



National Indian Health Board

Health Reporter

Spring 2016

Healthcare Funding in Indian Country – It Is More Than Just the IHS!



Chairman of the House Labor, HHS, Education and Related Agencies Appropriations Subcommittee Tom Cole (R-OK), a member of the Chickasaw Nation, chairs a committee hearing.

With the 2016 Elections on the horizon, outgoing President and Congress set to get out of town in mid-July, it is likely that not much is getting done in Washington this year. Health legislation like opioid abuse, mental health reform, and the nomination of a new Supreme Court Justice will all take a backseat. But that doesn't mean now is the time to give up on Indian health priorities.

One thing Congress is focusing on is FY 2017 appropriations. We will almost certainly have some form of continuing resolution – or CR – to keep the government funded from the end of the fiscal year on September 30 through the elections, but the rest of the outcome is unknown. It will depend on what happens at the polls, but there could be a year-long CR; a large, single, omnibus bill that would fund the government in FY 2017 passed in December; or lawmakers could delay appropriations until January so a new Congress and President can hash it out.

But, that means that Congress must still prepare for passing appropriations this year. The appropriations committees have been hard at work since the President's Budget Request was released in February, holding dozens of hearings. But, with federal budgets squeezed

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Special Diabetes Program for Indians Renewal: It's Never Too Early to Start



Advocates for SDPI visit Capitol Hill in early 2015 to discuss SDPI renewal. The program was renewed by Congress for 2 years shortly after their visit.

Congress established the Special Diabetes Program for Indians (SDPI) in 1997 to address the growing epidemic of diabetes in American Indian and Alaska Native (AI/AN) communities. As SDPI begins its nineteenth year of funding diabetes treatment and prevention programs in Indian Country, it is important to share success stories and improved outcomes in risk factors in order to educate federal decision-makers on the importance of the program.

SDPI funding is considered "mandatory" funding from the federal government. It is included with programs like Medicare, Medicaid, and Social Security where funding is automatically spent each year without going through the annual appropriations process in Congress. SDPI is currently funded at \$150 million per year, so it only accounts for a very small portion of what the government considers "mandatory" funding. Nonetheless, Congress has chosen only to authorize SDPI for short

periods of time, so we must go back to Congress for future reauthorizations.

Congress will need to reauthorize SDPI by September 30, 2017 in order for Tribes to provide continuous diabetes treatment and prevention programming. The usual legislative vehicle for SDPI will

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From the Chairperson

Dear Indian Country Friends and Advocates,

LESTER SECATERO



Welcome to a special public health edition of NIHB's Health Reporter! This issue focuses on disease prevention and health promotion, and why this is so critical to reducing health disparities for American Indians and Alaska Natives. We hope to see you at our 7th Annual Tribal Public Health Summit in Atlanta, GA from April 11-13, 2016, where there will be even more opportunities to learn about public health in Tribal Communities.

While we often focus on the impacts of direct patient care, it is critical to consider public health initiatives such as disease prevention, education, research for disease, injury prevention, and promotion of healthy lifestyles. Unfortunately, Indian Country continues to lag far behind other communities in basic resources and services. Across the nation, NIHB is working to elevate the public health needs for Tribal communities from Capitol Hill, to federal agencies, and with Tribal communities directly. It is critical for us to think about opportunities to raise our voice about the need for public health.

In February of this year, NIHB Executive Director Stacy A. Bohlen testified before the U.S. Commission on Civil Rights as they begin to update their 2003 report "A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country." As part of her testimony, she identified many struggles that Tribal communities face when it comes to accessing public health programs. She pointed out the difficulty Tribes have when competing with large state and local health departments for federal grants, and urged the commission to highlight these disparities in their new report.

NIHB's Tribal Healthcare Reform team continues outreach on the Affordable Care Act (ACA). This means increasing awareness in Tribal communities on the benefits for public health efforts that have come through the comprehensive healthcare law. You

can read about those benefits in detail on page 7. When NIHB goes to Tribal communities to provide training on the ACA, one key focus is always making sure that patients are aware of the 10 essential public health services guaranteed by the ACA.

And of course, NIHB's Department of Public Health Programs and Policy constantly works to elevate disease treatment and prevention in Indian Country. One effort that we will be focusing on in 2016, is outreach to Congress and Tribes on the renewal of the Special Diabetes Program for Indians (SDPI). This crucial program is only authorized through September 2017, so we must begin to lay the groundwork now. Check out the cover page of this issue to learn how you can become involved!

We remain committed to providing technical assistance to Tribes for public health efforts in many ways. NIHB provides insight and analysis into proposed federal rules and regulations as well as sample comments for Tribes. Though many of these federal regulations can be complex and often tedious to sort through, it is imperative that Tribal voices be heard. NIHB also provides technical assistance grants to Tribes for Public Health Accreditation. This crucial effort builds the capacity of Tribal public health programs so that they can operate stronger and more effective public health programs.

NIHB remains dedicated to promoting the health and wellness of Tribal Communities, and we hope that this edition of Health Reporter can provide you with new information about how you can become involved in the health and wellness of your community. We encourage you to provide input on this publication and all issues concerning the health and wellness of our people. NIHB is here to serve you.

Yours in Health,



Lester Secatero
Chairperson



NIHB Executive Director Stacy A. Bohlen testifies before the U.S. Commission on Civil Rights in February 2016 to describe the health funding needs of American Indians and Alaska Natives.

THE NATIONAL INDIAN HEALTH BOARD

**ONE VOICE AFFIRMING AND
EMPOWERING AMERICAN
INDIAN AND ALASKA NATIVE
PEOPLES TO PROTECT AND
IMPROVE HEALTH AND
REDUCE HEALTH DISPARITIES.**

THE WORK OF THE NATIONAL INDIAN HEALTH BOARD

The National Indian Health Board (NIHB) advocates on behalf of all federally-recognized Tribal governments – both those that operate their own health care delivery systems and those receiving health care directly from the Indian Health Service (IHS).

Located on Capitol Hill in Washington, D.C., NIHB provides a variety of services to Tribes, area Indian health boards, Tribal organizations, federal agencies, and private foundations, including advocacy, policy formation and analysis, legislative and regulatory tracking, direct and timely communication with Tribes, research on Indian health issues, program development and assessment, training and technical assistance programs, and project management.

NIHB is a 501(c)3 charitable organization.



Federal Tribal Advisory Committees – Where the Change Happens!

Indian Country needs your voice and your leadership in shaping federal health policy! One area where this is critical is by engagement with Tribal Advisory Committees. These committees provide an opportunity for Tribal representatives to set priority issues and recommendations to Federal officials on health-related issues and are a fundamental part of the government-to-government relationship that exists between Tribes and the federal government. Without Tribal engagement, the federal government won't be held accountable for their policies in Indian Country.

NIHB staff are pleased to provide technical support to Tribes in a variety of ways. NIHB routinely attends these advisory committee meetings and is capable of providing briefing material, talking points, and notes on key issues. NIHB plays an active role in advocating for all 567 federally recognized Tribes but more Tribal engagement is needed. Tribal leaders are able to provide the detailed and specific impacts that federal policy has in their communities. Tribal leaders and their representatives can also bring the personal stories that they hear every day about the effects that federal programs are having in their communities. It is critical for federal officials to hear their stories and this is routinely done through these advisory committees.

Over the last several years, the Obama administration has done much to improve Tribal consultation, but we must do our part to ensure that these meetings are meaningful and represent a wide array of perspectives from Indian Country. In order to develop comprehensive health policy for the benefit of Indian Country, Direct Service and Self-governance Tribal leaders must all be at the table to advocate for their communities. NIHB stands ready to assist in any way by providing committee meetings reports and news alerts through our website and e-mail listservs.

Please see the chart on the right for a brief overview of some of the Tribal advisory committees that are in need of your voice. To become involved and learn more about the Federal Advisory Committees and the NIHB Committees or to join one of our many NIHB listservs, please contact Sarah Freeman at sfreeman@nihb.org or call 202-507-4077. 

FEDERAL TRIBAL ADVISORY COMMITTEES

Tribal Technical Advisory Group to the Centers for Medicare & Medicaid Services (TTAG)	Provides input and advises CMS on health care policies and programs associated with Medicare, Medicaid, and State Children Health Insurance Programs in order to increase AI/AN access to CMS programs. For more information please visit: www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Tribal-Technical-Advisory-Group.html
HHS Secretary's Tribal Advisory Committee (STAC)	Advises, consults with, and makes recommendations on Tribal health programs and policies to the Secretary of The Department of Health and Human Services (HHS). Facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs. For more information visit: www.hhs.gov/about/agencies/iea/tribal-affairs/about-stac/index.html
Direct Service Tribal Advisory Committee (DSTAC)	Advises the Indian Health Service (IHS) Director on the development of health policy and participates in IHS decision-making that concerns the delivery of health care for Direct Service Tribes for more information visit www.ihs.gov/odsct/
Tribal Self-Governance Advisory Committee (TSGAC)	Advocates for all Self-Governance Tribes, suggests policy guidance on the implementation of the Tribal Self-Governance Program, and advises the IHS Director on issues of concern to all Self-Governance Tribes for more information visit www.tribalselfgov.org/
Information Systems Advisory Committee (ISAC)	Guides the development of Indian health information infrastructure and information systems, while also supporting standardized aggregate data for Indian health programs at a national level.
Tribal Leaders Diabetes Committee (TLDC)	Provides advocacy and guidance to the IHS Director to ensure the incorporation of appropriate culture, traditions, and values in program development, research, and community-based activities concerning diabetes and chronic diseases. For more information visit: www.ihs.gov/medicalprograms/diabetes/index.cfm?module=peopleTLDC
National Tribal Advisory Committee on Behavioral Health (NTAC)	Assists in the development and support of behavioral health throughout the IHS/Tribal/Urban (I/T/U) systems and works to ensure that services are broadly available and culturally integrated
Centers for Disease Control and Prevention (CDC) Tribal Advisory Committee (TAC)	Advises CDC/ATSDR on the promotion of healthy quality of life by preventing and controlling disease, injury, and disability affecting AI/AN communities. For more information visit: www.cdc.gov/tribal/tac/
SAMHSA National Advisory Council	Advises, consults with, and make recommendations to the Secretary and the SAMHSA Administrator, concerning matters relating to the activities and policies carried out by the Agency. For more information visit: www.samhsa.gov/about-us/advisory-councils/samhsa-national-advisory-council



SAMHSA Center for Mental Health Services (CMHS) National Advisory Council	Consults and makes recommendations to the Secretary of HHS, the Administrator of SAMHSA, and the Director of CMHS; reviews summary statements for applications submitted for grants and cooperative agreements. For more information please visit: www.samhsa.gov/about-us/advisory-councils/cmhs-national-advisory-council
SAMHSA Center for Substance Abuse Prevention (CSAP)	Consults and makes recommendations to the Secretary of HHS, the Administrator of SAMHSA, and the Director of CSAP concerning matters, policies, grants, and activities related to the Center. For more information please visit: www.samhsa.gov/about-us/who-we-are/offices-centers/csap
SAMHSA Center for Substance Abuse Treatment National Advisory Council (CSAT)	Advises, consults, and makes recommendations to the Secretary, the Administrator of SAMHSA, and the CSAT Director regarding activities, grants, policies regarding activities carried out by the Center. For more information visit: www.samhsa.gov/meetings/center-substance-abuse-treatment-national-advisory-council-meeting
SAMHSA Advisory Committee for Women's Services (ACWS)	Advises the Associate Administrator for Women's Services and the Administrator of SAMHSA on activities regarding women's substance abuse and mental health services; collect and review data; and report expenditures and estimated level of funding needed. For more information visit: www.samhsa.gov/about-us/advisory-councils/advisory-committee-women%E2%80%99s-services-awcs/committee-charter
SAMHSA Tribal Technical Advisory Committee (TTAC)	Provides a venue wherein Tribal leadership and SAMHSA staff can exchange information about public health issues, identify urgent mental health and substance abuse needs, and discuss collaborative approaches to address these needs. For more information visit: www.samhsa.gov/about-us/advisory-councils/tribal-technical-advisory-committee-ttac

National Institutes of Health Tribal Consultation Advisory Committee (TCAC)	Serves as an advisory board to NIH to help ensure that Tribes and AI/ANs have meaningful and timely input in the development of NIH policies and programs. For more information please visit: dpcpsi.nih.gov/thro/charter
Office of Minority Health (OMH) Health Research Advisory Council (HRAC)	Ensures that Tribes and AI/ANs have meaningful and timely input in the development of relevant HHS policies, programs, and priorities specific to AI/AN research. For more information please visit: minorityhealth.hhs.gov/hrac/
Office of Minority Health (OMH) Advisory Committee on Minority Health (ACMH)	Advises the Secretary for Minority Health on improving access to health care services and decreasing disparities in health care outcomes for AI/AN people. For more information please visit: minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=3

NIHB COMMITTEES

Medicare, Medicaid, and Health Reform Policy Committee (MMPC)	Provides technical support to the Centers for Medicare & Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) in regulation and program evaluation of the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA). For more information please visit: www.nihb.org/tribalhealthreform/mmpc/
Tribal Public Health Work Group	Composed of technical and public health subject matter experts to support the work of the Tribal Leaders on the Centers for Disease Control and Prevention (CDC) Tribal Advisory Committee (TAC)
Tribal Public Health Accreditation Advisory Board (TPHAAB)	Composed of subject matter experts and others interested in voluntary public health accreditation across Indian Country by advancing the quality and performance of public health departments. For more information please visit: www.nihb.org/public_health/accreditation.php

The Secretary's Tribal Advisory Committee meets on March 2, 2016 to discuss key issues with Department of Health and Human Services Secretary Sylvia Mathews Burwell.



Regulatory Action and Indian Health: It is More Important (And Exciting!) Than You Think

Too often, federal regulatory action is overlooked or forgotten. But it is a necessary and vital part of the government-to-government relationship that exists between Tribes and the United States. Tribes and all American Indians and Alaska Natives are able to participate in the rulemaking process. In recognition of how critical this is – and how complicated this process can be – NIHB has created a tool that tracks, organizes, and provides analysis on the latest rulemaking activities in Indian Country through the Roster of Pending Regulations (Roster) and the Regulation Review and Impact Analysis Report (RRIAR).

First, a little background. There is a difference between regulatory work and legislative advocacy. Congress creates and passes the law but the Executive Branch is the branch of government that enforces it. Through the rulemaking process, the legislation is clarified and implemented by the Administration. Proposed rules, letters, and guidance provide directives and requirements to enforce the statute. However, the rulemaking process also provides for public interpretation and input. This is where it is extremely important for Indian Country to be involved.

When a proposed rule is released, the public is notified and can provide comment on the proposed rule as well as provide additional data to the agency. This public comment period can typically last anywhere from 30 to 180 days. Proposed rules are published in the Federal Register. (www.federalregister.gov/)

Tribes, Tribal organizations, and interested parties all have an opportunity to provide recommendations and input into the creation of the final rule through the commenting process. At the end of the comment period, the Agency will read through the comments and determine whether or not to adopt the recommendations.

To assist Tribes, Tribal organizations, and American Indians and Alaska Natives in tracking the hundreds of proposed rules and regulations that come out each month, NIHB has created the Roster of Pending Regulations (Roster) and the Regulation Review and Impact Analysis Report (RRIAR). The Roster is released on a weekly basis through NIHB's website and our Regulation Workgroup list-serv. The Roster provides a running tally of the latest proposed rules or requests for information that might have an impact on Indian Country. The Roster provides analysis on what those impacts are, timeline for comments, and any other relevant information to assist Tribes in providing notice and comments of their own.

The Regulations Workgroup, a workgroup of NIHB's own Medicare, Medicaid, and Health Care Reform Policy Committee (MMPC) has a weekly teleconference where the Roster is discussed and recommendations are made on which ones NIHB will develop comments. Draft comments and template comments are then shared with Tribes and Tribal organizations. Please contact Sarah Freeman (sfreeman@nihb.org) for more information on the Regulations Workgroup.

The RRIAR is more comprehensive than the Roster and is updated on a monthly basis through NIHB's website. Not only does the RRIAR track the latest rulemaking activities but it also tracks whether the agency adopted the recommendations made by NIHB and other Tribal organizations in the comments it submitted. For example, in the recently released update to the Centers for Medicare and Medicaid Services' (CMS) policy on 100% Federal Medical Assistance Percentage (FMAP), CMS adopted many of the recommendations that NIHB and Tribes made in the comments they submitted. This is reflected in the RRIAR entry for this item. The RRIAR also provides a summary of the final rule and any subsequent agency action. It is an invaluable tool and we encourage all of Indian Country to use it.

In summary, it is vitally important for Tribes and their advocates to be involved in the federal rulemaking process. As the saying goes, "The Devil is in the details" and the details are where the federal agencies implement policy. With thousands of other stakeholders responding to proposed rules, Tribes *must* be part of the conversation to ensure that we protect Tribal sovereignty and self-determination and that Indian Country is not left out of any law's implementation.

In the coming months, NIHB will provide training material on how to effectively use the Roster and RRIAR. For more information or if you have any questions about how to access and use these tools, please contact Devin Delrow, Director of Federal Relations, at ddelrow@nihb.org or 202-507-4072. 📧



NIHB's Medicare and Medicaid Policy Committee meets in Washington, DC on February 24, 2016 to discuss how upcoming regulations will effect Indian health programs.

How the Affordable Care Act Impacts Public Health Services Across Indian Country

According to the American Public Health Association, “Public health promotes and protects the health of people and the communities where they live, learn, work and play. While a doctor treats people who are sick, those of us working in public health try to prevent people from getting sick or injured in the first place.” Public Health is concerned with threats to health based on population health analysis.

The passage of the Patient Protect Affordable Care Act (ACA) and the permanent reauthorization of the Indian Health Care Improvement Act (P.L. 110-148) have not only expanded direct healthcare options for all Americans but it has enhanced the delivery of public healthcare services for American Indian and Alaska Natives. The ACA influenced the public health system in three major ways:

- 1. Expanded insurance coverage** impacted how public health departments offer clinical services: Governmental public health agencies currently providing clinical services may transfer cases to the private sector, such as routine childhood vaccinations.
- 2. New care delivery models** that offered new opportunities to integrate public health principles and enhance requirements for hospitals to define and utilize beneficial community efforts: Public health practitioners will have the opportunity to share their expertise on assessing the health of populations, implementing community and broad-based solutions, and evaluating the outcomes of these solutions.
- 3. Public health services** have reached more people: Programs and services such as home visiting and other maternal child health programs and specialized behavioral health services will be made available to the general population, in addition to programs on prevention and protection.

Tribal governments are sovereign entities with the authority to enact their own health regulations to protect the health, safety, and welfare of their communities. Jurisdictional authorities in Indian country are complex, however, because the delivery of public health services is often distributed across Tribal, county, state, and federal public health systems, the Indian Health Service (IHS) continues to be the primary provider of public health services in some regions, but in other areas, Tribal

governments are increasingly assuming these responsibilities. Due to the underfunding of the Indian Health Service, Tribes are looking for innovative ways to fulfill the unmet needs of critical and chronic illnesses in their communities.

The Affordable Care Act established the Prevention and Public Health Fund (PPHF) to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. To date, the Fund has invested in a broad range of evidence-based activities including community and clinical prevention initiatives; research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and public health workforce and training. It is currently funded at \$2 billion per year, and is not subject to the annual Congressional appropriations process. You can learn more about what has been funded through the PPHF here: <http://www.hhs.gov/open/prevention/index.html>

Although there is a big focus on the Health Insurance Marketplace, it's important to remember the special protections in Medicaid and the Children's Health Insurance Program (CHIP) that also help increase access to public health services for American Indians and Alaska Natives. The Affordable Care Act also afforded states the opportunity to expand Medicaid. To date, 32 states and the District of Columbia have chosen to expand Medicaid, which expands the eligible population of those served by Medicaid to all adults making 138% or less than the federal poverty level. More Medicaid patients, means that more low-income people have access to more public health services such as immunizations, screenings for common chronic and infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease.

Some Tribes are also using the special protections and benefits of the Affordable Care Act as a means to provide Tribal Premium Sponsorship programs, which can enhance public health services to Tribal communities. Tribes can use Third Party Billing or

Purchased and Referred Care dollars to buy health insurance policies through the Health Insurance Marketplaces. Case studies have been performed by Tribes that would identify a population with a chronic illness and offer to buy them health insurance policies on the Health Insurance Marketplaces. In many studies it has been more cost effective for a Tribe to invest in paying these premiums than incur the cost through their Purchased and Referred Care program. They would also be able to third party bill the insurance providers increasing revenue for the clinic to provide more services. 🌿

ADDITIONAL RESOURCES FOR INFORMATION ABOUT THE SPECIAL PROTECTIONS OR PROVISIONS FOR AMERICAN INDIAN AND ALASKA NATIVES CAN BE FOUND ON THE FOLLOWING WEB PAGES:

MARKETPLACE RESOURCES

- Details on special Marketplace protections and benefits for AI/ANs are located at: www.healthcare.gov/tribal
- Printed Tribal materials to share with your community: CMS Marketplace information center: marketplace.cms.gov/getofficialresources/publications-and-articles/american-indian-and-alaska-native-publications.html
- IHS information on the Affordable Care Act: www.ihs.gov/aca/faq/
- Information for Tribal leaders and tribal health programs: National Indian Health Outreach and Education (NIHOE): tribalhealth-care.org/
- Additional Tribal outreach and education resources: CMS Division of Tribal Affairs: go.cms.gov/AIAN-OutreachEducationResources
- IHS Q&A call for Affordable Care Act questions: acainformation@ihs.gov

THE AFFORDABLE CARE ACT FOR AMERICAN INDIAN AND ALASKA NATIVE YOUTH: NEW TOOLKIT

NIHB will be releasing an educational Patient Protection and Affordable Care Act (ACA) toolkit for Native Youth within the next quarter. This toolkit will complement the toolkit created last year, "The Five Fast Facts on the ACA." The toolkit was produced in various versions, targeting both the American Indian and Alaska Native (AI/AN) Elder and Youth populations. While the previous toolkit focused on specific points about the ACA, the new Toolkit will take a closer look at the Affordable Care Act for Native Youth.

"Our Stories do matter, we are the youth that are going to make Indian Country better, and brighter tomorrow" says Madelynn Dancer from the Choctaw Nation of Oklahoma in the Youth toolkit video as she helps lead the next generation of Native Youth by discussing the federal trust responsibility. This toolkit will highlight Native Youth across Indian country who, like Madelynn, are doing great things in their Tribal communities. The toolkit will include several youth-led videos, as well as informative posters highlighting the youth, which outline what the ACA means for their community and them as young people.

Furthermore, the toolkit illustrates the federal trust responsibility that the United States government has with all federally recognized Tribes to provide quality healthcare and how the trust responsibility is implemented in the Affordable Care Act.

You can help make a difference and contribute to the creation and success of these toolkits by supporting NIHB. If you are interested in distributing any of NIHB's toolkits, current or previous, please contact the Tribal Healthcare Reform Outreach and Education Program Associate Win Reilly at WReilly@nihb.org or 202-507-4081. 📧



▶ Continued from page 1 — HEALTHCARE FUNDING IN INDIAN COUNTRY

again this year, we will need to get creative in steering funding towards Indian health programs.

As we all know, the Indian Health Service (IHS) provides core healthcare services to American Indians and Alaska Natives (AI/ANs). However, IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease prevention, education, research for disease, injury prevention, and promotion of healthy lifestyles. These types of programs are critical for reducing health disparities for AI/ANs. The federal trust responsibility to the Tribes must extend to federal public health agencies like the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Minority Health (OMH), National Institutes of Health (NIH) and the Health Resources and Services Administration (HRSA).

Many states and localities get base funding from the federal government in the form of block grants. Sometimes states pass these through to Tribes within their borders, but often Tribes never see any of these dollars. But without a local tax base and little (if any) outside funding, Tribal communities are often the most in need of public health dollars. Tribes were ignored during the formulation of the US public health system, and it is now time to redress this wrong.

Tribes are eligible to apply for many federal grants that address public health issues, however, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to even apply for the grants. That's where appropriations advocacy comes in.

At NIHB, we continue to advocate with the Appropriations Subcommittee on Labor, Department of Health and Human Services (HHS), and Education (which allocates annual funding for almost all HHS agencies besides the IHS) that Tribal priorities must be included in any allocated funding. For example, NIHB has requested a Tribal set-aside at the CDC for the Public Health Services Block Grant which provides funding to sustain the infrastructure within state health departments. Denying this stable source of funding to Tribes, denies them a significant opportunity to create the infrastructure required to address their own public

health priorities. NIHB has also requested that Congress instruct CDC to do specific outreach to Tribes on Hepatitis C. Rates of Hepatitis C in Indian Country continue to rise, surpassing other communities, and it is critical that CDC promote special outreach to Tribes on this serious disease. NIHB has also requested that Congress provide a 5 percent Tribal set-aside at all the CDC centers to ensure that funds are reaching the Tribes.

The SAMHSA FY 2017 President's Budget Request also made important investments for Tribal communities. This includes a \$5.2 million set-aside for Tribal Communities to implement the Zero Suicide Initiative and \$30 million for Tribal Behavioral Health Grants. SAMHSA also provides funding for the Circles of Care Program which offers three-year infrastructure/planning to provide AI/AN communities with tools and resources to design and sustain their own culturally competent mental health programs. NIHB recommended that Congress increase this funding by \$2 million in FY 2017 for a total of \$8.5 million.

Several other HHS agencies are also important for Indian health funding and it is critical that Indian Country's presence is known. NIH, for example, conducts medical research of all varieties. Tribal leaders have continually requested that NIH embark on a comprehensive study on historical and inter-generational trauma in Tribal communities so that we can better understand and treat behavioral health issues in Tribal communities. NIHB has also requested that OMH provide dedicated funding to increase the number of Affordable Care Act navigators dedicated for Indian Country.

So, when we are thinking about appropriations advocacy this year, Tribes and their advocates should consider opportunities at HHS agencies outside of the IHS. It is critical to tell lawmakers that the federal trust responsibility for health extends to *all* agencies of the federal government, and that they have a duty to ensure that funds appropriated by Congress reach Tribal communities. We are not necessarily asking Congress to increase funding for certain programs, just that the funding that is allocated is targeted to AI/ANs.

Please visit NIHB's legislative website for a variety of tools and resources that can help you with this at www.nihb.org or contact NIHB's Director of Congressional Relations, Caitrin McCarron Shuy, at 202-507-4085 or cshuy@nihb.org. 📧

NIHB Travelled Around the Country for Outreach and Education Tribal Days of Action!

For the 2015-2016 open enrollment period, as a part of the National Indian Health Outreach and Education (NIHOE) National Partners, the National Indian Health Board partnered with various organizations to host national and urban Tribal Days of Action! NIHB went everywhere from Arizona to Alaska, in an effort to reach as many American Indian and Alaska Native (AI/AN) communities as possible.

Department of Health and Human Services (HHS) Secretary Burwell challenged every Tribe to host an enrollment event, and NIHB was there to help! NIHB attended various events to train Navigators, Certified Application Counselors and others on different topics on the Affordable Care Act. Topics ranged from “Affordable Care Act 101” to “Special Provisions” and “Exemption Waivers” for American Indians and Alaska Natives. NIHB also provided support and training during enrollment events where families came out to enroll in healthcare.

NIHB’s mission is to educate as many assisters as possible to ensure American Indian and Alaska Native communities are serviced by individuals trained on the special provisions that apply to these communities. NIHB received requests from many participants to conduct more trainings and will be continuing these events throughout 2016.

With your support, we will continue working hard until we reach every American Indian and Alaska Native. NIHB is available to answer any questions or conduct trainings. NIHB provides assistance and trainings throughout the year. For more information, contact Dawn Coley at DColey@nihb.org or 202-507-4078. 🌟

A grandmother and her grandchildren at the Phoenix Benefits Fair where NIHB provided support for the event.

NIHB trained 69 Certified Application Counselors on how to better serve the AI/AN community at Navajo Nation in Gallup, NM.





Southern Oregon Diabetes Prevention Consortium Annual Diabetes Celebration.

SDPI SPOTLIGHT:

When Funding Stops, The Work Must Continue

The Special Diabetes Program for Indians (SDPI) has been preventing diabetes and saving the lives of American Indians and Alaska Natives for nineteen years. After almost two decades of diabetes treatment and prevention programs, this landmark grant provided through the Indian Health Service (IHS) is drastically changing. Since 2004, there have been three separate grant programs administered through the SDPI funding, including two demonstration projects that later turned into multi-year initiatives, the Diabetes Prevention (DP) and Healthy Heart (HH) projects:

- **SDPI Diabetes Prevention Program (DP): 38 programs.** Grant programs implement a proven lifestyle change intervention designed to reduce risk of diabetes in high risk individuals.
- **SDPI Healthy Heart Project (HH): 30 programs.** Grant programs use an intensive

case management approach to reduce cardiovascular disease risk in individuals with diabetes.

SDPI has been flat-funded at \$150 million a year, primarily through single year reauthorizations by Congress since 2002. This has created barriers for the Tribes and Tribal organizations that administer these services by making it difficult to retain qualified staff, provide continual services, and has made it impossible to allow new Tribes to compete for the funding up until this past grant cycle. Now, the SDPI is eliminating the DP/HH Initiatives entirely – leaving these 68 programs struggling to continue the prevention services by finding other funding or, worse, forcing them to shut down completely.

But, there is hope.

The Southern Oregon Diabetes Prevention Consortium – which includes the Coquille, Cow Creek Band of Umpqua and Klamath Tribes – is familiar with needing to be creative in the delivery of services to their Tribal members. Ms. Kelle Little, R.D., the Health and Human Services Administrator of the Coquille Indian Tribe Community Health Services, teamed up with Ms. Sharon Stanphill, Health and Wellness Director of the Cow Creek Band of Umpqua Indians, back in 2004 to create a consortium of the three smaller Tribes in Southern Oregon in order to meet the minimum active number of members served and receive SDPI DP funding. While each of these Tribes are fairly small and did not meet the minimum user population on their own, they still experience Type 2 diabetes at disproportionate rates. According to the Centers for Disease Control and Prevention (CDC) 2013 data, approximately 8.3% of Oregon's population has Type 2 diabetes. However, in the

three Southern counties, where the Coquille, Cow Creek Band, and Klamath Tribes reside, the populations experience diabetes at much higher rates, with diabetic populations of 10.8%, 12.1%, and 10.5%, respectively.

The consortium has worked to prevent the further spread of diabetes in their Tribal populations by providing education on healthy lifestyles for Tribal members and their families. These efforts, like those of the other DP/HH Initiatives, have made a difference. In the first decade of the 15-year-old program, participants saw their blood sugar drop 13 percent, bad cholesterol fall 17 percent, and kidney dysfunction plummet by a third. The Tribes initially went through an intensive process among the Tribal leadership and health directors to develop the consortium with a memorandum of understanding (MOU) and are now entering their 12th year of offering group-based and individual prevention services.

The consortium offers pre-diabetic patients 16 classes taught by doctors, counselors, and dietitians on new ways to cook, eat, and exercise. Participants are expected to quit drinking alcohol and to lose seven percent of their weight. They meet regularly in small groups for a year, and some choose to continue to participate in the maintenance phase of the program. Participants also get access to a personal lifestyle coach.

Lifestyle Coaches of the Southern Oregon Diabetes Prevention Consortium

- **Jill Boyce**, R.D., Lifestyle Coach, Cow Creek Health and Wellness Center
- **Danelle (Dani) Bliss**, Lifestyle Coach and Diabetes Health Educator, Coquille Indian Tribe
- **Erin Tecumseh**, Lifestyle Coach and Diabetes Prevention Coordinator, Klamath Tribal Health & Family Services

The strengths of the consortium lie in the long-term support from all three Tribes' Tribal leadership and that the Tribes involved have overlapping service areas. Meaning, Tribal members can participate in any of the three programs, and in times of staffing shortages the other programs can help fill-in the gaps.

The Path Ahead

Moving forward, after the DP/HH Initiatives will be completed at the end of FY 2016, the consortium will no longer formally exist through their MOU. All three of the Tribes will continue receiving some SDPI funding through the Community-Directed (C-D) grant program, but will take significant cuts – upwards of \$100,000 for all three programs. However, each of the Tribes have expressed the

“I truly believe this program can dramatically improve the health of the Klamath Tribes and bring us Mo ben dic hoslntablek!”
 (“good health” in the Klamath language)

-Taylor David, Klamath
SOUTHERN OREGON DIABETES
PREVENTION CONSORTIUM PARTICIPANT

need and interest for the diabetes prevention services to continue and have begun collaborating with other Portland IHS Service Area Tribes to develop innovative ways to roll these services into the Community-Directed programs.

The current plans include condensing the 16-week curriculum into an 8-week class and maintaining some full-time staff members to carry out the intensive individual lifestyle coaching features unique to the Diabetes Prevention Initiatives. Although the programs will lose the recruitment incentives like grocery gift cards, the consortium lifestyle coaches are confident that Tribal members will still participate and the programs will continue to show marked prevention of diabetes. The consortium has worked with over 150 active participants over the years and seen less than five percent of the pre-diabetic participants convert to a Type 2 diagnosis.

In addition to continuing the condensed DP curriculum through the Community-Directed program, the Cow Creek Band of Umpqua Indians Tribe is also planning to implement the Comprehensive Health Improvement Plan (CHIP) – formerly the Coronary Health Improvement Project - through their health clinic. CHIP is a lifestyle enrichment program designed to reduce diabetes risk factors through the development of better health habits. The goal is to lower blood pressure,

cholesterol, and blood sugar levels. This lifestyle program is billable for third party revenue and will provide many of the same education services that the SDPI DP program has provided.

Continued Resilience

Indian Country is not unfamiliar with short-term funding streams coming to an end and the creativity necessary to continue important health and human services in Tribal communities. With dedicated and inventive health professionals, like those at the Southern Oregon Diabetes Prevention Consortium, and supportive Tribal leadership, services can continue in new ways.

While the DP/HH Initiatives will no longer be formal grant programs, the SDPI will continue to provide Indian

Country with \$150 million for diabetes treatment and prevention Community-Directed grants through September 30, 2017. In order to ensure this important work continues, the National Indian Health Board and Tribes are requesting Congress to renew this critical program long-term. With long-term funding, SDPI programs could expand, strategically plan program activities, and recruit and retain staff to continue the preventive services and heart healthy education that the DP/HH Initiative programs have proven to be so effective Tribal communities.

We urge you to take up the call to action with us! Please consider inviting your Member of Congress to visit your SDPI program or arrange a meeting telling them about the importance of sustainable funding for health services. For tools and resources about Congressional outreach, please visit www.nihb.org/sdpi. 🌱

Tribal Public Health Accreditation Is... “Quality” “Credibility” “Empowerment” “Self-Determination”

At least that is what Tribal leaders and Tribal public health experts think. Last September during the NIHB Annual Consumer Conference in Washington, DC thirteen individuals including Tribal leaders and Tribal public health experts were interviewed for their views on Tribal public health accreditation. What surfaced from their views was that public health accreditation is a worthwhile investment for Tribes to build their capacity to assure that their public health system is capable of promoting and protecting the health of their people.

As many of us know, public health programs in Indian Country are often behind the rest of the country with far fewer resources and less infrastructure than states and localities. The U.S. Public Health system was largely developed in the mid-20th Century, between the federal government, states, and local governments before we saw the resurgence of Tribal sovereignty and self-determination. As a result, Tribal public health systems are often left out of federal and state funding streams, and have been playing catchup by cobbling together resources from federal, state, and private funding.

Public health accreditation is the measurement of a health department’s public health performance against a set of nationally recognized, practice focused, and evidence-based standards. Public health accreditation is being used by Tribes to actually build their public health systems. One of the more realistic and practical aspects of public health accreditation is that it doesn’t require a health system to provide all 10 Essential Public Health Services. What accreditation does require is that a Tribe define who and how those services will be provided in their community, properly aligning with the important principles of Tribal sovereignty and self-determination.

Public health accreditation is achieved by meeting specific standards and measures set forth by the Public Health Accreditation Board (PHAB). Since 2008, when PHAB was first developing the standards and measures, the National Indian Health Board facilitated Tribal involvement and continues to do so through

PHAB Board of Directors representation and coordination of the Tribal Public Health Accreditation Advisory Board (TPHAAB). TPHAAB is currently in the process of combining through the 261 page PHAB Standards and Measures V1.5 document to identify areas where the document could be even more relevant to Tribal public health systems.

It is no secret that, like any accreditation process, pursuing public health accreditation

requires considerable time, staff and leadership commitment, but the quality improvement products and outcomes are well worth the effort. Vickie Bradley, Deputy Health Director for the Eastern Band of Cherokee Indians describes what they have learned so far on their journey to public health accreditation, “Tribal Health improvement is primary. Accreditation is secondary.”

So, public health accreditation is more than checking off boxes to receive a prize at the end and receiving a plaque to hang on the wall, it is about assessing your processes as an organization, filling the gaps and building a public health system that provides the quality of public health services and assurances that all people deserve.

To reiterate in the words of Tribal leaders, *Tribal Public Health Accreditation Is... “Worthwhile” “Valuable” “the Future.”*

The full 15-minute Tribal Leaders’ Perspectives on Public Health Accreditation video will be available in mid-April on the NIHB website (www.nihb.org) after the video’s debut at the 7th National Tribal Public Health Summit in Atlanta, GA, April 11-14th. 📺

“And at the end of the day... it empowers our citizens that they will be able to say, ‘Hey, we have a competent Navajo Nation, we have competent staff, employees of the Department of Health and we can take care of ourselves.’ And that’s the bottom line.”

Russell Begaye
PRESIDENT, NAVAJO NATION

“I think anytime you can improve the level and quality of services to your people, it’s a benefit and I think this [public health accreditation] may be one way of doing it.”

Jefferson Keel
LIEUTENANT GOVERNOR, CHICKASAW NATION

“...so what’s really cool about public health accreditation is that they were founded with Natives in mind. So when the standards and measures were being developed, Tribal people were being consulted.”

Hannabah Blue
AMERICAN INDIAN PUBLIC HEALTH RESOURCE CENTER, NDSU

“I think it’s a really good exercise of Tribal sovereignty because it allows the Tribe to actually set public health standards on the reservation... and also exerts their sovereignty outside of their boundaries and exercises their relationship with the state and the locality when jurisdictions do cross.”

Byron Larson
ASSOCIATE DIRECTOR FOR THE URBAN INDIAN HEALTH INSTITUTE

For more information about NIHB’s Tribal Accreditation Support Initiative, visit www.nihb.org/tribalasi/index.php

Native Harvest – Tribes Celebrate Steps Towards Food Sovereignty

“Food sovereignty is an affirmation of who we are as indigenous peoples and a way, one of the most surefooted ways, to restore our relationship with the world around us.”

– Winona LaDuke

EXECUTIVE DIRECTOR OF HONOR THE EARTH

Food sovereignty is defined as “...the right of peoples to healthy and culturally appropriate food produced through ecologically sound and sustainable methods, and their right to define their own food and agriculture systems.” It is of exceptional concern to indigenous peoples around the world.

On November 21, 2014, the Navajo Nation passed the Healthy Diné Nation Act (HDNA), which imposes a 2 percent tax on junk food sold on the reservation and eliminates a 5 percent tax on fresh fruits and vegetables. This piece of legislation, triggered a new conversation across not only all of Indian Country, but the wider United States as a whole. It set a strong precedent signaling that Native Americans were taking a pivotal step towards revitalizing their ancestral rights to food sovereignty, and that the health and well-being of a nation’s constituents deserve to be under the protection of the law.

Several other states and localities have also taken the initiative – enacting soda taxes, restricting junk food advertising directed to children, opening school cafeteria salad bars, or placing bans on trans fats. Think tanks, doctors, and even politicians have lauded these efforts to impose and enforce policies that have direct implications for consumer health.

According to the Trust for America’s Health, a health policy organization out of Washington D.C., nearly 80% of AI/ANs are overweight or obese, and 1 in 2 youth are slated to develop diabetes in adulthood. These statistics are the result of multiple interacting factors. It is not uncommon for residents of reservations to drive upwards of 150 miles roundtrip to access a supermarket, while convenience stores and fast food options abound. Poverty levels, reaching higher than 60% in some communities, further complicate access to healthy



Nisqually Tribe members harvest Native fruits and vegetables for their Head Start elders program.

foods. And despite the fact that nearly 70% of reservations lands are agricultural, farming remains an incredibly arduous and expensive venture to begin because of legal restrictions.

Indeed, poorer health outcomes in Native communities can be directly linked to loss of food sovereignty and traditional Tribal lands, and a transition from an agrarian to sedentary lifestyle.

But, we are seeing a strong renewal of native food programs throughout the country. A resurgence of traditional Native farming and investments in cultural revitalization not only have implications for better health, but also for economic sustainability. The Healthy Diné Nation Act is an excellent example of a policy aimed at deterring unhealthy food consumption, increasing healthy food consumption



Young Oneida’s harvest one of the 3 Sisters (maize) as part of their Native foods program.

and generating revenue for public use. Other examples include the Oneida Tribe’s investment in traditional organic farming while working on food sovereignty assessment toolkits, and the Shakopee Mdewakanton Sioux pioneering the Seeds of Native Health Campaign.

At the National Indian Health Board, we work to build on the progress made by Navajo, Shakopee, Oneida and others by brainstorming further policy initiatives that can address chronic diseases such as obesity and diabetes. By working on a list of new health policy suggestions that are focused on improving Native rights to self-determination, we hope to make it easier for Tribes to enact the solutions they already know are effective.

NIHB is also working with other leaders in the field such as the Notah Begay III Foundation, and the Indigenous Food and Agriculture Initiative at the University of Arkansas School of Law. This includes analysis of federal, Tribal and state policies around obesity, with a specific focus on agriculture policies that have made it difficult for Native farmers to gain traction. NIHB will then be able to make distinct policy recommendations to remedy these setbacks. Striving for the full manifestation of Tribal sovereignty has always been NIHB’s goal, and we look forward to the implications these new projects have on bringing that goal to fruition. 🌱



In 2015, the 6th Annual NYHS was held in Washington, DC. NIHB hosted 24 youth from 14 different Tribal Nations and Alaska Native Villages. Pictured here, are the youth meeting with the White House Department of Intergovernmental Affairs.

NIHB's Annual Native Youth Health Summit – Help Empower Our Native Youth to Stand Up for Health!

Storytelling to create positive, powerful change has long been a part of many traditional American Indian and Alaska Native lifestyles. As has honoring and empowering our next generations – our youth.

American Indian and Alaska Natives (AI/ANs) are a young population – with the current median age of AI/ANs living on reservations being 26 years old, compared to the median age of the entire U.S. at 37 years old. Our youth are the culture bearers for the future, and as such, we must protect and empower them to move Indian Country forward in a good and healthful way.

The National Indian Health Board (NIHB) works to do just that by providing a platform for the voice of AI/AN youth in health and public health advocacy work at the Annual Native Youth Health Summit. The NIHB has hosted an Annual Native Youth Health Summit for the past six (6) years and has served over 124 Native youth from across Indian Country – a group of 25-30 students each year. The youth summit focuses on listening to and learning from youth storytelling, developing the capacity of Native youth to engage in Indian health solutions, and teaching youth how to advocate for the changes in healthcare and public health systems they believe are important to their communities.

The youth summit is a five day event that provides youth with key opportunities for relationship- and skill-building that allows them to return home feeling empowered, connected



The Navajo Nation graciously hosted the 2014 NYHS in their lands, where over 18 Native youth from around Indian Country were able to gather and participate in each other's' traditions and lifeways, while learning about healthy lifestyles and how to be strong advocates for Indian health. Pictured here, are the youth after participating in the 2014 Navajo Nation Fair Parade.

to other Native youth, and well equipped to be the next generation of advocates for improved Indian health. Using a strengths-based lens, youth tell their personal stories about the health and resiliency of themselves, their families, and their communities. Through a three-day workshop hosted in partnership with the **Healthy Native Communities**

Partnership, Inc. youth create digital stories that bring attention to important health issues while also sharing their vision on how to improve. Wearing the traditional regalia of their Ancestors, youth close out the youth summit by sharing their powerful digital stories with Tribal leaders, Tribal health directors, legislative aides, and fellow Native youth



YouTube

All digital stories created at NIHB’s past youth summits can be found on the National Indian Health Board YouTube channel.

“What strong young people. They are going through so much. But, one feels their sense of hope, optimism and courage. These videos are treasures. They are little windows into communities, families, Tribes. And they are current which runs so contrary to what most people see about Natives. All tribal leaders should see these!”

– Jeanne Givens
COEUR D’ALENE TRIBAL ELDER

at the Annual Native Youth Health Film Festival.

The National Indian Health Board then uses the digital stories created at the Annual Native Youth Health Summit throughout the year to elevate the voices of AI/AN youth, showcase the health and resiliency of Tribal communities, and advocate for important health programs and policy in Indian Country.

But, NIHB can’t make the Youth Summit a success without your help!

We are seeking event sponsors, supply donations, and sponsorship of attendees. To learn how you can support the upcoming 2016 Native Youth Health Summit, please contact Michelle Castagne at 202-507-4083 or mcastagne@nihb.org.

Tribal Public Health Institutes – A Pathway to Improving Wellness in Indian Country

Public health is an increasingly important component of healthcare. In today’s world where people are regularly living longer, and facing chronic diseases, infectious disease outbreaks, and significant concerns over environmental and behavioral health, the public infrastructure and workforce serves to support population health beyond the four walls of a clinic.

However, public health systems are as complicated. There are unique needs around epidemiology, research, surveillance, evaluation, workforce development, interventional approaches, data management, and systemic integration. Public health is a complex and intricate web of services and service providers.

Indian Country has a unique public health service infrastructure that is comprised of Tribal health departments, and the Indian Health Service, various Indian health boards and consortia, Tribal epidemiology centers, and non-profit entities. These distinct services work together – both formally and informally – to ensure services and resources are provided to Tribal members. However, there are opportunities to strengthen the infrastructure, identify gaps in service, and create an entity to help satisfy unmet needs.

“Public health institutes” have become a convention created in the United States to help fill the gaps identified in this public health web. There are currently over 40 public health institutes (PHIs) operating in the United States – primarily within the boundaries of the states in which they are located. However, none of the existing PHIs are American Indian or Alaska Native specific, and this dearth has recently re-invigorated a discussion around a need to create a public health institute for Tribes and Tribal members.

A key objective of the National Indian Health Board’s strategic plan is to create a Tribal Public Health Institute as part of a strategy to support capacity building within Indian

Country. The Board of Directors of the National Indian Health Board had the foresight more than six years ago to see that there is a space within the existing field for a Tribal public health institute.

Over the past year, NIHB has been engaging with key stakeholders in the field to discuss and propose approaches for how NIHB can stand up a Tribal public health institutes that would: 1.) be beneficial, 2.) fill a need, and 3.) solidify a collaborative and support approach. NIHB would like to create something that can serve as a unifying national voice for public health advocacy and policy, lead out national efforts to support public health accreditation and quality improvement in Indian Country, and undertake national research and data collection projects – three areas that have been identified to NIHB as gaps that currently exist and that NIHB has the ability to fill.

Of course, there can be as many AI/AN-specific Tribal public health institutes as needed and called for by the Tribes. NIHB is excited to undertake creating a single one that can fulfill a piece of the work that needs to be done. NIHB is equally excited to support other Tribes and Tribal programs as they explore the possibility of creating public health institutes for themselves and the Tribes in their areas.

It is an exciting time for public health in Indian Country – as advocacy efforts recently have created new and stimulating initiatives and funding streams. These accomplishments cannot be short lived and American Indian and Alaska Native specific public health institutes can help ensure that short term gains become long term successes. While there are a lot of questions that remain as to how a Native-serving public health institute would be governed, what services they provide, and how they would interact with the existing public health infrastructure in Indian country – these are questions around which NIHB will be working in order to create something unique and dynamic.



National Indian Health Board Calls for Indian Health Service Accountability and Creation of an Oversight Task Force

The National Indian Health Board (NIHB) held its 1st Quarterly Board of Directors meeting in Washington, DC on January 20 and 21, 2016. The quarterly meetings are a venue for twelve area representatives from throughout the country to discuss new and old initiatives for the National Indian Health Board, and to ensure that current efforts honor the organization's mission of one voice affirming and empowering American Indian and Alaska Native Peoples to protect and improve health and reduce health disparities. It is also an opportunity for the Board to meet with Tribal leaders and Tribal members from throughout the country to discuss the current state of Indian health and prioritize targeted actions of NIHB.

An example of the extensive work to be done, which was discussed during the meeting, comes from the tragic and heart wrenching experiences of Omaha, Winnebago Rosebud Sioux Tribal members. The Board of Directors invited members of the Omaha, Winnebago and Rosebud Sioux Tribal Councils to attend

the Board meeting to discuss the atrocities that occurred and are still ongoing at the Indian Health Service hospital in eastern Nebraska established to meet the healthcare needs of Tribal members. These tragedies include the preventable deaths of five Tribal members under the care of trained medical professionals at the shared hospital. The Centers for Medicare & Medicaid Services (CMS) rescinded its accreditation of the Winnebago-Omaha hospital, limiting the hospital's ability to bill for essential services. Reports from across Indian Country confirm this type of situation is not limited to the Omaha-Winnebago hospital.

So moved by the gravity of the situation, the Board of Directors made a motion to take action. President Russell Begaye of the Navajo Nation, and Navajo Area representative to the Board, initiated the action by asking, "How long are we going to tolerate this? What about those who don't have a voice?" He suggested that NIHB undertake a two-pronged approach to the problem:

The National Indian Health Board will conduct and document an investigation on the many IHS shortcomings, through the use of a third-party, non-governmental agency; and The National Indian Health Board will oversee the construction of a special task force to address the shortcomings highlighted in the aforementioned investigation and reconstruct the IHS to provide quality healthcare to all patients.

The board voted unanimously to make these priorities for the National Indian Health Board in the coming calendar year. This is the first step to holding federal actors accountable for maintaining a quality healthcare system for American Indians and Alaskan Natives as outlined in the trust responsibility the federal government has with Tribes.

The board will discuss the next steps on how to implement the taskforce during their next quarterly board meeting on April 10, 2016 in Atlanta, Georgia. 🇺🇸

The National Indian Health Board met on January 20, 2016, to discuss key issues surrounding Indian Health, including quality of care issues at several IHS-operated hospitals. During the meeting, they passed a resolution directing NIHB to create a special task force to investigate these issues.



▶ Continued from page 1 — SDPI RENEWAL EFFORTS

no longer be available, since the underlying bill was passed permanently. So, a new bill will need to be chosen in which to attach SDPI renewal and other public health programs known as the “Medicare Extenders.” This is why it is essential that Tribal communities and SDPI programs share their success stories. But, what makes an effective success story to policymakers?

1. Engage the correct **audience**.
2. Include a **personal story** about the impact the program has made on an individual or family.
3. Use state, county, or Tribal **data** to demonstrate improved outcomes.
4. Create a hand-out with an easy to understand and pleasing **design**.

Audience

So, with over 535 members of Congress, and hundreds of federal employees, who should the success stories be directed to? It is always a good idea to begin with the Senators and Representatives of the district in which the SDPI program is based. Tribal leaders and SDPI program staff should establish a good relationship with Senators and Representatives by inviting them to events like Tribal Council meetings, cultural events and facility tours. It is also important to educate Tribal leaders and the media about how SDPI is changing Tribal communities, so they can also be informed when visiting Capitol Hill or federal agencies. Tribal leaders are critical ambassadors in this process because they are often in meetings in Washington or interacting with federal officials through the process of Tribal Consultation.

Personal Story

Storytelling is a powerful means of passing on histories, lived experiences, and establishing common ground with those you are sharing with. In modern times, storytelling can also be a meaningful advocacy tool. Members of Congress (and their staff) are influenced by people’s opinion – especially if there is a personal story involved. In fact, according to the Congressional Management Foundation, 88% of Congressional staffers said that personal messages from constituents influenced their decisions.

The forms of storytelling that NIHB has utilized and found to be useful with policymakers, include written testimony, verbal storytelling in face-to-face meetings, digital storytelling, and site visits with Senators and Representatives. A powerful, lasting form of storytelling is, of course, written testimony. NIHB collects written stories from SDPI program participants from around Indian Country and houses them in an online story bank on the “Diabetes in Indian Country” (www.nihb.org/sdpi) website. These stories are used in Capitol Hill visits, published in monthly and quarterly newsletters and sent to members of the Tribal Leaders Diabetes Committee. The oldest and most traditional form of storytelling is oral storytelling. When used in advocacy efforts, this often means meeting face-to-face with the target audience and including certain “asks” for policy or programming change. Increasingly popular forms of storytelling in the age of technology, is videography and digital storytelling. Digital storytelling is a short digital media production using video clips, photos, music, and a narrative to tell a story.

Data

Everyone processes information differently. According to the theory of left- and right-brain dominance, each side of the brain controls different types of thinking. Additionally, people are said to prefer one type of thinking over the other. For example, a person who is “left-brained” is said to be more logical, analytical, and objective. A person who is “right-brained” is said to be more intuitive, thoughtful, and subjective.

When talking about the importance of pairing data with personal stories, the personal story is likely to appeal to the right side of the brain—the side that feels, believes, can imagine and sees the whole picture. While the data is likely to appeal to the left side of the brain - the logical, analytical, the side that processes facts. So, by including both personal testimony and data in a story, there will be something for everyone to connect with. You have the potential to reach a bigger audience.

When choosing data to include in a story, there are three rules to follow: 1) Is the data recent? 2) Is the data from a reputable source? 3) Is the data relevant to the story?

Design

The design of any written testimony or educational handout should be simple, focused on the content of the success story, and include at least one image or photo. Any charts, graphs, or images depicting data should have clear measurements, as well as accompanying text to ensure the audience understands what the data means and how it’s relevant to the story.

It’s Never Too Early to Start Storytelling!

SDPI renewal remains a top legislative priority for NIHB. Congress will need to renew SDPI again before September 2017 to ensure that established SDPI programs throughout Indian Country continue to receive the resources needed to fight diabetes and its related complications.

NIHB will re-launch the SDPI reauthorization campaign at the NIHB National Tribal Public Health Summit in April. The reauthorization campaign will focus on strengthening relationships with key members of Congress, educating new congressional members, and cultivating new SDPI supporters and champions. This campaign offers Indian Country an opportunity to become engaged in the SDPI renewal effort by coordinating and planning SDPI grantee site visits by Congressional leaders and by visiting members of Congress on the need for SDPI to continue. NIHB also will ask Area Indian Health Boards, Tribal leaders, practitioners, and AI/ANs to share their SDPI success stories and health outcomes data with NIHB. With this input, NIHB will tell the SDPI story to Congress and disseminate this information on the “Diabetes in Indian Country” website. By sharing these stories and information, Indian Country delivers the message that SDPI is an urgent priority – one that merits continued federal support. The challenge of diabetes remains daunting, but our determination to beat it is greater. Together, we are beating diabetes for our ancestors, our communities, and future generations. 🌟



Upcoming Events

7th Annual NIHB Tribal Public Health Summit

April 11-13, 2016
Atlanta, GA

Tribal Self-Governance Consultation Conference

April 24-28, 2016
Orlando, FL

Medicare Medicaid Policy Committee Annual Spring Retreat

June 14-15, 2016
Location: TBD

HHS Secretary's Tribal Advisory Committee Meeting

June 7-8, 2016
Washington, DC

NIHB Annual Tribal Youth Health Summit

August 1-5, 2016
Location: TBD

Direct Service Tribes Annual Meeting

August 30-September 1, 2016
Rapid City, SD

HHS Secretary's Tribal Advisory Committee Meeting

September 13-14, 2016
Washington, DC

33rd NIHB Annual Tribal Health Conference (Consumer Conference)

September 19-22, 2016
Phoenix, AZ

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National Indian Health Board Annual Tribal Health Conference



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NIHB Sponsors Native Youth To Provide Remarks On Children's Mental Health In Indian Country

WASHINGTON, DC – On Tuesday, March 8, 2016, the National Indian Health Board (NIHB) was pleased to sponsor the participation of Wiyaka Little Spotted Horse in a Congressional Briefing on Native Children's Mental Health. The briefing was hosted by the American Academy of Pediatrics and co-hosted by NIHB, the American Academy of Child and Adolescent Psychiatry; the Center for Native American Youth; and the School-Based Health Alliance.

The briefing included an overview of the mental health challenges American Indian and Alaska Native (AI/AN) children face and a discussion of what policies and programs work in addressing their mental health needs. The briefing featured the perspectives of Native youth, the experiences of health care providers serving AI/AN children, and a discussion of the role schools play in serving children's mental health needs.

Wiyaka Little Spotted Horse is a student from the Oglala Sioux Tribe and lives on the Pine Ridge Reservation in South Dakota. During the briefing she courageously told her story about her own experience growing up with family addiction and hardships. She also bravely told the audience of over 60 Congressional staff about her own struggles with mental illness and how she was able to get treatment – despite the nearest facility being over six (6) hours away.

One of the biggest impacts on Wiyaka's life was participation in a Lakota cultural healing camp. During this camp, she and the other youth participants learned teachings of Lakota culture and language, including how to use them in everyday life. She learned how to pray, make healthy choices and make positive contributions to others. "I got to learn about my culture and it made me feel closer to who I am" she said, "using Lakota values in my everyday life is important to my being."

Wiyaka is now committed to advocating on behalf of other Native youth who are facing similar challenges. She made the following recommendations to those present at the briefing:

Secure funding for additional youth advocates in the court system. "We need people there to speak for us, and help the youth navigate this scary and complicated process," she said. Congress should provide sustained funding for cultural camps for both boys and girls. The camp that Wiyaka went to was funded through community donations and, therefore, may not be sustainable.

Congress should provide funding for safe houses for youth in Tribal communities so they have somewhere to go in times of behavioral health crises or family issues at home. Congress should also provide funding for wellness centers for people to learn coping

skills, family therapy services, and other programs. "This could get families talking about their issues right away before it gets bad," she explained.

NIHB first met Wiyaka when she came to NIHB's 2015 Native Youth Health Summit. While at the summit, Wiyaka put together a digital story about her experience. You can view that story at www.nihb.org.

Ms. Wiyaka Little Spotted Horse recently won a \$500.00 Summer of Creativity Grant through the Youth Service American organization. Wiyaka is passionate about art and poetry as a means of healing and self-expression and will be using the grant money to host a series of events in her Tribal community where youth can creatively express themselves through art, poetry and digital storytelling. Wiyaka is an active youth advisory board member for the Lakota Children's Enrichment (LCE). LCE will mentor Wiyaka through the project and assist her in inviting health professionals and other Native youth leaders to join in raising awareness of behavioral health issues experienced by Native youth.

For more information on what NIHB is doing to support Native youth please visit www.nihb.org/public_health/1st_kids_first.php 🌐

Wiyaka Little Spotted Horse (left) stands with fellow panelists at a Congressional briefing on Children's Mental Health on March 8, 2016.



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