



National Indian Health Board

Health Reporter

Spring 2015

ACA Tribal Days of Action Reach Urban Indian Communities



Raina Thiele, White House Associate Director of Intergovernmental Affairs and Public Engagement, addresses the audience at the Chicago ACA Urban Tribal Day of Action event.

The National Indian Health Board (NIHB) and the National Council of Urban Indian Health (NCUIH) joined the White House, the Department of Health and Human Services (HHS) and the Indian Health Service (IHS) to conduct outreach and education on the Affordable Care Act (ACA) to American Indians and Alaska Natives (AI/AN) living in urban communities.

Through the ACA Urban Tribal Days of Action, NIHB, NCUIH along with representatives from HHS, IHS and Centers for Medicare and Medicaid Services (CMS) worked urban Indian health centers and programs to hosted four ACA events at Urban Indian Centers in Dallas, Salt Lake City, Chicago and Houston, respectively. NIHB and NCUIH gave an ACA overview and addressed the AI/AN exemption waiver at each event.

Then Indian Health Service Acting Director Yvette Roubideaux wrote in her blog on January 15, 2015, "The benefits available under the Affordable Care Act to American Indians and Alaska Natives are especially important to Urban Indian consumers who may live too far away to receive care from their Tribe's hospital or clinic. They also may not be eligible to receive any purchased/referred care due to not living within the Purchased/Referred Care Service Delivery Area. The Marketplace offers an opportunity for Urban Indian consumers to obtain a plan that will allow them to receive care from local providers. Depending on their income,

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Tribal Leaders Go to Capitol Hill in Support of SDPI



Tribal representatives speak with staff from the office of Senator Wyden (D-OR) on the Special Diabetes Program for Indians on February 3, 2015.

WASHINGTON, DC

Tribal leaders took to Capitol Hill on February 3, 2015 to provide outreach and education to Congress on the Special Diabetes Program for Indians (SDPI). Over 15 individuals participated in visits to nine Congressional offices. The group met with members of both the House of Representatives and the Senate. The Tribal delegation included representatives from Cowlitz Indian Tribe; Cow Creek Band of Umpqua Tribe of Indians; Navajo Nation; Sault Ste. Marie Tribe of Chippewa Indians;

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From the Chairperson

Dear Indian Country Friends and Advocates,

As we move into 2015, we are grateful to our Member Organizations, Tribes and our American Indian and Alaska Native Peoples who continue to support the National Indian Health Board (NIHB). We will be seeing many of you at the NIHB Tribal Public Health Summit in Palm Springs California from April 7-9. The conference is a great time for anyone interested in building the public health capacity of Indian Country to come together and share our stories and knowledge. This year's theme, "Strengthening the Circle: Building the Skills of the Tribal Public Health Workforce," summarizes the important goal of this event. We hope to see you there!

In 2015, we have a newly elected Congress, with many new opportunities to move a legislative agenda forward for Indian Health. NIHB set forth its priorities for 2015 before the Senate Committee on Indian Affairs on January 28, 2015. During this hearing NIHB Executive Director Stacy Bohlen testified on important issues such as increased appropriations for the Indian Health Service (IHS); Advance Appropriations for IHS; building Public Health Infrastructure in Indian Country and implementation of the Indian Health Care Improvement Act. On February 3, 2015, NIHB hosted Tribal leaders on Capitol Hill as they provided outreach and education on the renewal for the Special Diabetes Program for Indians.

Already in 2015, NIHB has been on the road conducting Tribal Education and Outreach seminars about the Affordable Care Act (ACA). Since January, our team has done trainings in five states and the District of Columbia, training over 600 people. We held enrollment events wherever we have gone and listened and learned about Tribal concerns. NIHB has also hosted five youth webinars on the ACA and three webinars

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.*

on the American Indian/ Alaska Native exemption waiver which, together, had participation from hundreds of individuals across Indian Country. We are so grateful for the many partners we have had on this journey and look forward to many more events in 2015. The ACA represents a historic opportunity for Indian health and NIHB will continue to provide outreach and education.

The Public Health Programs and Policy Department continues many important projects including support for the Tribal Leaders Diabetes Committee; the Methamphetamine and Suicide Prevention Initiative (MSPI); and Public health accreditation projects. In this issue, we highlight the importance of Tribal Epidemiology Centers (TECs). In short, the TECs serve as the public health authorities for Indian Country. This work is *critical* in reducing health disparities for Indian Country and we encourage you all to become familiar with the fantastic work your local TEC is doing.

NIHB relies greatly on your support to mobilize the Affordable Care Act campaign and advance the legislative and policy agenda on Indian health. We always look forward to working with you to help restore healthy native communities. 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



Sharing Knowledge with Future Generations Through Research and Evaluation

Throughout Indian Country the terms *research* and *evaluation* have historically had very negative connotations associated with them. These connotations were based on the experiences of countless Indigenous people throughout Turtle Island who were subject to unwanted invasions by colonizers under the guise of gathering data for *scientific research*.

The acts employed to collect this data and the ways in which this data was used were not for the benefit of Tribes or Tribal people. Given this conflicted relationship between Tribal peoples and research, documenting the good work being done in Tribal communities in a systematic way can sometimes be difficult; however, remembering that Tribal peoples have been conducting research and evaluation since the beginning of time can make it easier.

Through the telling of oral and written histories Tribal peoples have always documented what worked and did not work so well. At their core, research and evaluation are simply ways to preserve and share precious knowledge with current and future generations.

In an effort to work with Tribes to share best practices in addressing health disparities, a growing number of research and evaluation professionals are actively working to push for the utilization of research methods that align with Tribal values and do not further oppress Tribal peoples.

The use of focus groups and Community Based Participatory Research along with the education and training of Tribal peoples in conducting research and evaluation are just a few of the ways in which the current face of research in Tribal communities is changing for the better. In this financial climate where most funding sources ask for the impact of dollars to be clearly documented, research and evaluation are necessary parts of everyday work in the healthcare field. ■

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.



Advance Appropriations for IHS – An Opportunity For Additional Outreach

President Obama released his FY 2016 Budget Request to Congress on February 2, 2015. This is the first step in the annual appropriations process. Congress will now consider the request and determine overall funding levels for the Indian Health Service, Bureau of Indian Affairs and the rest of the federal government by the end of the fiscal year on September 30, 2015. The FY 2016 Budget Request makes many historic investments in Indian Health. The Administration is proposing Indian Health Service funding at **\$5.1 billion** in FY 2016. (The IHS Tribal Budget Formulation Workgroup requested \$5.4 billion for IHS in FY 2016). This is \$486 million over the FY 2015 level and 49 percent increase since FY 2008.

However, getting IHS to the \$5.1 billion level might not become a reality by September 30. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year.

It is more likely that the government will operate on a “continuing resolution or “CR.” The length of a CR can vary significantly from just a few weeks to several months. The result is that Tribal health programs are left to make long-term decisions with only short-term money guaranteed. Often programs must determine whether and how they can enter into contracts with outside vendors and suppliers, plan programmatic activities, or maintain current personnel.

Indian Country deserves better. Funding for the Indian health system is a result of Treaties and other legal obligations made by the federal government with Indian Country and should not be held hostage each year. Adopting an advance appropriations process is one solution advocates are pursuing to assist Tribal and IHS facilities fiscally plan more efficiently. Advanced appropriations would mean Tribal and IHS facilities would know their funding levels one year in advance. Congress uses a similar funding procedure for the Veterans’ Health Administration.

NIHB and its partners are encouraging Tribes to help educate Congress on this important issue. We are also encouraging you to share your story on how funding delays have impacted health care delivery at your Tribe. You can learn more by visiting: http://nihb.org/legislative/advance_appropriations.php ■

“Our People Continue to Live Sicker and Die Younger Than Other Americans,”

SAID THE NATIONAL INDIAN HEALTH BOARD BEFORE SENATE COMMITTEE ON INDIAN AFFAIRS JANUARY 28TH HEARING – HIGHLIGHTING NATIVE AMERICAN PRIORITIES FOR THE 114TH CONGRESS

WASHINGTON, DC

On Wednesday, January 28, the Senate Committee on Indian Affairs held its first hearing during the 114th Congress to gain an overview of American Indian and Alaska Native’s priority issues. National Indian Health Board (NIHB) Executive Director Stacy A. Bohlen (Sault Ste. Marie Chippewa) testified before the Senate Committee on Indian Affairs in an oversight hearing to explore “Indian Country Priorities for the 114th Congress.”

Also testifying were: The Honorable Aaron Payment, Midwest Area Vice President, National Congress of American Indians; Mr. Melvin Monette, President, National Indian Education Association; Mr. Gary Davis, President/CEO, National Center for American Indian Enterprise Development; and Mr. Vance Homegun, 2013 Champion of Change, Center for Native American Youth.

In his first hearing as Committee Chair, Senator John Barrasso (R-WY) noted in his introductory remarks that: “As Chairman, my top priorities are jobs, energy and natural resource development, healthcare, education, juvenile justice, and tribal self-governance.” New Committee Vice Chairman John Tester (D-MT) said: “I look forward to working with...everybody...on this committee to move Indian Country forward.” The hearing clearly demonstrated the continuing bi-partisan, collaborative commitment to continue being the legislative nexus for the advancement of issues important to American Indians and Alaska Natives.

“Our Peoples continue to live sicker and die younger than other Americans,” said Bohlen. “Our lifespan is 4.2 years less than other Americans and on some reservations, like Wind River – home of the Northern Arapaho Tribe in Wyoming – where life expectancy is only 49 years. ...It’s more than time that we must stand together to change these realities.” Affirming the federal government’s trust responsibility for American Indian and Alaska Native Health, the NIHB set forth an agenda for change. NIHB will diligently work with the Committee to advance these Tribal objectives.

Ms. Bohlen set forth the Tribal Health agenda, including such issues as:

- Mandatory and increased appropriations for the Indian Health Service
- Advance appropriations for Indian Health Service (like the Veteran’s Administration)
- Exemption for Tribes from all sequestration and rescission cuts
- Medicare-Like Rates for Purchased Referred Care for non-hospital providers



NIHB Executive Director Stacy Bohlen Testifies before the Senate Committee on Indian Affairs on January 28, 2015.

- Exemption for Tribes from the Employer Mandate in the Affordable Care Act (ACA)
- Correcting the Definition of Indian in the ACA
- 5-year renewal of the Special Diabetes Program for Indians at \$200 million per year
- Oversight on implementation of the Indian Health Care Improvement Act (IHCIA)
- Long-term, sustainable methods to fully fund Contract Support Costs
- Investment into Indian Country's public health infrastructure.

To read NIHB's full written statement, please visit <http://nihb.org/legislative.php>

To view a video of the hearing, please visit: www.indian.senate.gov ■

Tribes Continue to Express Concern Over the Employer Mandate in the Affordable Care Act



The Employer Shared Responsibility rule, also known as the "Employer Mandate," went into effect on January 1st, 2015. It says that an employer who has 50 employees or more must offer their employees insurance or pay a tax penalty. Tribal governments, who employ at least 50 persons, are currently counted as large employers for application of this rule, causing great concern across Indian Country.

In general, American Indians and Alaska Natives (AI/ANs) are exempt from the Individual Mandate to purchase health insurance. This is in recognition of the fact that AI/ANs should not be forced to purchase healthcare that is obligated by the federal government's trust responsibility and which is delivered through the Indian Health Service (IHS).

The employer mandate forces Tribes to divert funding necessary to sustain Tribal health programs, which by right should come from the federal government, and redirect it to the purchase of employee health insurance. In these circumstances, the employer mandate essentially results in Tribes funding the federal government: either they take their limited Tribal funding (some or all of which might be federal funding anyway) and pay it to the IRS in the form of a tax penalty, or they purchase insurance from private companies, which then pay IHS after keeping between 15-20% of the premium payments off the top. Tribal subsidization of the United States does not respect either the trust responsibility or the government-to-government relationship between Tribes and the United States. In many cases, a majority of Tribal government employees are AI/AN who, as noted above, are exempted from the individual mandate to purchase health insurance.

Tribes across the country have contacted the National Indian Health Board (NIHB) about this issue and NIHB has begun reaching out to key policy makers to educate them on Tribal concerns. Staff from NIHB and technical advisors also have met with Internal Revenue Service (IRS) about the Employer Mandate and plan to continue conversations on the topic.

NIHB's Medicare and Medicaid Policy Committee (MMPC) wrote a letter that was submitted to the White House on behalf of NIHB and United South and Eastern Tribes, Inc. (USET) that outlined Tribal concerns over the Employer Mandate and requested assistance from the Administration in finding relief for Tribes.

NIHB remains committed to finding a solution to this serious problem and will continue to follow up with members of Congress and the Administration. As always, NIHB will keep its Tribal constituents up-to-date on the latest information. If you have further questions or would like to become involved, please contact our Director of Policy and Advocacy, Richard Litsey at rlitsey@nihb.org or the Program Manager for Medicare and Medicaid Policy, Devin Delrow at ddelrow@nihb.org. ■

It's Tax Time! What You Need to Know About Health Coverage Exemptions and IRS Form 8965



It's tax filing time and April 15th will be on us before we know it! This purpose of this article is to let you know what is required if you did not have health care insurance last year and to let you know what to do if you did have health care insurance. As part of the Affordable Care Act, individuals had to have health care coverage beginning in 2014 **or** make a shared responsibility payment with their tax return. For American Indians and Alaska Natives (AI/ANs) there are exceptions to this rule.*

The exceptions, more properly called *exemptions*, are available only from the Marketplace or by claiming them on your tax return. During the enrollment process of attaining health care coverage from the Marketplace, many AI/ANs filed the application but never received their Exemption Certificate Numbers (ECN). If that is your case, you may now file an **IRS form 8965**, Health Coverage Exemptions, with your tax return and obtain the exemption. If you did receive the ECN you can use that number on the form to obtain your exemption. IRS form 8965 can be found by typing "IRS Form 8965" into an internet search engine to locate the form and instructions.

In the instructions, there is a list of the various exemptions available for individuals filing the form, including for members of Indian Tribes. The form defines Members of Indian Tribes as, "a member of a Federally-recognized Indian Tribe, including an Alaska Native Claims Settlement Act (ANCSA) Corporation Shareholder (regional or village), *or you were otherwise eligible for services through an Indian health care provider or the Indian Health Service.*" So if you fall within this definition you are exempt from

the individual mandate to obtain health insurance and you will not be subject to a shared responsibility payment. You must file the tax form 8965 in order to obtain the exemption.

So who must file IRS form 8965? Those who:

1. Are required to file a tax return, AND
2. Do **not** have minimum essential coverage for yourself and everyone else in your tax household (e.g. if you have employer-sponsored health coverage or have purchased coverage separately), AND
3. Want to report or claim a coverage exemption for yourself or another member of your tax household

Once you have completed form 8965 you should attach it to your tax return whether you use form 1040, form 1040A, or form 1040EZ. There are AI/ANs who are not required to file a tax return, in which case their tax household is exempt from the shared responsibility payment and they do not need to file a tax return to claim the coverage exemption.

The instructions for form 8965 are helpful to determine if any payment is owed for not having "minimum essential coverage" and no exemptions are available for your use. Here are some examples that are considered minimum essential coverage:

- A plan or coverage offered in the small or large group market within a state.
- A self-insured health plan for employees.
- Health insurance an individual purchases directly from an insurance company or the Marketplace
- Health insurance an individual is provided through a student health plan.
- Medicare Part A coverage and Medicare Advantage plans
- Children's Health Insurance Program (CHIP).
- Comprehensive health care programs offered by the Department of Veterans Affairs.

This list is not exhaustive but it illustrates the types of coverage that is typically held by AI/ANs and satisfies the definition of minimum essential coverage.

For additional information please contact Richard Litsey (rlitsey@nihb.org) or Devin Delrow (ddelrow@nihb.org) at the National Indian Health Board or call (202) 507-4070. ■

**Disclaimer: Information provided is for informational purposes only, and should not be considered as legal advice. For questions on your personal situation seek the advice of a legal or accounting professional.*

The Affordable Care Act: From a Native Youth Perspective

With the implementation of the Affordable Care Act (ACA), many outreach and education efforts have focused on the youth demographic, both nationally and at the Tribal level. The White House and Department of Health and Human Services (HHS) have partnered with the United National Indian Tribal Youth, Inc. (UNITY) and the National Indian Health Board (NIHB) to broadcast across Indian Country webinars on exactly what Native youth need to know about the ACA.

Jared Massey, a student at Arizona State University and a Programs Support Assistant with UNITY is active in the webinars, sharing both his experiences with health insurance and encouraging his peers to look into their options in the Health Insurance Marketplace.

According to the Centers for Medicare and Medicaid Services (CMS), about 30% of young adults are uninsured, representing more than one in five of the uninsured. This rate is higher than any other age group, and is three times higher than the uninsured rate among children. The Native youth uninsured rate is possibly higher, with young Native males the most likely to not have coverage. Jared shares his perspective about the Affordable Care Act and its benefits for Native youth:

In your opinion, why is it important for Native youth to know about the Affordable Care Act?

The Affordable Care Act is one that is probably unknown on most reservations.

Our people don't understand the importance of health coverage until an accident or incident occurs, so it's important for Native American Tribes to know the importance of health coverage. We live in an era of time where Native youth are becoming more aware of the opportunities that lie beyond the borders of our reservations, and with those opportunities, they take chances. There is always a fear of getting hurt physically while being away from the reservation, but the Affordable Care Act gives Native youth a peace of mind knowing that they will be covered. It's especially important for those Native youth that will be pursuing higher education off the reservation.

How can federal agencies, national Indian organizations and other entities promoting the ACA effectively reach the Native youth population?



Jared Massey, a student and UNITY employee, shares his perspective about the Affordable Care Act and its benefits for Native youth.

Two words: social media. As time has progressed our people have learned to adapt and with that came the use of social media. As a student worker I know the impact it makes when reaching youth all at once, and at one place, which is Facebook. Another possible route these agencies can take is reaching high school students through presentations and workshops at the high school. Utilizing Facebook, Twitter, Instagram, and email is very important. Creating a partnership with organizations that have a network of youth will also be important and successful. Attending national conferences, events, and summits will increase the ACA's purpose and exposure to its benefits.

Is there apathy among Native youth about having health insurance coverage? If so, why?

Yes! Native youth tend to follow their parent's footsteps and if a parent isn't informing their children about the Affordable Care Act, then these youth will never know. Knowledge is key, and many Native youth are simply uneducated about this Act. I'm pretty confident that most of my peers are uneducated about the Act as well because most are still living on the reservation, and when you're living on the reservation there is a mindset that it doesn't apply to them. It took an injury while traveling for me to realize the importance of having some kind of health coverage, I can no longer say "I'm Native American" and receive free health care, I too, need to be covered.

Why is it important to you, a young Native male, to have health insurance?

The Affordable Care Act is important to me not only because I'm Native American, it's important because I'm also a college student, and with that I also face many challenges being away from Indian Health Service facilities. The Act has allowed many young Native Americans, like myself the ability to freely travel without fear that I may not be covered if an accident were to occur. I'm currently pursuing higher education in an urban setting and I'm hours away from my Tribe's Indian Health facility, so the Act allows not only myself, but also many young Native Americans the ability to seek health service without the fear of being rejected.

Jared Massey is a member of the White Mountain Apache Tribe from Arizona. He is also a hoop dancer. As a member of Arizona State University's Chi Alpha, Massey will be traveling to Greece and Macedonia in the summer of 2015. ■

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ACA Tribal Days of Action Reach Urban Indian Communities



Caption: Nearly 275 Native youth attended an event at the University of Utah in Salt Lake City that feature Lakota musician Frank Waln and information about the Affordable Care Act, provided by NIHB and NCUIH.

they may qualify for Medicaid or a zero or low cost plan through the Marketplace.”

DALLAS, TX • JANUARY 16, 2015

On January 16, the Urban Inter-Tribal Center of Texas hosted a community event for AI/AN individuals and families to learn about insurance options and to receive free in-person assistance from trained enrollment assistors. Nearly 150 individuals signed-in, but organizers estimate that 180 people attended. On-site enrollment assistors answered questions, helped with enrollment in Medicaid or Qualified Health Plans in the Marketplace, or assisted with applications for the exemption from the shared responsibility payment. About 25 Navigators and Certified Application Counselors participated in a special training related to the Indian provisions in the Affordable Care Act, provided by NIHB.

SALT LAKE CITY, UT • JANUARY 20, 2015

The event in Salt Lake City was a little different from the other events. The Affordable Care Act wasn't the main focus, but the topics centered on Native youth and their future, which includes maintaining healthy lifestyles. Lakota musician Frank Waln gave a compelling keynote address to nearly 250 Native youth from Salt Lake City-area schools. Waln, most recognizable for his riveting role in MTV's *Rebel Music*, talked about his experience growing up on the Rosebud Sioux reservation and his unwavering passion for making music. He also encouraged the youth to “follow their dreams and not lose sight of their cultural roots and identity.”

NIHB gave a special presentation on what Native youth need to know about the ACA, such as free preventative screenings for depression and diabetes. Representatives from the Salt Lake City Urban Indian Center and Take Care Utah (the Navigator entity) were also in attendance to help with enrollment and provide insurance information specific to Utah.

CHICAGO, IL • JANUARY 27-28, 2015

Another great success occurred in Chicago with the Affordable Care Act Urban Tribal Days of Action. Raina Theile, the Associate Director, for Intergovernmental Affairs at the White House also traveled to Chicago with NIHB and NCUIH to help with ACA training during for the Tribal Urban Days of Action. Nearly 160

people attended both education and enrollment events. The first gathering, held on January 27, 2015 at the Kateri Center of Chicago, attracted about 40 Tribal members and state officials. The second event on January 28, held at the Chicago American Indian Center, brought approximately 120 community members.

At both events, NIHB and NCUIH provided information about the Affordable Care Act, exemption from the tax penalty and how the ACA relates to the urban Indian population. Representatives from the regional Department of Health and Human Services, Centers for Medicare and Medicaid Services and Get Covered Illinois were also in attendance to help with enrollment and answer questions about the Marketplace and Medicaid eligibility

HOUSTON, TX • FEBRUARY 5, 2015

In Houston, it was an evening of entertainment, food and ACA education. NIHB once again provided an AI/AN and the Marketplace training for local Navigators and Certified Application Counselors, who helped several attendees enroll in low-cost Marketplace plans. About 80 people, representing 14 Tribes, attended the event with one woman driving nearly 200 miles from San Antonio.

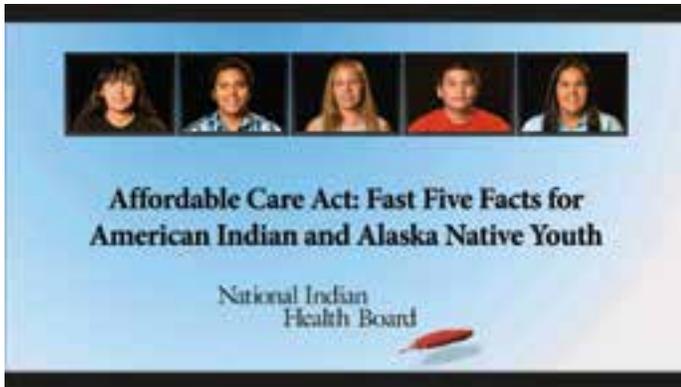
“Each speaker presented the material in a way that everyone could understand. The information gave a great boost to our efforts to sign up more people to the ACA. On behalf of the Native American Health Coalition and the Native American Indian Community, thank you for a memorable and effective presentation and we hope you will visit Houston again,” said Chance Landry, Executive Director of the Native American Health Coalition in Houston.

Rudy Soto, Policy Analyst with the National Council of Urban Indian Health contributed to this article. ■



Members of the Lenape Tribe look at the IRS guidance for filing an AI/AN exemption form at the Houston Urban Tribal Day of Action

A Toolkit: Five Fast Facts about the ACA for Native Youth



Five Native youth highlight Five Fast Facts that Native youth need to know about the Affordable Care Act in a PSA supported by NIHB and CMS Tribal Affairs.

The National Indian Health Board (NIHB) and the Centers for Medicare and Medicaid Services' (CMS) Division of Tribal Affairs joined forces to create Affordable Care Act (ACA) educational materials specifically for the Native youth population – with the help of NIHB's Youth Summit participants.

Youth Summit students learned about the Five Fast Facts that Native youth need to know about the ACA, and some shared on film their experiences with the Indian Health Services, health disparities in their family and how insurance may help their loved ones. The materials, highlighting the Five Fast Facts, include three Public Service Announcements (PSAs), a poster and brochure.

THE FIVE FAST FACTS THAT NATIVE YOUTH NEED TO KNOW ABOUT THE AFFORDABLE CARE ACT ARE:

1. They can be added to or kept on their parent or guardian's health insurance until they turn 26 years old.
2. They will be covered for prevention screenings for STDs, HIV, pregnancy, depression and diabetes.
3. Their additional coverage will allow them to receive services outside of the Indian Health Service.
4. Medicaid is an additional option for health coverage.
5. Their parents can file an exemption from the tax penalty for them.



Frank Waln, Lakota musician who was featured on MTV's Rebel Music, gave a keynote address to 275 Native students about always remembering their cultural identity.



Houston-based Navigators learn about the American Indian and Alaska Native protections under the ACA at the Houston Urban Tribal Day of Action.

Chairperson of the Sault St. Marie Tribe of Chippewa Indians, Aaron Payment, is a great proponent of quality health care for all American Indians and Alaska Natives, especially the Native youth population. Chairman Payment is active in the "Native Youth and ACA" webinars recently hosted by the White House and the Department of Health and Human Services (HHS), and those presented by NIHB.

"The most compelling reason [the ACA is important] is that the greatest health disparities in America are with our Native youth; their need is the greatest," Chairman Payment said. "American Indian Tribes pre-paid for health benefits into perpetuity though the millions of acres of land ceded per treaties pursuant to the United States Constitution. Native youth have a right and a responsibility to take advantage of what their ancestors provided. The Affordable Care Act represents an honest start to fulfill this treaty and trust responsibility."

According to HHS reports from the Substance Abuse and Mental Health Services Administration and the National Center for Chronic Disease Prevention and Health Promotion, over 40% of Native youth are overweight (20.1%) or obese (20.8%) compared to 30% of the general population, and the prevalence of diabetes in Native youth is five times that of Caucasian youth.

NIHB and CMS' youth-specific ACA PSAs, posters and brochures are vital resources to keep youth thinking about their health and being that voice for their family about the importance of having health insurance coverage.

"In our Indian way, we believe great wisdom can come from our youth. With a larger proportion of our population being youth, they have the greatest likelihood of getting the word out to their family decision makers," Chairman Payment added.

To learn more about the ACA Native Youth Toolkit, contact April Hale, NIHB Tribal Health Reform Outreach and Education Communications Coordinator, at 202-507-4077 or ahale@nihb.org. ■



Organizers and speakers of the Dallas Town Hall Meeting on the Affordable Care Act. (L-R) Angela Young, Administrative Director of the Urban Inter-Tribal Center of Texas; Rudy Soto, Policy Analyst, NCUIH; April Hale, Tribal Health Reform Communications Coordinator, NIHB; Kimberly Fowler, Director of Technical Assistance, NCUIH; Geoffrey Roth, Senior Advisor to the Director, IHS; Dawn Coley, Director of Tribal Health Reform, NIHB; Dr. Rodney Stapp, Executive Director of the Urban Inter-Tribal Center of Texas.

Continued from page 1

Tribal Leaders Go to Capitol Hill in Support of SDPI

Pueblo of Zuni; Astariwi Band of Pit River Indians; the Santa Ynez Band of Chumash Indians; and the Tohono O'odham Nation.

SDPI will expire on September 30, 2015 unless Congress acts. The legislation that typically serves as the legislative vehicle for SDPI, the Sustainable Growth Rate Fix (also known as the "Doc Fix"), which governs the rates physicians are paid by Medicare, expires on March 31, 2015. It is still unclear if Congress will find a way to pay for the overall bill which is estimated to cost over \$150 billion. If there needs to be another short-term patch for the Doc Fix, Tribes are asking that SDPI be included in that reauthorization.

"The Tribes across the nation have proven that they deserve to be re-authorized," said Rosemary Nelson with the Astariwi Band of Pit River Indians in California.

"Fewer of our people nationwide are having to submit to dialysis," said Cathy Abramson, Councilwoman for the Sault Ste. Marie Tribe. "This program is saving lives! I remain optimistic that Congress will continue to appropriate funds for SDPI. It needs to be funded permanently. We need to continue to educate Congress, especially the newly elected."

Created by Congress in 1997, SDPI is one of the nation's most strategic and comprehensive efforts to combat type 2 diabetes in Indian Country. Currently, SDPI provides grants for diabetes treatment and prevention services to 404 Indian Health Service (IHS), Tribal, and Urban Indian health programs in 35 states. SDPI employs a variety of interventions from medication control, to dietary changes and physical activity. These interventions fol-



Tribal leaders meet with Congresswoman Jamie Herrera Buetler (R-WA) on SDPI.

low a culturally competent method that connects the intervention to appropriate customs and norms permitting for activities such as traditional food gathering, traditional dance classes and bison distribution. These connections mean program participants feel empowered to make serious and lasting healthy lifestyle changes.

SDPI is working! Between 1995 and 2006, the incidence of End-Stage Renal Disease in American Indian and Alaska Native (AI/AN) people with diabetes fell by nearly 28 percent – a greater decline than any other racial or ethnic group. The average blood sugar level, as measured by the hemoglobin A1C test, decreased from 9.0 percent in 1996 to 8.1 percent in 2010.

"The reduction in kidney disease saves thousands of dollars, cuts medical care cost, and most importantly – saves lives. It's a win-win partnership," said Nelson.

It is vital that this important program is renewed this spring so we can ensure that this life-saving program continues. "Everyone needs to call their legislators and tell their story. Our people's lives depend on it!" said Abramson.

Please visit www.nihb.org/sdpi for more information on SDPI and renewal efforts throughout Indian Country. ■

Denver Indian Health and Family

"EAT MORE FRUITS AND VEGETABLES... EXERCISE FOR 30 MINUTES AT LEAST 5 TIMES A WEEK...GET 10,000 STEPS A DAY ON YOUR PEDOMETER!"

We have all heard similar sound bites of health information before, right? As simple as it may seem, this advice can be difficult to follow in many environments – especially in Tribal and urban Indian communities.

Serving families, friends and neighbors of the Denver Indian Health and Family Services, Kathy Canclini, RN, MN, CDE and her diabetes prevention team provide education on exactly just how Natives residing in the community can carry out that advice in the Denver, Colorado area. The Special Diabetes Program for Indians (SDPI) makes this program and over 400 other diabetes prevention programs throughout Indian Country possible.

WHAT IS SDPI?

SDPI is a critical program aimed at treatment and prevention of Type 2 diabetes in American Indian and Alaskan Native (AI/AN) communities.

At a rate of 2.3 times the national average, AI/ANs have the highest prevalence of diabetes than any other ethnic group (Indian Health Service DDTP, 2011). SDPI is attempting to change these troubling statistics by combatting the complications that often accompany a diabetes diagnosis. For example, since the beginning of SDPI, AI/AN communities have seen improvements in blood sugar levels, reductions in cardiovascular disease, increased number of weight management programs for youth, and an increase in the promotion of healthy lifestyle behaviors in AI/AN communities. The success of the program is due to the nature of the grant in that it allows AI/AN communities to design culturally-appropriate interventions that address local priorities.

SDPI SPOTLIGHT:

Services, Inc. Special Diabetes Project



Chris Willis, Diabetes Prevention Specialist and Certified Personal Trainer, works with patient to promote healthy exercise techniques at Denver Indian Health and Family Services' Special Diabetes Project.

HOW IT'S DONE IN DENVER

Thanks to the continued funding of the SDPI Community Directed Grant Program, Canclini and her team have created a fun and successful weight management program that has helped 116 participants to complete at least 4 of 7 classes in the 4 years that the program has existed. Many more have completed parts of the program. The cleverly named program, Fork 'n Road, teaches community members how they can eat healthier (fork) and increase exercise (road) in a safe and inexpensive way.

Canclini believes that in this particular urban Indian health center, as in many Tribal and urban Indian health centers, limited finances are the largest barrier that her patients face. Many clients who visit the clinic have budgets that rely on food banks for sustenance and makes transportation around a large city a challenge. "When patients have a multitude of other things going on in their life, taking care of themselves can fall by the wayside," Canclini says as she explains how the urban health center focuses on a holistic approach to their patients' well-being.

Based on the "Balancing Your Life and Diabetes" curriculum designed by the IHS Division of Diabetes Treatment and Prevention,¹ the Fork n' Road program is a series of seven classes. The classes cover topics such as behavior change, goal setting, behavioral aspects of weight loss, general nutrition, label reading, meal planning and individualized meal plans, cardio/ strength/ flexibility/balance practice and a home exercise program.

During the first class, participants go through an overall health assessment and a physical fitness evaluation to establish their current baseline of health and wellness, as well as identify areas of interest, need, and their weight loss goal. Participants receive pedometers and exercise bands which provide them with an inexpensive way to do cardio and strength training at home without paying for a gym membership. The other team member of DIHFS' diabetes program team, Chris Willis, Diabetes Prevention Specialist and Certified Personal Trainer, is available

Canclini and her team have provided 8 helpful hints for maintaining your own successful weight management program.



for one-on-one fitness training with participants. He is a Certified Diabetes Exercise Specialist and, as such, counsels regarding lifestyle adaptations.

Canclini stressed that the need for services like the Fork n' Road program has dramatically increased in the Denver area, even though SDPI funding has stayed the same since 2002. In the clinic's diabetes audit, the number of active Diabetes Registry patients has steadily increased every year since 2010, from 79 active patients, to an anticipated 150+ for the current year. In addition, the number of pre-diabetes patients has increased from 69 in the past to 140 in 2014. Based on the size of the AI/AN population in Denver (just over 55,000 AI/ANs²) the potential exists to offer more services to a larger portion of the AI/AN population. DIHFS is seeking outside funding to supplement their SDPI grant, and hope to keep the momentum of their successful program for many years to come.

The National Indian Health Board would like to thank Denver Indian Health and Family Services for their contribution to this article.

For more information on NIHB and SDPI efforts, as well as how you can become further engaged in education and outreach, please contact Michelle Castagne, NIHB Public Health Project Coordinator, at MCastagne@nihb.org or 202-507-4083. NIHB also invites you to access SDPI resources at www.nihb.org/sdpi. ■

¹ http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Resources/InstantDownloads/My_Native_Plate_Edu_Tips_508c.pdf

² <http://www.census.gov/regions/denver/>

Good Oral Health Care Can Lead to Better Management of Diabetes

By Deb Utacia Krol / Native Health News Alliance

Jeanne Eder Rhodes didn't realize how the simple acts of regularly brushing and flossing her teeth could lead to better health for diabetics. Rhodes, 66, who recently retired as head of the University of Alaska's history department, was diagnosed with type 2 diabetes in 1998.

"I didn't learn about the importance of oral care until 2004," says Rhodes, a Dakota Sioux from the Fort Peck Reservation in Montana. "My dentist said that he could tell how my diabetes was doing just by examining my teeth. That's when I started paying attention to my gums and teeth."

Oral health and diabetes experts alike universally agree that proper oral care is an essential tool in managing diabetes. The American Diabetes Association reports in its online journal that "periodontal treatment leads to an improvement of glycemic [blood sugar] control in type 2 diabetic patients for at least three months."

In a population where some one-third of all Native diabetics and 25 percent of all American Indians and Alaska Natives age 65 and over have lost all their teeth, maintaining good oral health is vital to the health of all Native people.

However, too many Natives are not seeing a dentist regularly. "Just as you have to get an annual physical examination, you also need to get a dental examination," says Dr. Anh Thu Becker, a dentist at Native Health, a Phoenix community health facility that serves many Phoenix-area Native people. "Most people think 'if it doesn't hurt, I don't have a problem.'"

Healthy teeth = healthier body

Dr. Alex Cota, a dentist with Sun Life Family Health Centers in Sun City, Arizona, says that he can tell a new patient has diabetes with just a simple diagnostic instrument – his nose. "A basic sign of diabetes is breath that smells like a rotten apple," Cota says.

Reduced resources in communities served primarily by Indian Health Service facilities may also contribute to less oral care. IHS is aware of the connection, though, and it offers information for both patients and providers on including oral care education and evaluation in diabetes management programs.

However, "By the time people have symptoms [like inflamed and bleeding gums]," Becker says, "it's too late to prevent periodontal disease" and the possibility of bone and tooth loss that can result from delaying treatment.

Cota adds that bone loss is especially worrisome for diabetics, as dentures are harder to fit. Also, he warns diabetic patients that gum care is still a priority even after losing healthy teeth to periodontal disease, as a fungal infection known as candidosis can occur.

Failing to maintain good oral health has other pitfalls for diabetics. "Because diabetes lowers a patient's resistance to infection,

periodontal disease is harder to treat in diabetics," Becker says. "Uncontrolled blood glucose is very worrisome."

Cota says that chronic inflammation, such as uncontrolled gum diseases coupled with diabetes, also contributes to a host of other diseases linked to diabetes such as:

- Thrush
- Canker sores
- Life-threatening conditions like coronary heart disease and kidney disease



A patient being seen at Native Health's dental clinic in Phoenix, Arizona.

Becker notes that periodontal disease, which starts as gingivitis or inflamed, bleeding gums, is caused by bacterial growth in the mouth. "We all have these bacteria in our mouth," she says. "Controlling the bacteria levels in your mouth will control gum disease. There is a balance between healthy teeth and a healthy body."

Home care is the basis of good oral care for all. Becker says, "Patients have to be the ones to care for their teeth."

She recommends that people brush their teeth at least twice a day and floss daily, and visit a dentist for twice-yearly cleanings and exams.

Cota adds, "Simple treatments like cleanings don't cost nearly as much as treating advanced oral diseases. It's like paying \$100 for a filling or \$1,000 for a root canal from not getting the filling."

People with periodontal disease, which like diabetes is a chronic, incurable condition, will need to have deeper cleanings three to four times a year. Antibiotics can also be prescribed in some cases, Becker says.

Also, Becker stresses, "Don't smoke – smoking causing basal constriction of blood vessels, and smokers are 20 times more prone to get periodontal disease."

Just as diabetics are urged to keep their blood sugar under control, Becker says that keeping oral bacteria in check prevents a host of health threats. "It's all about control," she says.

Indeed, maintaining good oral health contributes to good overall health; the ADA notes that a 1 percent change in A1C levels contributes to an average 35mg/dl drop in blood glucose.

Dentists now routinely take medical histories of new and regular patients, and regularly check for signs that may indicate undiagnosed diabetes or other diseases.

When dentists & physicians collaborate – you benefit

A 2014 American Dental Association study encouraged dentists and other medical providers to collaborate as part of a chronic care model. A collaborative model might include dental office screenings for diabetes and pre-diabetes, which in the study were found to provide important health benefits.

Dental Therapists Can Close the Oral Health Gap for Native Youth

by Ryan Ward and Joaquin Ray Gallegos with the Center for Native American Youth

On a winter morning, Alayna Eagle Shield, 24, rises early in her home on the Standing Rock Indian Reservation in North Dakota. She wakes her two children and readies them to embark on a long trek across the frozen prairie in search of dental care.

“In my community the only time we are seen by a dentist is when we stand in line before the sun comes up on Monday mornings...even then we are not guaranteed care,” she explains. “Since we cannot afford to get our teeth fixed in a big city, many of our youth grow up with missing teeth.”

Too many Native Americans like Alayna and her family go without dental care each year. This is especially true of Native American youth. Seventy-two percent of Native youth currently suffer from untreated tooth decay. As a result, they experience severe health problems that, when left untreated, can lead to life-threatening conditions like cardiovascular disease and diabetes.

Beyond the long-term health problems stemming from lack of access to care, there is the simple yet devastating issue of the pain. Littlebear Sanchez, 22, Mescalero Apache from New Mexico, described this problem recently in an op-ed: “Last year, as a result of poor access to dental care, I suffered in pain for many months with a broken, infected tooth. As the pain became unbearable, I even tried pulling the tooth out myself.”

The biggest obstacle to improving dental care in tribal communities is their remote location. The dentists that do come often leave soon after.

According to Health Resource Services Administration (HRSA), the primary federal agency tasked with improving access to health care, 77 percent of U.S. counties are designated as dental care shortage areas (a full list can be found here). This means there are simply not enough dentists to serve the population in a given geographic area. In some cases, there are no dentists at all. Native children are particularly hard hit by lack of dental care access. Utilizing HRSA’s data and the 2010 U.S. census information, the Center for Native American Youth determined that nearly 50 percent of the nation’s 2.1 million Native youth live in one of these dental care shortage areas.

Though this problem impacts nearly one million Native American children, it is not just a Native American problem. Low income populations and rural communities are similarly affected. Even if there is a dentist, data suggests that 80 percent don’t accept Medicaid as payment for services, meaning many people — even ones with a dentist in their community — are still left behind.

But the positive side of the story is in the U.S., Indian Tribes have led the way in delivering life-changing care despite those challenges.

Ten years ago, the Alaska Native Tribal Health Consortium (ANTHC) and Alaska Tribes looked at the oral health of rural communities and saw an alarming problem. Untreated dental decay was ravaging communities — some with rates of decay five times that of the general population. Communities that once had incredibly low rates of decay began seeing spikes in cavities due to the introduction of processed foods and other changes in diet.

Alaska Tribe had attempted to improve oral health and attract dentists with lucrative employment packages and loan-payback models but those failed to bring dental providers to their remote communities. Learning from this shortfall, they sought a new way to bring care to remote villages. Eventually they landed on an evidence-based, tried and true method in existence for nearly a century: mid-level providers.

Alaska Tribe dental health aide therapists (DHAT) — think of them as nurse practitioners or physician’s assistants, but for teeth — are part of a dentist-led team. While prevention through education is fundamental to the goal of DHATs, within their limited scope of practice, DHATs are able to safely treat active oral disease.

Unlike dentists, who are required to learn an expansive set of procedures, DHATs focus on a small number of the most common preventive care procedures and train extensively on those. They are thoroughly trained on pediatric care, which makes up sixty-percent of their work, and they learn motivational interviewing to better interact with families. Once they have finished more than 3,000 hours of training, including 400 hours of work alongside a dentist, DHATs continue their practice under the general supervision of a dentist. This means that they can work in off-site locations like small villages accessible only by plane while their supervising dentist is back at a regional clinic. This model means that the supervising dentist has more time to perform complicated, higher cost procedures while still having final say over all the work done by the DHATs.

As a result of this innovative program, instead of seeing a dentist every couple of years, if at all, Alaska Native communities have continuous care from DHATs who use airplanes, boats, and snowmobiles to reach their rural patients. For the first time in more than a hundred years, Alaska Native communities are seeing cavity-free children.

This cost-effective mid-level model has been part of health systems in more than 50 countries for a hundred years. In fact, the first Alaskan dental therapist class was educated in New Zealand, where dental therapists have practiced since 1921. Dental therapists are the most studied dental providers in the world. Regardless, Alaska continues to demonstrate the effectiveness and safety of mid-level providers through their 27 practicing DHATs.

Despite this success, the DHAT model is opposed at every turn by mainstream organized dentistry. In 2006, the American Dental Association (ADA) and the Alaska Dental Society unsuccessfully sued the tribal health consortium and each of the original practicing DHATs. While mid-level providers are now legally protected in Alaska, the ADA continues to block legislation establishing mid-level providers for low income communities in other states. As a result, those who are most at-risk are left without care and often take drastic measures, like Littlebear Sanchez’s effort to pull out his own tooth. ■

This article was reprinted with permission from the Center for Native American Youth. Ryan Ward is a senior program associate and Joaquin Gallegos is a health policy fellow with CNAY. Learn more about the CNAY’s work at cnay.org.



Dr. Mary Williard, Director of Dental Health Aide Therapist Training Program, trains DHAT students in Alaska.

Tribal Epidemiology Centers – Working to Eliminate Health Disparities in Indian Country

Epidemiology is a field that deals with the incidence, distribution, and control of a disease in a population. Tribal Epidemiology Centers (TECs) work in partnership with the local or area Tribes to improve the health and well-being of their Tribal community members by offering culturally-competent approaches that work toward eliminating health disparities that are faced by American Indian and Alaska Native (AI/AN) populations.

Accomplishing this often requires that TECs work to coordinate with the Tribes, the Indian Health Service (IHS), other federal agencies, state agencies, and academic institutions throughout the country. There are currently 11 TECs in the United States however it is important to note that the TECs are not Tribal specific to one individual Tribe or Nation and they are not IHS region/area specific.

Tribal Epidemiology Centers provide various types of support and services due to the variation of the TECs organization structure, divisions, Tribal populations, and their mission and goals. The following are some examples of the support and services offered by the TECs:

- Providing timely and accurate access to meaningful health data.
- Updating community health data profiles that are specific to the Tribes.
- Training in epidemiology to Tribal members to improve health programs through enhancing capacity to collect and analyze data.
- Assisting Tribes in data management and reporting requirements.
- Assisting, coordinating and facilitating a public health response to disease outbreaks and clusters in Tribal areas, dissemination of surveillance data, and investigation of disease outbreaks and clusters.
- Supporting and/or coordinating Tribal health surveillance systems.
- Supporting systems that share, improve, and disseminate aggregate health data of AI/AN populations for the purpose of advocacy and to further the understanding of health disparities.
- Maintaining and/or enhancing the Tribal system for developing/implementing health promotion/disease prevention (HP/DP) programs or studies in cooperation with other public health entities that are working to improve AI/AN health.
- Providing technical assistance in planning and evaluating current Tribal health programs and systems. ■



TRIBAL EPIDEMIOLOGY CENTERS

Alaska Native Tribal Epidemiology Center
907-729-4567
www.anthctoday.org/epicenter

Albuquerque Area Southwest Tribal Epidemiology Center
505-962-2602
www.aastec.net

California Tribal Epidemiology Center
916-929-9761
www.crihb.org/ctec

Great Lakes Tribal Epidemiology Center
715-588-3324
www.glitc.org/programs/epi-home

Inter-Tribal Council of Arizona Tribal Epidemiology Center
602-258-4822
www.itcaonline.com/

Navajo Tribal Epidemiology Center
928-871-6585

Northern Plains Tribal Epidemiology Center
605-721-1922
www.aatchb.org/epi

Northwest Tribal Epidemiology Center
503-228-4185
www.npaihb.org/epicenter/about_the_epicenter

Rocky Mountain Tribal Epidemiology Center
406-252-2550
www.rmtec.org

Oklahoma Area Tribal Epidemiology Center
405-652-9204
www.ocaithb.org

United South and Eastern Tribes Epidemiology Center
615-872-7900
www.usetinc.org/Programs/USET-THPS/TribalEpiCenter.aspx

Urban Indian Health Institute Tribal Epidemiology Center
206-812-3030
www.uihi.org

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► Continued from page 12
Good Oral Health Care Can Lead to Better Management of Diabetes

When Cota sees signs of diabetes, he refers his patients to a Sun Health Center physician; Becker refers to a Native Health provider. They will also refer a patient with other warning signs such as changes in the tongue to a physician for evaluation.

However, patients should also notify their dentists of any health concerns, says Cota. “Even if diabetes is in a patient’s medical records, they should still tell their dentist before having work done,” he says. “We can be ready to properly treat our diabetic patients if we know.”

Rhodes, who has private insurance but was treated at an innovative diabetic management program for Native people while in Alaska, says that after her dentist educated her about how maintaining her dental health enhances her diabetic management, she “got on the program.”

She purchased an electronic vibrating toothbrush and WaterPik water flosser, and added oral care to her health regimen, which includes diet, exercise and checking her blood sugar four times a day.

She sees her dentist regularly for exams and cleanings, and while living in Alaska, her A1C level, which provides a person’s average level of blood glucose, dropped from 10 percent to 7 percent.

“I could actually feel the difference” that proper dental care makes in general health, says Rhodes, who is also exploring pre-contact dental care means like willow toothpicks and sage teas.

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This is the latest in a series of oral health stories produced by the Native Health News Alliance (NHNA), a partnership of the Native American Journalists Association (NAJA).

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