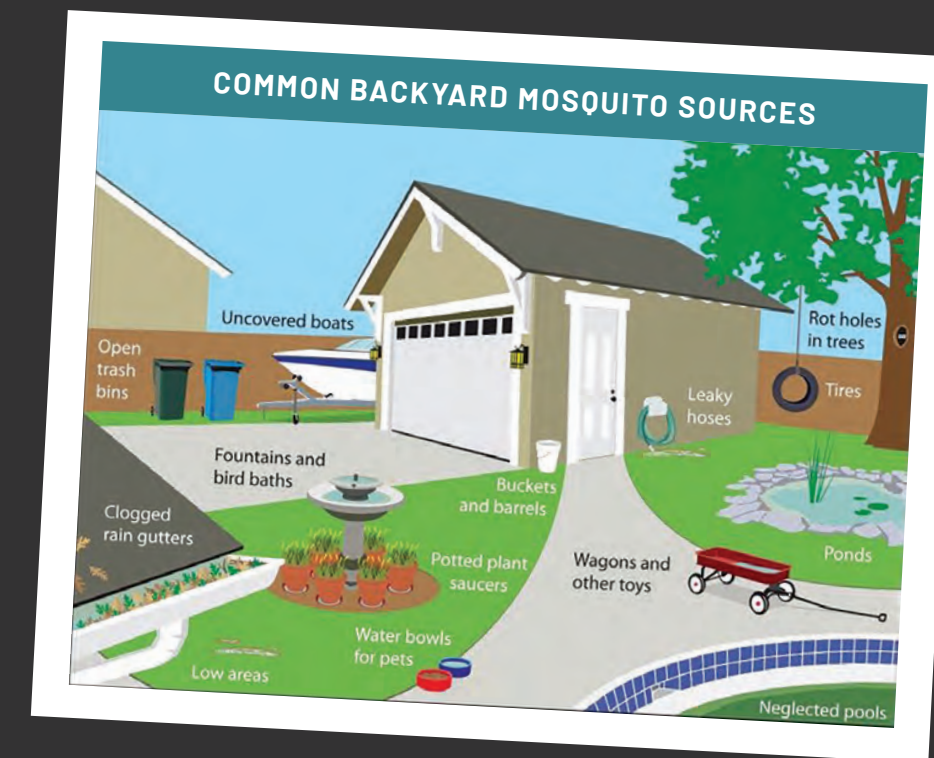
#### THE YUP'IK

The Yup'ik people of Alaska's Yukon-Kuskokwim Delta confront increasing challenges from climate change, including shifts in mosquito populations and disease risks. Drawing upon their cultural resilience, Yup'ik communities have revived traditional practices like constructing elevated traditional homes called "qasgiq" to mitigate mosquito exposure. Additionally, storytelling and community gatherings served as platforms for sharing Indigenous knowledge about navigating mosquito-infested environments, helping to reinforce cultural identity while adapting to changing environmental conditions.

### Climate Change Impacts on Tribal Health

#### THE OJIBWE

The Ojibwe People, whose ancestral lands encompass the Great Lakes region, also experience the notable effects of climate change on mosquito habitats and associated health risks. Rising temperatures and altered precipitation patterns contribute to the proliferation of disease-carrying mosquitoes, threatening community health. In response, the Ojibwe People prioritized environmental monitoring and community health education programs. Traditional teachings about ecosystem interconnectedness and seasonal cycles informed efforts to adapt to changing mosquito-borne disease patterns while preserving cultural practices deeply rooted in the natural world.



### Collaborative Approaches: Integrating Traditional and Scientific Wisdom

#### THE HO-CHUNK

The Ho-Chunk Nation in Wisconsin collaborates with university research programs and governmental agencies to develop comprehensive mosquito abatement strategies. By integrating traditional ecological knowledge with cutting-edge scientific research, the partnership has yielded innovative solutions tailored to the Ho-Chunk community's needs and cultural context. For instance, community-led research projects explored the efficacy of indigenous plant extracts in mosquito control while respecting tribal sovereignty and cultural protocols. This collaborative model serves as a blueprint for engaging Indigenous communities in the co-creation of sustainable and culturally sensitive approaches to combat climate-driven mosquito challenges.



# LEAD EDUCATION & TESTING IN TURTLE MOUNTAIN



*Turtle made of recycled tire rims.*

A healthy environment is a crucial component for ensuring healthy people and communities. Every day, the air we breathe, water and food we consume, and the indoor and outdoor spaces we inhabit have the potential to promote or threaten human health. Many Tribal communities are taking action to improve environmental health. The Turtle Mountain Band of Chippewa Indians recently participated in an education and environmental testing program to address lead contamination in their community

## What is lead?

Lead is one example of an environmental exposure that has the potential to harm human health. Lead is a naturally occurring element found in the earth's crust – where it is not harmful. However, due to human activity, lead contamination in the environment is widespread. Air, water, soil, and even the dust particles inside our homes can contain lead and threaten human health. While lead can cause harm to almost every organ or system in the body, it is well-documented to cause adverse health effects on the brain and nervous system. Adverse health outcomes include slowed growth and development, learning and behavior problems, and hearing and speech problems (CDC). Therefore, it is essential to understand what lead is, where it can be found, and how to prevent lead exposure to keep us and our families healthy.

Common sources of lead exposure include homes built before 1978 when lead-based paint was used, drinking water that passes through lead pipes, cosmetic and other consumer products that contain lead, and living near airports due to leaded gasoline use

Environmental health focuses on the relationships between people and their environment to foster healthy and safe communities.

(CDC). Although some uses of lead have been banned, past and current uses of lead still pose a threat to human health.

Lead is particularly dangerous for children, especially children under the age of 6. Children's smaller bodies absorb more lead than adults. Additionally, their brains and nervous systems are still developing, so they are more sensitive to lead's damaging effects. Younger children also tend to put their hands in their mouths, increasing the amount of lead exposure. Specific adverse health outcomes in children include lower IQ and decreased ability to pay attention (CDC).



Lead poisoning is often difficult to see. If you are concerned that you or your child has been exposed to lead, speak to a healthcare provider about getting a blood lead test and ask your Tribe about lead abatement programs.

## Lead prevention at Turtle Mountain

Thankfully, there are actions we can take to minimize our contact with lead. Education is the first step to fully understanding how a community is affected and to come up with solutions that will be successful. The U.S. Environmental Protection Agency (EPA) created a curriculum providing resources and tools to prevent lead exposure. The Lead Awareness in Indian Country: Keeping our Children Healthy curriculum is a great way to start having conversations about lead in your community and learn how to reduce potential lead exposure through home and personal hygiene, nutrition, or getting in contact with lead mitigation professionals. For additional information, check out CDC's Childhood Lead Poisoning Prevention Program.

Lead testing is another crucial action item to better understand the level of risk for lead exposure. It is also an excellent opportunity to build partnerships with other environmental groups. Turtle Mountain partnered with the National Indian Health Board, Badlands, Inc., Minnesota Valley Testing Laboratories, Inc., and the state of North Dakota to perform multiple lead tests



**Actions to Reduce Potential Lead Exposure.**  
**SOURCE:** U.S. EPA Lead Awareness in Indian Country: Keeping our Children Healthy

in water, soil, and wall paint in priority locations around the community to keep children and elders safe.

**If you want to learn more about Lead Awareness in Indian Country: Keeping Our Children Healthy or get lead testing done in your community, contact NIHB's environmental health team at [environmentalhealth@nihb.org](mailto:environmentalhealth@nihb.org)**



Aubrey (NIHB), Nick (Badlands), Dri (NIHB), and Jack (IHS) after a day of collecting water, soil, and paint samples.



A State of North Dakota employee uses the X-ray fluorescence (XRF) machine at a local recreation center.



Nick, Badlands, collecting a soil sample at the local Elders center.

"Childhood Lead Poisoning Prevention Program." Centers for Disease Control and Prevention, 9 Jan. 2024, [www.cdc.gov/nceh/lead/default.htm](http://www.cdc.gov/nceh/lead/default.htm).

"Tribal Lead Curriculum." United States Environmental Protection Agency, 1 Mar. 2024, <https://www.epa.gov/lead/tribal-lead-curriculum#:~:text=The%20Curriculum%20was%20designed%20with,health%20and%20cultural%20practices%3B%20and>.

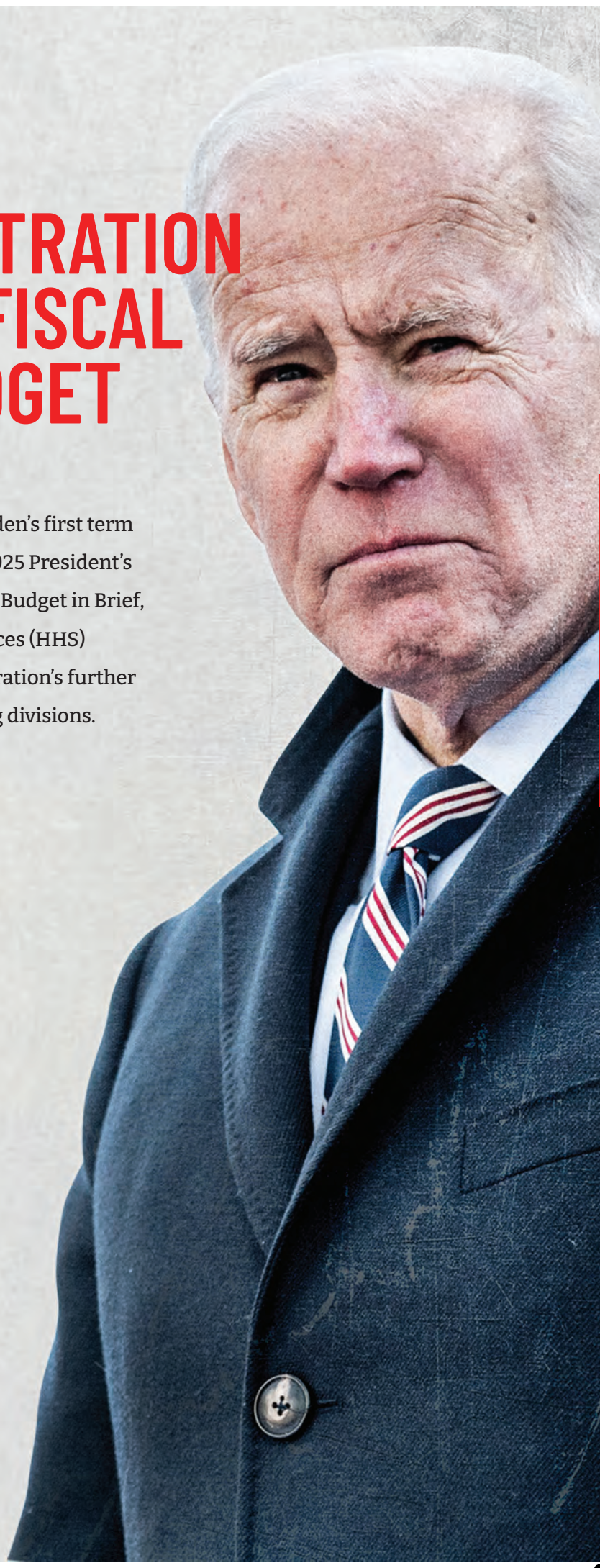


# BIDEN ADMINISTRATION RELEASES ITS FISCAL YEAR 2025 BUDGET

**T**he final budget proposal of President Biden's first term has arrived with the release of the F.Y. 2025 President's Proposed Budget on March 11, 2024. The Budget in Brief, the U.S. Department of Health and Human Services (HHS) F.Y. 2025 budget narrative, lays out the Administration's further priorities for HHS and its agencies and operating divisions.

At a high level, the Biden Administration continues to focus on the impacts of substance use disorders, opioids, and mental health on the U.S. population coming out of the COVID-19 pandemic. As part of its F.Y. 2025 request, the Administration has also requested that the expanded tax credits for ACA health benefits coverage be made permanent. This coverage supports more families to receive coverage under the ACA, including in states that have not expanded Medicaid yet. Finally, as part of the President's efforts to focus on health equity, the Administration focuses on improving maternal health outcomes, continuing its appropriations request to move the IHS to mandatory appropriations, and improving access to health care in rural America—including Indian Country.

**RIGHT:** *The introduction of the President's F.Y. 2025 Proposed budget also begins the season for Congressional budget work.*



In HHS' Budget in Brief, the Administration specifically calls out its alignment with Executive Order 14112, Reforming Federal Funding and Support for Tribal Nations to Better Embrace our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination, through its support of Tribal self-determination. In addition to that support, the Administration requests a 16

The Biden Administration shows continued commitment to close funding gap for IHS/Tribal/Urban Indian providers.

percent increase over F.Y. 2023 for IHS at \$8 billion. The increase continues the Administration's commitment to close the funding gap for IHS/Tribal/Urban Indian (I/T/U) providers. It continues its budget request to move IHS funding to mandatory beginning in F.Y. 2026, including adjustments for population, inflation, and pay cost growth, among other factors.

The proposal for IHS includes \$21 million for substance and opioid use disorder treatment, \$7 million for maternal health, and \$15 million for its initiative Ending HIV and Hepatitis C in Indian Country. The budget proposal also includes \$435 million in support of electronic health record modernization, \$994 million for facilities, including \$174 million for maintenance and improvement, \$200 million for sanitation facilities construction, and \$260 million for health care facilities construction. The President's proposed budget does more than double the section 105(l) lease payments level to \$349 million in F.Y. 2025. It makes requests in both contract support costs and section 105(l) accounts for administrative funding for these

programs capped at \$10 million each.

The Indian Health Service has also dropped two of its legislative requests (A-19 proposals) in its F.Y. 2025 Congressional Justification (C.J.). IHS continues to advance many of its previous A-19 priorities, including reauthorization of the Special Diabetes Program for Indians at \$250 million on a three-year, tiered reauthorization, IHS sequestration exemption, and several other critical staffing-focused proposals. In the new C.J., however, IHS has dropped two of its proposals that were included in previous fiscal years. The first proposal dropped would be to waive Indian hiring preference requirements for IHS positions. It has also dropped its A-19 proposal to extend IHS emergency hiring authority for mission-critical staff beyond 30-day appointments.

The introduction of the President's F.Y. 2025 Proposed budget also begins the season for Congressional budget work. The F.Y. 2025 budget is still subject to negotiated caps under the Fiscal Responsibility Act of 2023 (P.L. 118-5), and the Congressional budget resolution will follow those levels. The House Appropriations Subcommittees have already begun their work to solicit public testimony on the budget, the Interior-Environment Subcommittee having shared its request in late March 2024. Health-Labor Subcommittee should release its request in early April 2024. Senate Appropriations Subcommittees are expected to release their guidelines in late April or May 2024.

**You can see the documents referenced here:**

- President's Proposed Budget for F.Y. 2025 (The "Skinny" Budget)
- HHS Budget in Brief FY 2025 Budget Narrative
- IHS Congressional Justification for F.Y. 2025
- HHS FY 2025 Budget Webpage (including Agency Congressional Justifications) ■





IMPROVING TRIBAL ACCESS TO PUBLIC HEALTH DATA

# USING LAW AS A TOOL FOR EQUITY



**S**ystemic exclusion of Tribes in the development of national public health infrastructure, like disease surveillance systems, contributes to the serious health inequities experienced by American Indian and Alaska Native (AI/AN) people.

Data has been recognized as foundational to public health for the past century. Yet, Tribes frequently lack reliable access to public health data about their own citizens. While Tribes across the country are investing in and expanding their public health systems, without timely access to public health data, Tribes cannot adequately track the spread of disease, make data-informed decisions, identify those at high risk for severe illness or mortality, or evaluate public health interventions.

AI/AN people are simultaneously citizens of three sovereigns: the United States, their state of residence, and the Tribe in which they are enrolled. However, public health infrastructure in the United States has developed with states at the center, with strong deference to state public health authority. For public health surveillance, disease reporting is typically governed by state law and managed by state data systems. After data deidentification, certain data is also shared with CDC. In this system driven by federalism, Tribes have no clear place.

Despite clear public health authority, Tribes and TECs continue to face **immense barriers** to accessing data.

Certain things, however, are abundantly clear under U.S. law. Tribal sovereignty – the inherent right or power of Tribes to govern themselves – has been repeatedly affirmed by the U.S. Supreme Court, the U.S. Constitution, and hundreds of Indian treaties and federal statutes, and, in fact, predates the existence of the United States itself. Tribal nations' inherent sovereignty is the legal basis for the status of Tribes as public health authorities. Public health authority refers to the authority of a sovereign government to engage in public health activities as part of its official duties, to protect and promote the health of the people within its jurisdiction.

No federal law is needed to grant Tribes the authority to engage in public health activities; this authority is inherent to sovereign governments. However, federal

law has recognized Tribal public health authority and, in the case of Tribal Epidemiology Centers (TECs), granted public health authority for data access. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines “public health authorities” to include state, local, and Tribal agencies and permits access to identifiable health information otherwise protected under federal law to prevent or control disease or injury. In addition, the permanent reauthorization of the Indian Health Care Improvement Act designated TECs as public health authorities for the purposes of HIPAA. IHCA also states that the Secretary of Health and Human Services “shall grant to each epidemiology center . . . access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.” Tribal public health authorities – including both Tribes and TECs – have the right, responsibility, and legal authority to access public health data.

## Challenges to Data Access

Despite clear public health authority, Tribes and TECs continue to face immense barriers to accessing data. Because states govern most public health data systems, states become the de facto arbiters of access to public health data. Tribes often find themselves at the mercy of individual relationships between the Tribe and state government officials. Considering the often fraught history between states and Tribes, this is not a recipe for data equity. Even in states with positive relationships with Tribes, challenges frequently result from state officials' lack of understanding around Tribal sovereignty and Tribal public health authority, including among states' legal counsel.



In some cases, federal agencies hold the data Tribal public health authorities need. However, a 2022 Government Accountability Office (GAO) report found that federal agencies have failed to comply with federal law by withholding health data from Tribal Epidemiology Centers. Although the relevant agencies agreed to implement the GAO's recommendations to improve data sharing with Tribes, little progress has resulted since. With no mechanism to enforce the law, Tribes are left with little recourse. These access issues are compounded by the federal underinvestment in Tribal public health infrastructure, resulting in outdated health data systems and insufficient access to Tribal epidemiologists, data scientists, informaticists, and the legal counsel needed to establish necessary and beneficial data sharing agreements. Federal inaction persists despite urgent needs and in violation of federal law.

### Opportunities for Success

NIHB has worked tirelessly alongside our Tribal and TEC partners to increase access to essential public health data through several parallel paths. NIHB's Tribal Health Equity Data Symposium in September 2023 created a forum for Tribal health policy and data experts to discuss their experiences and priorities around data access. At the invitation to present at several national conferences, NIHB staff have taken every opportunity to provide education to Tribal, federal, state, and local public health professionals about on Tribal public health authority and data access. NIHB's advocacy and technical assistance have ensured Tribal leaders and policymakers are fully informed on the priority issues, and that these issues remain top-of-mind for federal officials. Most recently, NIHB was invited to publish an article on these topics in the *Journal of Law, Medicine, and Ethics*, contributing to the literature frequently referenced by public health officials and policy advisors. NIHB has played a key role in bringing these Tribal data access issues to national attention.



*NIHB Federal Relations Director A.C. Locklear and Senior Policy Analyst Carrie Field present on Tribal public health authority and data access at the 2023 National Tribal Health Conference in Anchorage, AK.*

In addition, this year NIHB has supported the first two Tribes in the nation to get connected to the growing national system for electronic case reporting (eCR). eCR is a system that allows for the automatic transmission of data on reportable diseases from the electronic health records of health care providers to public health authorities for the purposes of disease surveillance. eCR sends data to all appropriate authorities automatically and simultaneously, allowing Tribes to equitably receive data within their jurisdiction. This ensures clear recognition of Tribes as public health authorities and ensures that Tribes receive public health data regardless of data sharing relationships with the state. Stephanie Jay, MPH, with the Turtle Mountain Band of Chippewa Public Health Department, explained, "Electronic case reporting will greatly improve the communication between healthcare providers and our Tribal public health department, and the real-time data will provide a timely response to potential outbreaks that can improve health equity. Access to Tribal member health data is crucial for public health's efforts to respond to detection of a disease, surveillance, investigation, and response." ■

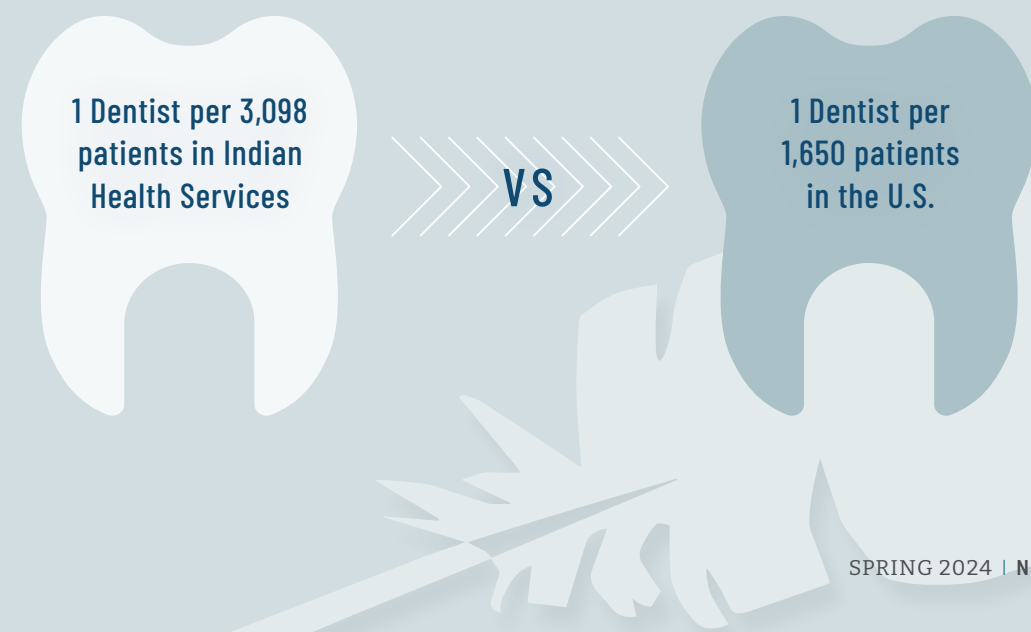
## DENTISTRY & ORAL HEALTH

# Urgency of AI/AN Oral Health Providers in American Indian and Alaska Native Communities

The importance of oral health and equitable access to oral healthcare cannot be overstated, as they are fundamental to overall health and well-being. However, disparities in health outcomes have been notably higher in ethnic communities, particularly among American Indian and Alaska Native (AI/AN) populations, a trend exacerbated by the COVID-19 pandemic<sup>1</sup>. Research indicates a pronounced decrease in dental visits within American Indian communities, including those served by Indian Health Services facilities, during and following the pandemic, underscoring persistent oral health disparities among AI/AN populations compared to non-AI/ANs<sup>3</sup>.

Despite strides made since the establishment of Indian Health Services, access to oral healthcare remains unequal for tribal members residing in both rural and urban areas served by these facilities, with disparities only widening since the onset of the pandemic. The scarcity of dental providers within Indian Health Services, with one dentist per 3,028 patients compared to the national average of one

dentist per 1,650 patients, underscores the pressing need for increased dental providers, particularly AI/ANs<sup>2</sup>. Notably, studies show that the presence of underrepresented minority dentists, including AI/AN, significantly influences job satisfaction, with a majority indicating a commitment to serving their own racial/ethnic group and vulnerable/low-income populations.





Among practicing underrepresented dentists (including AI/AN, Black, and Hispanic or Latino dentists), 53.7% indicated that service to one's own racial/ethnicity group and 58.2% reported service to vulnerable/low-income populations influenced job satisfaction.<sup>3</sup> The Average percent of the AI/AN patient population treated by AI/AN dentists was 20.4%, compared to 3.7% of the AI/AN patient population treated by Black dentists, and 3.9% of the AI/AN patient population treated by Hispanic or Latino dentists.<sup>3</sup>

Efforts to address these disparities include the expansion of AI/AN dental providers, leveraging their cultural knowledge to improve oral health outcomes within their communities. Models such as Dental Health Aide Therapists (DHATs) and Primary Dental Health Aides (PDHAs), as demonstrated in Alaska's Dental Health Aide Therapist model, have shown promise in enhancing oral health outcomes among Alaska Native communities<sup>5</sup>. Increasing awareness and educational opportunities for AI/AN students in dentistry can help bridge workforce shortages and improve oral health outcomes in AI/AN communities.

Innovative programs like the Dental Therapy Education Program at Skagit Valley College, in collaboration with the Swinomish Indian Tribal Community, aim to address ongoing oral health workforce disparities

among underrepresented minorities, specifically AI/AN communities. Similarly, the Alaska Dental Therapy Educational Program, in partnership with organizations like the Alaska Native Tribal Health Consortium and Iñisaġvik Tribal College, provides training for DHATs to meet basic dental care needs in rural Alaska Native communities. Furthermore, legislative initiatives in several states, Washington, Oregon, Idaho, Arizona, New Mexico, Vermont, Minnesota and most recently Wisconsin, have approved DHATs to practice, extending the reach of culturally competent oral healthcare.

Organizations like the Society of American Indian Dentists (SAID), founded by the U.S.'s first Native American dentist Dr. George Blue Spruce Jr., play a pivotal role in promoting dental health, encouraging AI/AN youth to pursue dentistry careers, and supporting the unique concerns of AI/AN dentists. With membership doubling in recent years, SAID continues to champion culturally significant oral healthcare and foster the growth of AI/AN dental providers.

The ongoing increase in AI/AN dental provider not only promises culturally sensitive oral healthcare but also addresses the oral health needs of all AI/AN communities, marking a significant step toward health equity. ■

#### RESOURCES

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## INFECTION CONTROL

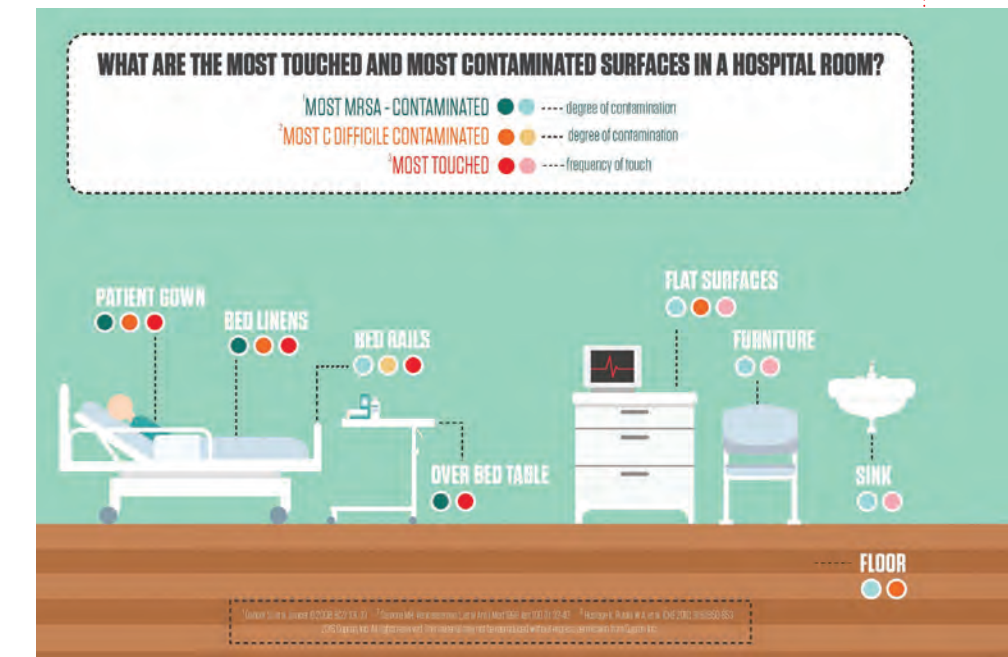
# What are “High Touch” surfaces?

## Follow CDC Cleaning and Disinfection Guidelines

We've heard it repeatedly: To fight the spread of COVID-19, wash your hands and clean “high-touch” areas. But what exactly are high-touch areas? They are common surfaces like the frames and rails of hospital beds, door handles, light switches, countertops, remote controls, monitors, sinks, and toilets. Patients, staff, and visitors shed germs into the environment when they cough, sneeze, or have diarrhea - high-touch surfaces should be cleaned daily because they can act as vectors, allowing germs to move from one person to another.

Clean visibly dirty surfaces with soap and water. Then, disinfect using an approved Environmental Protection Agency (EPA) List N product. Follow the label's directions for proper disinfection product use. Environmental services technicians should follow this 2-step process when cleaning from clean to dirty areas and from high to low surfaces, with the restroom always cleaned last to reduce the risk of spreading bacteria and viruses.

For daily cleaning and discharge, all surfaces should be cleaned and disinfected with a damp microfiber or disposable cloth moistened correctly with a quality



**ABOVE:** The combination of high-touch and high-contamination surfaces leads to most hospital-acquired infections. Here, you see where they overlap in patient rooms with C-Diff and MRSA

cleaner or disinfectant and disposed of before using a fresh cloth to clean the next area. The diagram at the top highlights common “high touch” surfaces to which the environmental services technician should pay special attention. These may include the bedrail, the over-bed table, and the call button, to name a few.

When minimizing infection, understanding the difference between cleaning and disinfecting is crucial. Cleaning removes visible dirt, debris, and dust from surfaces. Disinfecting eliminates disease-causing bacteria and viruses. Improper cleaning and disinfection in healthcare settings play a role in the spread of



healthcare-associated infections (HAIs) – infections people get while receiving healthcare for another condition. Therefore, cleaning and disinfection is an important infection prevention and control measure to prevent germs' presence, replication, and spread in healthcare facilities.

“You cannot heal in the same environment that made you sick.”

Each facility's infection control program and environmental services management team determines what surfaces your facility considers “high touch,” as it can vary from facility to facility. The Centers for Disease Control and Prevention (CDC) releases guidelines for environmental infection control in healthcare

facilities. Healthcare facilities should follow established guidelines like those from the CDC to guide their environmental cleaning and disinfection.

However, when cleaning an isolation room, wear the appropriate personal protective equipment or PPE and follow proper doffing technique before leaving the patient room. If wearing a respirator mask, remember to remove it after leaving the room and immediately perform hand hygiene before donning new gloves to clean the equipment used. A supervisor should carefully inspect at the end of each cleaning session to ensure no germs are overlooked.

Nursing, infection preventionist (IP), and environmental services should work together to ensure that there are clear lines of responsibility for cleaning and disinfection. A checklist of all surfaces, equipment, and areas to be cleaned and disinfected, along with who, when, and how often these tasks are to be performed is key to ensuring staff members understand their role. ■

## National Indian Health Board



The Tribal Environmental Justice Technical Assistance Center is providing **free technical assistance** to Indian Country for funding opportunities related to environmental justice! Eligible entities to receive technical assistance (TA) include:

- **Federally recognized Tribes**
- **Tribal organizations**
- **Tribal consortia**
- **Tribal enterprises and corporations**
- **American Indian and Alaska Native individuals**

**To learn more  
and to request  
TA, scan the  
QR code below:**



Email [environmentalhealth@nihb.org](mailto:environmentalhealth@nihb.org) with questions

## BREAKING THE CYCLE

# Behavioral Health in Tribal Communities

*“Hold on to what is good, Even if it's a handful of earth.  
Hold on to what you believe, Even if it's a tree that stands  
by itself. Hold on to what you must do, Even if it's a long way  
from here. Hold on to your life, Even if it's easier to let go.  
Hold on to my hand, Even if someday I'll be gone away from you.”*

— CROWFOOT, BLACKFOOT WARRIOR & ORATOR, 1830 – 1890



**P**rior to colonization, Indigenous peoples across North America maintained health and wellness for thousands of years through traditional practices. Culture served as the key protective factor and primary prevention for many mental health and substance use disorders. Historically, traditional healing and culturally centered ways of living provided holistic mental wellness. Forced assimilation policies and programs harmed Tribes and created behavioral health disparities and negative health outcomes. Colonization had a devastating impact on eroding Native culture through government policies that still have impact today. Today, many individuals, families, and communities have been impacted by experiences causing physical and mental health adversities throughout their lifespan but still continue to rely on their culture.

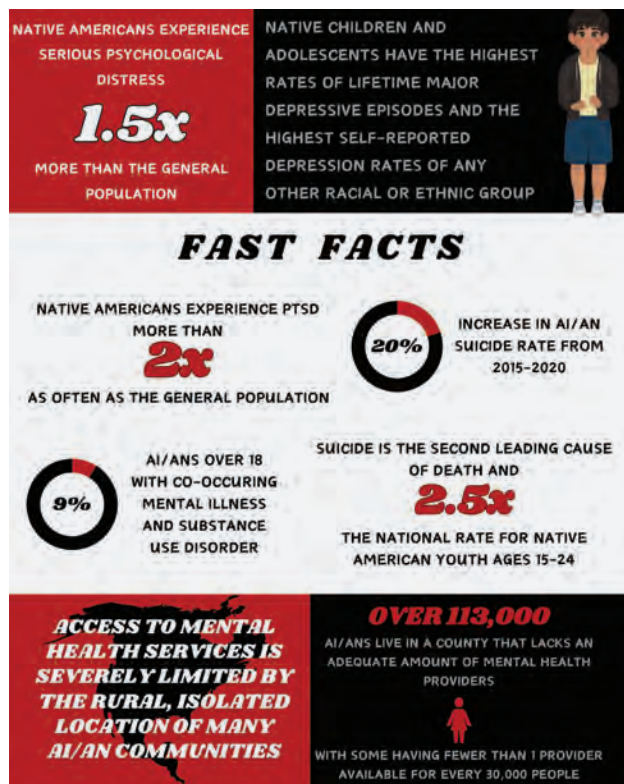
Culture itself can be defined in multiple ways: it is the customs, arts, social institutions, and achievements of a particular group; the way of life for an entire society; or what guides an individual and community. Within Native cultures are the elements needed for recovery and wellness. Whether it is dancing at a powwow, learning to basketweave with an elder, or practicing

medicine, there is strength in embracing cultural values. Involvement in your Tribal community can relieve stress and anxiety, as well as allow you to connect with your culture, promoting cultural engagement.

The lived experiences of American Indian and Alaska Native (AI/AN) historical trauma and adversity have contemporary descriptions and diagnoses: adverse childhood experiences, post-traumatic stress disorder, substance use disorders, and suicidal ideation—all of which have accompanying strategies for prevention, treatment, and recovery. Without appropriate treatments early, behavioral health concerns can become compounding comorbidities putting further strain on both the behavioral and medical health resources on which our communities depend.

Many barriers impact access, quality, and availability of health, behavioral health, and related services for AI/AN people. These issues include provider and personnel shortages, limited resources, and obtaining services without traveling great distances. Additionally, there are concerns related to funding, such as amounts, distribution mechanisms, allocations, sufficiency, and reporting requirements.





## how to break the cycle

& PROVIDE BETTER CARE TO OUR COMMUNITY

- 01 INCREASE AWARENESS OF MENTAL HEALTH AND ITS CONNECTION TO CHRONIC DISEASES
- 02 CONDUCT STIGMA AWARENESS TRAINING WITH MEMBERS OF THE COMMUNITY
- 03 EDUCATE PROVIDERS ABOUT UNIQUE MENTAL HEALTH ISSUES IN THE NATIVE POPULATION
- 04 ADVOCATE FOR POLICIES THAT PROMOTE SOCIAL JUSTICE, EQUITY, AND EQUALITY
- 05 CREATE AND PROVIDE COMPREHENSIVE, AFFORDABLE HEALTH COVERAGE FOR EVERYONE
- 06 SHIFT THE FOCUS OF MENTAL HEALTH CARE TO PREVENTION AND EARLY INTERVENTION
- 07 BETTER INTEGRATE TRADITIONAL HEALING AND SPIRITUAL PRACTICES WITH MODERN HEALTHCARE
- 08 DEVELOP A MORE PERSON-CENTERED CARE PHILOSOPHY

## FEDERAL TRIBAL ADVISORY COMMITTEES

### Tools to Realize the Federal Trust Responsibility

Tribal Advisory Committees (TACs) are advisory bodies consisting of members of American Indian and Alaska Native (AI/AN) Tribes. TACs provide advice, recommendations, and input on policy and program issues impacting AI/AN healthcare providers and patients across various operating divisions within the Department of Health and Human Services (HHS) and the Indian Health Service (IHS).

TACs represent one way the federal government can uphold its trust and treaty responsibilities. Known as “trust responsibility” or “the federal trust responsibility,” the United States (US) has a unique legal responsibility to provide health services to Tribal members, established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions.

TACs are powerful tools to help the federal government collaborate with Tribes and Tribal communities throughout the US. TACs serve as a vehicle at the beginning of the policy formulation process, which allows HHS operating divisions to solicit and incorporate Tribal input early on in policy and program formulation before a formal policy consultation. Because TAC members represent Tribes and Tribal communities across the US, these bodies offer a rich range of opinions and views to help shape decision-making.

Increased Tribal participation is crucial in ensuring Tribal priorities are represented across all agencies. TACs are vital to enhancing the relationship between the federal government and Tribal nations. However, many agencies struggle to retain Tribal leaders on the TACs and fail to fill vacant seats. For example, six of the twelve area seats on the IHS National Tribal Advisory Committee on Behavioral Health (NTAC) are currently vacant.

TACs provide a unique opportunity for Tribal leaders and their representatives to speak directly with federal officials about how federal policies impact their respective communities by sharing the experiences of Tribal citizens and the effects federal programs are having on individuals, and should be a vehicle for acquiring a broad range of Tribal views; instead, many regions are going entirely unrepresented. Federal officials must hear these stories; these committees are critical to facilitating such discussions.



ABOVE: NIHB Staff and IHS Direct Service Tribal Advisory Committed (DSTAC) Leadership at the DSTAC 3rd Quarter meeting in Rapid City, S.D.

Tribal leaders do not need prior specialized technical knowledge to serve on a TAC. The National Indian Health Board (NIHB) and various regional health boards provide technical support to Tribal leaders serving on TACs. NIHB staff routinely serve as technical advisors to Tribal leaders serving on TACs. NIHB attends all TAC meetings in this capacity and provides briefing materials, policy, budgetary analysis,

Just as federal policy and programs once sought to eradicate AI/AN identity, there must be an equally vigorous contemporary response that assists in reconnection and revitalization of identity. NIHB will work to strengthen and assess the availability of critical services, gaps in services, and opportunities for improvement to meet community needs. Additionally, we will advance Tribal and federal strategic efforts and programs to provide existing pathways to build or expand strategies that more effectively address healing from trauma. ■

#### RESOURCES

**988 Suicide & Crisis Lifeline** — Provides no-cost crisis support services to those in need of assistance. Call or text 988, or chat online at 988lifeline.org.

**StrongHearts Native Helpline** — Is a 24/7 confidential and anonymous culturally-appropriate domestic and sexual violence helpline for Native Americans that offers several services at no cost. Visit [strongheartshelpline.org](http://strongheartshelpline.org) or call 1-844-7NATIVE

**National Runaway Safeline** — Is a 24/7 hotline, including text and chat, that responds to youth and families in crisis, serving as the national communications system for any youth who is being bullied, in crisis, thinking of running away, or homeless. The safeline is free, confidential, and will connect youth to resources in their community. Visit [1800runaway.org](http://1800runaway.org) or call 1-800-RUNAWAY.

**The Trevor Project** — Provides 24/7 no-cost crisis support services for 2SLGBTQIA+ young people. Call 1-866-488, text 678-678, or chat online at [thetrevorproject.org](http://thetrevorproject.org).

**Trans Lifeline** — Connects trans people to the community, support, and resources they need to survive and thrive. Call 877-565-8860, or visit [translifeline.org](http://translifeline.org).

**notOK app** — Is a free digital panic button to get you immediate support via text, phone call, or GPS location when you're struggling to reach out. Visit [notokapp.com](http://notokapp.com) to download.

**SAMHSA Native Resources** — Organizations, articles, and other resources that American Indian and Alaska Native communities can use to promote mental wellness.



talking points, and notes on priority issues to.

The Biden administration has expanded the role of TACs across the federal government, providing an unprecedented opportunity to expand access and elevate Tribal health priorities across the federal government. NIHB is prepared to do its part to ensure all TAC meetings are meaningful and represent a wide array of perspectives from Indian Country. To develop a comprehensive health policy for the benefit of Indian Country, direct service, and self-governance, Tribal leaders must all be at the table to advocate for

Tribal communities. NIHB stands ready to provide technical assistance to any Tribal leader who wishes to serve on a TAC.

*Please see the chart below for a brief overview of TACs that need Tribal voices.* To learn more about the federal Tribal Advisory Committees, request technical assistance, or stay updated on TAC news, please contact Garrett Lankford, NIHB Federal Relations Analyst, at [glankford@nihb.org](mailto:glankford@nihb.org). You can also find more information on NIHB Tribal Advisory Committee Resources at [www.nihb.org/tribal\\_resources/committees.php](http://www.nihb.org/tribal_resources/committees.php)

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

##### Administration for Children and Families (ACF) Tribal Advisory Committee

To seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of ACF programs.

##### Centers for Disease Control and Prevention (CDC) Tribal Advisory Committee

Advises on policy issues and broad strategies that may significantly affect AI/AN communities. Assist in fulfilling its mission to promote health and quality of life by preventing and controlling disease, injury, and disability through established and ongoing relationships and consultation sessions.

##### Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG)

TTAG provides advice and input to CMS on policy and program issues impacting AI/ANs served by CMS programs. Not a substitute for formal consultation with Tribal leaders, TTAG enhances and improves increased understanding between CMS and Tribes.

##### Secretary's Tribal Advisory Committee (STAC)

To seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation, or Executive Order.

##### Veterans' Affairs (VA) Tribal Advisory Committee

Advises the Secretary on ways the VA can improve the programs and services to better serve AI/AN Veterans. Committee members make recommendations to the Secretary regarding such activities.

##### National Institutes of Health (NIH) Tribal Advisory Committee

The TAC is advisory to the NIH and provides a forum for meetings between elected Tribal officials (or their designated representatives) and NIH officials to exchange views, share information, and seek advice concerning intergovernmental responsibilities related to the implementation and administration of NIH programs.

##### Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Technical Advisory Committee (TTAC)

The SAMHSA TTAC provides a complementary venue where Tribal representatives and SAMHSA staff exchange information about public health issues in Indian Country, identify urgent mental health and substance abuse needs in AI/AN communities, and discuss collaborative approaches to addressing these issues and needs.

##### Health Resources and Services Administration (HRSA) Tribal Advisory Council

A vehicle for acquiring a broad range of Tribal views, determining the impact of HRSA programs on the AI/AN health systems and population, developing innovative approaches to deliver health care, and assisting with effective tribal consultation.

# TRIBAL PUBLIC HEALTH CAPACITY BUILDING

## A Collaborative Commitment to Performance/ Systems Improvement and Service to Indian Country

Public health Performance Improvement and Systems Improvement (PISI) for Tribal public health programming includes the ongoing actions and reinforcement put in place to ensure that public health initiatives and programs are efficient, meeting their overall objectives, and continuously being improved to promote the health and well-being of Tribal citizens. Common approaches to PISI are often demonstrated through pillars of quality improvement, systems integration, and the evaluation of public health programming. This may show up during the conduction of performance management, establishing program goals and expected outcomes, satisfaction surveys and even the coordination of cross-sector collaboration. Ongoing PISI efforts are essential for monitoring and demonstrating program success, promoting the sharing of resources, and increasing access to care and participation. Projects that encompass these practices often meet desired project outcomes and can adapt and generate buy-in for continuity.





## BUDGET

# Special Diabetes Program for Indians Receives First Funding Increase in Decades

The Special Diabetes Program for Indians (SDPI), one of the most successful public health programs in the United States, has been reauthorized by Congress with its first funding increase in 20 years. The SDPI was reauthorized in the minibus package (P.L. 118-42) passed by Congress on March 8, 2024, and the program was reauthorized through December 31, 2024. Congress reauthorized the program at a new funding level, putting SDPI at \$160 million annually. SDPI had previously been funded at \$150 million annually.

Senators Susan Collins (R-Maine) and Jeanne Shaheen (D-N.H.) worked to secure the first increase for the program in 20 years. Tribal Leaders and NIHB staff worked effortlessly in collaboration with Capitol Hill champions to ensure the SDPI reauthorization included the long-deserved increase for this highly successful program. The Tribal Leaders Diabetes Committee (TLDC) members participated in Capitol Hill advocacy in the fall of 2023, visiting Senate and House offices to raise awareness for the program's success and needs. The SDPI has proven to be a highly impactful public health model to address specific community and cultural needs, demonstrating decreases in the incidence of Type 2 Diabetes and Prediabetes in American Indian and Alaska Native communities. SDPI has also generated government savings over time to the Medicare Program of \$520 million by reducing the need and reliance on diabetes-related end-stage renal disease treatment.

The reauthorization provided approximately \$10 million in new funding for the program. This means SDPI will see an increase in both FY 2024 and FY 2025. The authorization in the minibus adjusted the daily rate for the program from \$410,958 to \$438,356. The new annualized rate funds SDPI at the \$160 million level going forward. In real terms, SDPI will receive a total of \$155,424,657 in FY 2024. This total includes the totals from the four Continuing Resolutions (CRs) passed by Congress at the \$150 million annualized level, plus the funds made available

in the minibus bill at the \$160 million annualized level between March 9 and September 30, 2024. FY 2025 will see SDPI funded at \$160 million if it is reauthorized at the current annualized rate. SDPI is currently funded through Q1 FY 2025 for \$40 million. The total increase SDPI has received in funding through the end of calendar year 2024 is approximately \$8 million.

Although SDPI has been reauthorized, it will expire again soon on December 31, 2024. Congress will need to reauthorize SDPI before that deadline. The good news is that SDPI has legislation in Congress to reauthorize the program at \$170 million annually for two full years, and that legislation has already gone through regular order. The House passed H.R. 5378, the Lower Costs, More Transparency Act, which includes SDPI reauthorization. The Senate has also passed a clean bill to reauthorize SDPI out of the Senate Health, Education, Labor, and Pensions Committee (S. 1855), which awaits a vote in the full Senate.

The National Indian Health Board (NIHB) has already started to raise awareness of the new funding cliff and the need to further reauthorize the program. Failure to reauthorize SDPI will create unnecessary program uncertainty and impact the continuity of care for the patients who depend on this highly effective program. If your Tribe or program is interested in engaging on SDPI reauthorization, you can reach out to your elected members of Congress. NIHB has data and advocacy resources available for those looking to get involved. If you will be in Washington, DC, NIHB can help with outreach to Capitol Hill while you are visiting. ■



Several resources (i.e. PHAB Standards & Measures, Core Competencies for Public Health Professionals, MAPP 2.0, etc.) are available to provide guidance relevant to various PISI efforts, however, Tribal public health departments are often challenged due to limited Tribal-specific examples and templates that speak to Tribal public health capacity and infrastructure needs. Tribes have been uniquely challenged to demonstrate innovation in many of their approaches to adapt and modify existing toolkits and frameworks to fit the unique dynamic and contributions afforded by Tribal culture.

NIHB shares in the mission of ensuring access to tools that reflect Tribal PISI needs. Since 2018, the Strong Systems, Stronger Communities (SSSC) funding opportunity (previously the Tribal Accreditation Support Initiative (Tribal ASI)), which is funded through a cooperative agreement with the Centers for Disease Control and Prevention's National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce, has provided Tribes and Tribal organizations with training and resources to implement PISI projects and build public health capacity. Previously funded projects have included community health assessments, strategic planning, and workforce development.

An integral component of this program's success is the robust network that allows NIHB to fill gaps in Tribal-specific resources for subawardees as well as other Tribes and organizations requesting technical assistance and resources. NIHB's capacity to provide this relevant and Tribal specific support is made possible through the guidance and first-hand expertise extended by the very Tribes that we serve.

Among the Tribes that have supported these efforts, we recognize Cherokee Nation Public Health Service for their dedication and commitment to serve Indian Country. In addition to the great work that their public health department does for their citizens, they have

also displayed a consistent effort to assist and encourage other Tribal public health departments engaged in performance and systems improvement efforts. Cherokee Nation has contributed through continuous representation with the Tribal Public Health Accreditation Advisory Board (TPHAAB) which provides insight and recommendations to improve the public health accreditation journey for other Tribes. Under the SSSC program they served as a PISI mentor, hosting a peer Tribe for learning, sharing of best practices, and fellowship. Cherokee Nation has been an exemplary partner in the effort to improve access to Tribal resources and representation, providing guidance on many topics related to accreditation, gaining leadership buy-in, and establishing public health authority.

Cherokee Nation was the first Tribe to earn public health accreditation in 2016 and recently achieved reaccreditation status in December of 2023, making them the first Tribe to receive national recognition for PHAB reaccreditation! As a panelist in NIHB's recent national Tribal public health accreditation webinar, Cherokee Nation Health Director, Lisa Pivec, offered the following context for their service, "I'm happy to help anyone that is pursuing public health accreditation because I feel like the more Tribes that pursue this, the stronger voice we have collectively across Indian Country. If the majority of Tribes could pursue public health accreditation or the work that goes along with it to establish your services, we could change the health of the nation. We could really impact the communities that we live in."

As we continue to build relationships and resources needed to promote the health and wellbeing of Tribal citizens, we thank Cherokee Nation and other Tribes for their continued support and highlight their efforts as inspiration for us all to remain dedicated to the collective goal of improved public health in Indian Country. ■



# WHAT THE OPIOID CRISIS HAS TAUGHT US ABOUT CO-OCCURRING SUBSTANCE USE IN INDIAN COUNTRY

**A**mid the national spotlight on the opioid crisis, ongoing cries for support to address alcohol and methamphetamine use within American Indian and Alaska Native (AI/AN) communities have often been quieted. Despite headlines and national calls to action, Substance Use Disorders (SUDs) continue to be one of the most devastating plagues Tribes have endured in history. Although AI/ANs represent only 2.9% of the U.S. population, Tribal communities experience the highest rates of alcohol, marijuana, cocaine, and hallucinogen use disorders.<sup>1</sup> Alarming, AI/ANs face the highest rates of methamphetamine use, with past-month use exceeding three times the rate of any other group.<sup>2</sup> Additionally, they are more likely to report drug use in the past month (17.4%) or year (28.5%) than any other group.<sup>3</sup> SUD and drug use are rooted in historical trauma and intensified in Tribal communities by socioeconomic disparities and lack of funding and coordination of programs — which creates inequitable access to healthcare resources.

**LEFT:** *The national opioid crisis is very real, and opioid misuse continues to kill people daily. Our stories of loss are all too common.*

The national opioid crisis is very real, and opioid misuse continues to kill people daily. Our stories of loss are all too common. In fact, 130 people a day die from opioid-related drug overdoses.<sup>4</sup> From 2019 to 2020, overdose deaths surged by 30% in the United States as a whole, revealing stark disparities among various groups. Notably, overdose death rates among non-Hispanic AI/AN individuals soared by a deadly 39%, highlighting the urgent need for targeted intervention.<sup>5</sup> There is no denying that opioid use, especially fentanyl, constitutes a crisis deserving of time, energy, and priority action. But, is the full attention on opioids in Tribal communities unintentionally shifting our focus from other substances that continue to cause terrible harm?

While addressing the pressing need for funding, real-time resources, and attention to combat the opioid

AI/ANs are **3.6 times** more likely than whites to die of alcohol-related causes, including liver disease.

crisis, it is crucial to recognize the ongoing impact of alcohol and methamphetamine use within AI/AN communities. Additionally, it is essential to acknowledge that opioid use does not always occur in isolation but may be combined with other substances. These other substances continue to exact a heavy toll, contributing to countless health issues and higher mortality rates—whether used with or separately from opioids.

AI/AN individuals have disproportionately high rates of alcohol-related concerns when compared to many other groups. Historically, between 70% and 95% of all arrests have been connected to alcohol-related crimes in Tribal communities. Alcohol Use Disorder — a result of abusable forms of alcohol largely unknown to Tribal communities prior to European colonization — continues to be a significant and deadly problem among AI/ANs, with disproportionately high rates of alcohol-related fatalities persisting despite national averages.<sup>6</sup> According to the Indian Health Service, from 2016-2020, AI/ANs experienced a significantly higher rate of alcohol-related deaths compared to the rest of the US population.<sup>7</sup> AI/ANs are 3.6 times more likely than whites to die of alcohol-related causes, including liver disease.<sup>8</sup>

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In addition to alcohol, methamphetamines continue to harm our Tribal communities. Methamphetamines have highly addictive properties and are associated with severe health, legal, and environmental consequences, including cardiovascular problems, infectious diseases, and psychosis. Additionally, its use often leads to high-risk behaviors such as violence and risky sexual activities, impacting both individuals and their families with increased rates of child abuse, neglect, and involvement with the foster care system. Communities also face social challenges, including increased criminal activity, systemic violence, and more significant risks of transmitting infectious diseases like Hepatitis C and HIV. Methamphetamine use among AI/AN individuals is nearly four times higher than among non-AI/AN populations, highlighting a pressing need for new treatment approaches, as there are currently no approved medications or new innovative models for addressing this problem.<sup>2</sup>

Substance Use Disorder (SUD) is not an acute condition; instead, it is a chronic disease similar to diabetes and cancer. It necessitates a chronic disease management approach strategy and corresponding funding. According to the Office of National Drug Control Policy (ONDCP), American AI/AN populations exhibit notably high percentages of lifetime (64.8 percent), past-year (27.1 percent) illicit drug use, and current non-medical use of prescription drugs (6.2 percent). Efforts to address these challenges and disorders will unlikely lead to immediate resolution or disappearance. However, it is essential to strategize and implement plans to manage these diseases effectively.<sup>9</sup>

AI/ANs are disproportionately in need of alcohol and illicit drug use treatment compared to other groups.

Despite this, only a fraction receive treatment, with just 3.5% accessing care out of the 13% who require it. Although heavily involved in Tribal and federal justice systems, only 45% of AI/AN individuals receive treatment, leading to a higher likelihood of legal involvement over receiving necessary care. Barriers to accessing treatment include transportation issues, lack of insurance, poverty, inadequate funding of Tribal programs, and a shortage of appropriate facilities in their communities.<sup>1</sup>

Effectively tackling the Tribal opioid crisis means adequately addressing alcohol and methamphetamine use as well. Tribes should not be pressured to adopt an either/or approach to substance use. Still, they should be equipped to implement a comprehensive and nuanced strategy that acknowledges the intertwined complexities of how substance use occurs in their communities — including other co-occurring mental health concerns. Efforts must be prioritized to provide non-competitive funding and to implement and integrate evidence-based methods with practice-based traditional healing approaches. Given that SUD is a chronic disease, initiatives similar to the Special Diabetes Program for Indians (SDPI) should be established to equip Tribes to address SUD within a foundation of Tribal sovereignty and a Tribally driven continuum of care. **Addressing disparities within an Indigenous Social Determinants of Health framework and embracing cultural protective factors is imperative.** Collaboration across sectors, free from stigma, is essential to provide comprehensive SUD prevention, treatment, and recovery support that respects a more complete picture of how Tribes experience substance use in their communities. ■

9. *Highlights by Race/Ethnicity for the 2022 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration. 2022. Retrieved April, 4, 2024. <https://www.samhsa.gov/data/sites/>*

## POLITICS

# SUPREME COURT SKEPTICAL OF FEDERAL GOVERNMENT'S ARGUMENT IN CONTRACT SUPPORT COST CASES

**O**n March 25, 2024, the Supreme Court of the United States (SCOTUS) heard oral arguments in *Becerra v. San Carlos Apache Tribe* and *Becerra v. Northern Arapaho Tribe*. The two cases were previously consolidated and were heard together at the oral argument (*the consolidated case is Becerra v. San Carlos Apache Tribe 23-250*).

### Why It Matters

A favorable decision for the Tribes in this case could have major impacts on IHS funding. The government speculated that such a decision would require Congress to cut funding significantly from other sources to meet the additional CSC obligations, though it is impossible to say for sure where the cuts might come from. IHS, as often as it has requested additional funding, has not received even a fraction of the amount that it would need to fully fund Indian health care, much less a potential increase in CSC obligations. IHS relies largely on Congress for program funding while billing third-party payors provides additional

and much-needed, funds. Congress will also decide if and where cuts would be needed to fund any additional CSC obligation. A decision in favor of the government would mean that Tribes would be responsible for any costs associated with expending program income through third-party revenues, which Tribes are required to do by the contracts with IHS.

### SCOTUS Oral Arguments

The federal government's position focused on attacking the Tribes' arguments rather than advancing their own. The government explained that a finding for the Tribes would upend the 35-year-old statutory



scheme governing CSC. Next, the government pointed to unsubstantiated predictions that a judgment in favor of the Tribes could triple the CSC obligation of IHS. Finally, the government argued that the Tribes' argument violates Congress's directive that IHS reimburse expenses only for those directly attributable to the contract between IHS and the Tribes. In closing, the government painted a picture of the appropriations impact that a finding for the Tribes could have by pointing to several pending CSC cases where Tribes are seeking millions of dollars in CSC.

**Counsel for the Northern Arapaho Tribe** focused his argument on the idea that the purpose of providing CSC to Tribes participating in self-determination contracts is to put them on equal footing with IHS as if IHS was the entity operating the health program. Counsel also explained that the contracts require Tribes to spend third-party revenue they receive from Medicare, Medicaid, and private insurers to "further the general purposes of the contract." In so doing, Tribes are limited to expending that revenue on expenses that are within the scope of the contract itself and not unrelated expenses.

**Counsel for the San Carlos Apache Tribe** kept his argument brief and painted a picture of his client's severely underfunded Emergency Medical Service (EMS) program. Counsel explained that his client's EMS program was so severely underfunded that IHS demanded, in its contract with the Tribe, that the Tribe maintain an efficient billing system to collect third-party revenue. IHS included this requirement because the agency knows that such an operation is imperative to a program's success since IHS is woefully underfunded itself and IHS has heavily relied on third-party revenue for years.

### Justices Question Counsel

**Justice Alito** and **Justice Kavanaugh** quickly made known their concerns about the implications of "ballooning" CSC obligations and what that would mean for future IHS appropriations. In response, counsel for the Tribes argued that their clients are required to spend third-party revenue by both the contracts and the statute which creates a CSC obligation on the part of IHS, irrespective of future appropriations implications. Therefore, Congress would have to act in some

way to provide additional funding, though it would not necessarily have to take funding away from direct service Tribes. Counsel also pointed out that the government presented no evidence in the lower courts that support their estimation for the "ballooning" of CSC obligations, meaning that the estimate is not properly before the Court.

In contrast, **Justice Gorsuch** and **Justice Sotomayor** expressed deep concern over the state of health care in Indian country, with Justice Sotomayor citing that, on a per capita basis, spending on Indian health care is 1/3 of other non-Native federal healthcare programs. Considering this troubling fact, Justice Sotomayor quipped that, even if IHS were required to provide the requested CSC, it is not like Tribes would have the surplus in CSC funds for "luxury healthcare spas," but maybe enough to achieve a minimal level of health care.

**Chief Justice Roberts** and Justice Kavanaugh were interested in learning about the association between CSC and a Tribe providing services to "non-beneficiaries," or non-Natives. The Justices focused their questions on how much of an increase in CSC obligations a Tribe can create by providing services to non-beneficiaries. Counsel explained that, while the issue was not before the Court in these cases, not every Tribe undertakes this practice, and the ones that do usually have extreme limitations. Further, any increase that a Tribe would create would be negligible. Counsel for Northern Arapaho pointed out that his client offers services to non-beneficiaries but only in the limited context of non-beneficiaries who are employed by the health program, thereby increasing CSC obligations by fraction of a percentage. Counsel for the Tribes also explained that the issue could be litigated in a later case or that Congress could create a formula to reduce CSC to Tribes who offer such services.

**Justice Jackson's** participation in questioning counsel was primarily directed at the government. The Justice inquired whether the government's interpretation

Ultimately, it seemed that a majority of the Justices were understanding of the Tribes' position and that they weren't persuaded by the government's closing argument.

of the statutes aligned with the Indian canon of construction, which requires ambiguous statutes to be read in a way that favors Tribes. Counsel for the government argued that the canon's incorporation into the contracts need only be used if the Court finds the statutes to be ambiguous, while counsel for the Tribes argued that the Court must apply the canon from the outset. However, Counsel for the Tribes urged that the Court need not even apply the canon, as the statutes unambiguously require IHS to provide CSC under the facts of the cases.

**Justice Barrett** did not have much to ask of any of the parties. The Justice's questions were limited to helping her better understand the parties' interpretation of the statutes that permit the collection of CSC and the different types of CSC.

Ultimately, it seemed that a majority of the Justices were understanding of the Tribes' position and that they were not persuaded by the government's closing argument that listed the millions of dollars Tribes are requesting in pending cases in federal court or the potential "ballooning" of CSC obligations. The Court is expected to issue its decision in the case in June of this year.

### What are Contract Support Costs?

IHS provides healthcare to Tribes under the Indian Health Care Improvement Act (IHCA). Those programs are funded by both congressional appropriations and revenue that IHS collects from third-party

*A favorable court decision for the Tribes could have major impacts on IHS funding*



payors, though important to program success, the latter has not always been an available source of revenue. The Indian Self Determination and Education Assistance Act (ISDEAA) requires IHS to contract with willing Tribes to transfer the operation of federal programs that IHS would otherwise administer under the IHCA. IHS provides the contracting Tribe with the equivalent amount of appropriated funds IHS would have used to run the federal program. The appropriated funds that are given to the Tribe are called the “secretarial amount.”

On top of the secretarial amount, IHS provides CSC to Tribes participating in self-determination contracts. Tribes receive CSC for reasonable costs for activities a Tribe must carry on as a contractor to ensure compliance with the terms of the contract, but which:

1. Normally are not carried on by [IHS] in [its] direct operation of the program; or
2. Are provided by [IHS] in support of the contracted program from resources other than those under contract.

The CSC that are eligible costs for the purposes of receiving funding include the costs of reimbursing each tribal contractor for reasonable and allowable costs of:

1. Direct program expenses for the operation of the federal program that is the subject of the contract; and
2. Any additional administrative or other expense incurred by the governing body of the Indian Tribe or Tribal organization and any overhead expense incurred by the tribal contractor in connection with the operation of the Federal program, function, service, or activity pursuant to the contract.

25 U.S.C. § 5325(a).

## Why are Contract Support Costs at Issue in this Case?

The collection of third-party revenue (TPR), from sources like Medicare, Medicaid, and private insurers, has not always been an available source of program funding. Congress, in realizing how devastatingly un-

The NIHB has a proud history of advising the U.S. Congress, IHS and other federal agencies.

derfunded IHS was, authorized the collection of TPR by HIS to supplement, but not replace, what Congress appropriated to IHS. Congress later authorized Tribes participating in Self-Determination contracts with IHS to collect and spend TPR, as it realized that Tribes were reducing program capacity on expenses that IHS normally did not incur. However, the federal government and Tribes disagree as to whether IHS is required to pay CSC on expenditures of TPR. Notably, Tribes are required by their contracts with IHS to spend TPR to further the general purpose of the contract.

The National Indian Health Board Submitted an Amicus Curiae Brief in the Case: On February 19, 2024, the National Indian Health Board (NIHB), joined by a number of Tribes and Tribal organizations, filed an “amicus curiae” (Latin for “friend of the court”) brief in *Becerra v. San Carlos Apache Tribe*. The resolution of this case hinges on two statutes that are fundamental to the delivery of health care in Indian Country – the Indian Health Care Improvement Act (IHCA) and the Indian Self-Determination in Education and Assistance Act (ISDEAA).

The NIHB has a proud history of advising the U.S. Congress, IHS and other federal agencies, and private foundations on the health care issues of AI/ANs. In this case, NIHB advised the Supreme Court of the United States on the role of IHCA through its brief. The NIHB brief advocated for a ruling that favors Tribes, as that is what IHCA requires. The brief’s argument draws from the legislative history of IHCA, it explains why the statute was enacted, why and how it has been amended in lockstep with ISDEAA, how it governs the delivery of health care in Indian Country, and it offers background to the disparities in Indian health care. ■

## EVENTS

# Tribal Environmental Health Summit

NIHB partnered with the Centers for Disease Control and Prevention (CDC)- Agency for Toxic Substances and Disease Registry (ATSDR) to host a series of free regional summits on the topic of environmental health in Indian Country. Each summit featured Tribal leaders, environmental health practitioners, subject matter experts, and federal partners engaging on topics relevant to each region. The summits intended to connect people from different professional backgrounds and Tribes, communities, federal agencies, Tribal organizations and state and local entities to address various environmental health and environmental justice issues affecting Indian Country. Each summit was designed for participants to: Exchange knowledge, Share best practices, Provide policy recommendations, and Identify solutions to address environmental health and environmental justice/health equity issues affecting Tribal communities.

The summits took place between the months of July and August and were two day summits. The locations of each summit were Oklahoma City (Southern Plains), Phoenix (Tucson), Billings (Great Plains), and Greenbay (Bemidji and Nashville). There were a number of topics at all summits: discussion on the Tribal Public Health Data Site, PFAS, Water Sanitation and Safe Water, Climate and Health, Brownfields, Mining Reclamation, Lead Poisoning, and Funding Opportunities available to Tribes.

The summits emphasized the importance of bringing together professionals from various backgrounds including Tribal leaders, environmental health practitioners, subject matter experts, federal partners, Tribal



organizations, and state and local entities. Participants had the opportunity to exchange knowledge and share best practices related to environmental health and environmental justice issues affecting Tribal communities. The summits provided a platform for participants to discuss and develop policy recommendations aimed at addressing environmental health and environmental justice/health equity issues in Indian Country. These recommendations informed policy development at the Tribal, federal, and state levels, advocating for policies that prioritize the health and well-being of Tribal communities.

The summits also raised awareness about a range of environmental health issues impacting Tribal communities, including PFAS contamination, water sanitation, climate change, brownfields, mining reclamation, lead poisoning, and funding opportunities. By engaging in the discussions, sharing experiences, and accessing resources, the Tribal communities are hopefully better equipped to advocate for their environmental health needs and implement sustainable solutions. ■

“I attend many conferences as a pain management person, as a yoga therapist and I always come away with takeaways for Natives. It’s not like your other conferences where you already know the stuff and can play on your phone. You really can and need to pay attention here and take away stuff.” — **KATRINA EVERHART**

“I encourage everyone to attend the Tribal Environmental summit. It is a really positive, energy packed summit where you get to hear the perspectives of the tribes. My immediate takeaway is looking for innovative solutions using the indigenous knowledge or the ecological system. My Dine (Navajo) knowledge system that I share with others and that I want other tribes to share with me so that we can have a solution oriented pathway to how we can address environmental issues, public health issues and climate change.” — **EDWARD DEE**





National Indian Health Board 

# PLEASE HELP SUPPORT HEALTH EQUITY FOR INDIAN COUNTRY

*Your gift to the National  
Indian Health Board  
supports advocacy and  
capacity building efforts  
for every Tribe.*



## UPCOMING EVENTS

### NATIONAL NATIVE HARM REDUCTION SUMMIT

JULY 16 - 18TH, 2024

*Shooting Star  
Casino, White  
Earth Nation*

### AMERICAN DENTAL THERAPY ASSOCIATION ANNUAL CONFERENCE

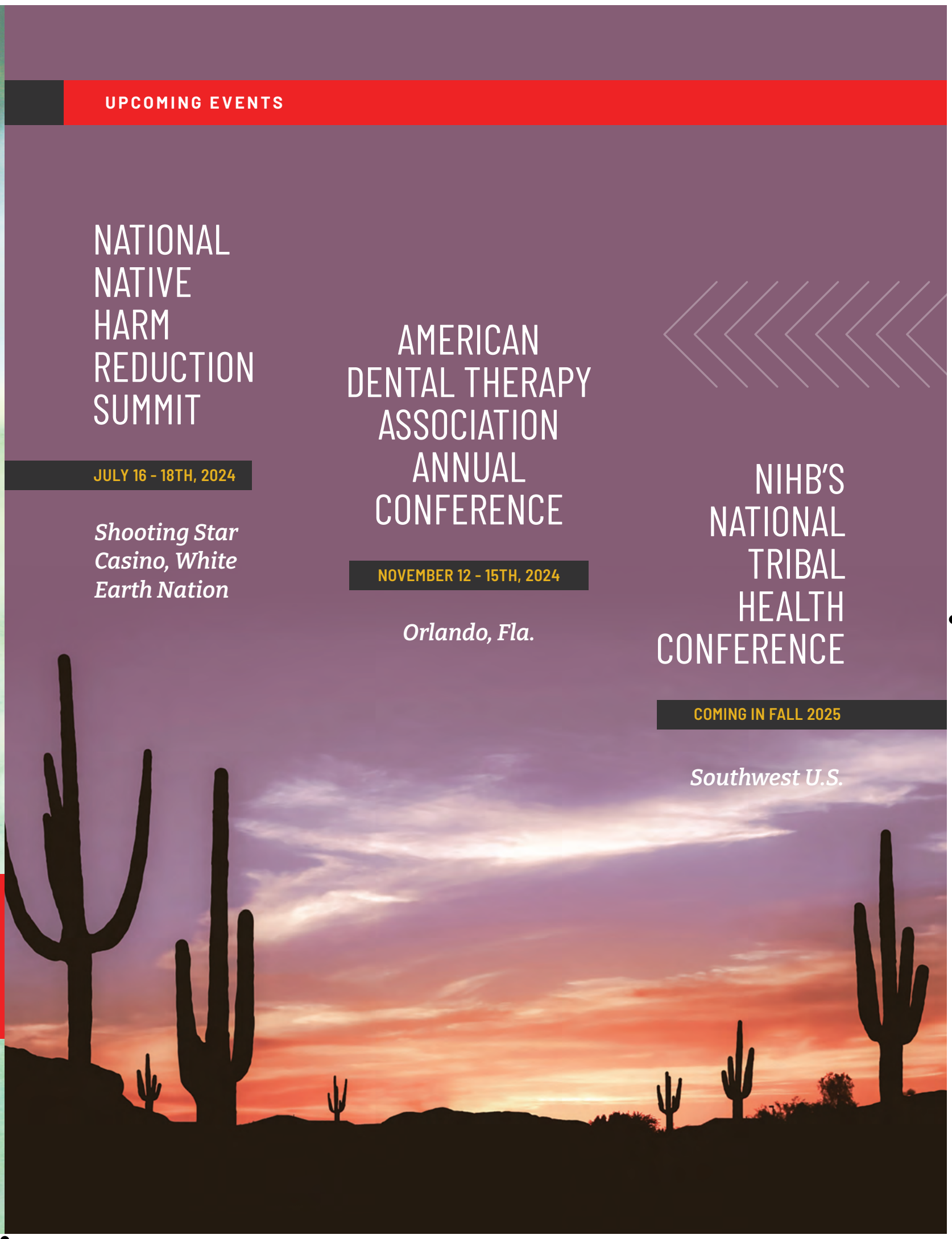
NOVEMBER 12 - 15TH, 2024

*Orlando, Fla.*

### NIHB'S NATIONAL TRIBAL HEALTH CONFERENCE

COMING IN FALL 2025

*Southwest U.S.*







National Indian  
Health Board

[NIHB.ORG](http://NIHB.ORG)

