



National Indian Health Board

# Health Reporter

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## Sequestration Hits Home: Tribal Governments Begin to Feel the Impact of Automatic Cuts



NIHB Chairperson Cathy Abramson testifying on April 24, 2013 before the House Interior, Environment and related Agencies Appropriations Subcommittee.

On March 1, 2013, federal programs became subject to the process known as “sequestration.” As part of the Budget Control Act of 2011 (P.L. 112-25), as amended by the American Taxpayer Relief Act (P.L. 112-240), federal spending became subject to a 5.1 percent across-the-board reduction. Because these cuts must be achieved over seven months instead of twelve, the effective percentage of reductions is approximately 9 percent. This reduction includes the Indian Health Service (IHS) which provides access to health care for 2.2 million American Indians and Alaska Natives (AI/ANs). The sequester cuts \$220 million from the IHS budget.

Additionally, the 0.2 percent rescission enacted by the recently-passed Consolidated and Further Continuing Appropriations Act (P.L. 113-06) further reduces the IHS budget in the amount of \$8 million for a total cut of \$228 million from the IHS’ FY 2013 budget. These cuts, combined with government rescissions since FY 2011, mean that the IHS has lost \$240 million in the last three years alone.

Initially, concerned parties believed that IHS would be subject to the same 2 percent cut slated for other health service agencies based on a 1985 legislative model for sequestration. However, the Administration ultimately determined that IHS would be subject to the larger cut affecting other discretionary programs. The 1985 model and the current framework spares Medicare, Medicaid, Veterans Affairs, and the State Health Insurance Program for Children from the full sequester.

The National Indian Health Board (NIHB) believes that reducing IHS funding by the full sequestration rate breaches the federal government’s trust responsibility to the Tribes. Accordingly, NIHB calls on the Congress to enact a legislative fix.

The White House initially predicted that cuts to IHS will mean 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits each year, though detailed budget numbers have not been released. Tribal governments are beginning to project what this cut will mean for them. For example, the Sault Ste. Marie Tribe of Chippewa Indians estimates that sequestration will be a \$1.5 million cut from their health care programs. This could result in the elimination of two Dentists, four dental technicians, three family practice physicians and three registered nurses. The amount of people treated could be reduced by as much as 12,400 or 23 percent of primary care visits.

NIHB is working to inform Congress on the devastating effects that sequestration will have on Tribal health programs. On Monday April 22, 2013, NIHB briefed Congressional staff and Tribal leaders on the effects of sequestration and urged Tribal leaders to share their stories about the impacts of sequestration with Congress.

On April 24, 2013, NIHB’s Chairperson Cathy Abramson testified before the Interior Appropriations Subcommittee on Interior, Environment and Related Agencies and the Senate Committee on Indian Affairs. The response of lawmakers on these two committees demonstrated their deep disappointment that IHS has been subject to sequestration. Representative Jim Moran (D-VA) pointed out that, because Tribal governments

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## From the Chairperson

### Dear Friends,



Since the last edition of the National Indian Health Board's (NIHB) *Health Reporter*, Indian Country has witnessed and experienced the devastating cuts of sequestration. Tribes suffer from these cuts in many different areas of operation, but particularly in the area of Indian Health, where, even before sequestration, funding levels only covered 57% of need. The numbers represent, but only partially convey the situation in communities across Indian Country.

To give a more complete picture of the damage caused by sequestration, some Tribes are telling their stories. The National Indian Health Board has heard from Tribes who have had to cut staffing, reduce primary care visits, and curtail behavioral health services. These changes are more than unacceptable; in many instances, they translate into critical care not received and irreversible damage to life and limb. *We must send a message to Congress that Indian Country must be held harmless from sequestration and other funding cuts.* NIHB encourages you to work with us on this important campaign.

While NIHB works on this overarching issue, we also are implementing a strategy to educate the public and members of Congress on the need for continued funding for the Special Diabetes Program for Indians (SDPI). Although NIHB and our partners have accomplished impressive work over the last year with reauthorization of the SDPI, the authorization will expire in September 2014. The SDPI is our nation's most effective effort in combatting diabetes in American Indian and Alaska Native communities; it must continue. NIHB asks you to meet with our staff as we work to coordinate our efforts to protect SDPI and ensure it receives the funding necessary to remain a model program.

Although NIHB asks for your participation in these specific campaigns, we also call on Tribal leaders, Tribal health directors, medical practitioners, advocates, and other American Indian/Alaska Native individuals to engage with NIHB to create the first ever National Tribal Public Health Policy and Action Agenda.

NIHB will develop this Policy and Action Agenda in several stages. First, NIHB will gather all those attending our National Tribal Public Health Summit to participate in an interactive forum which will identify National Tribal Public Health Policy priorities, strategies and actions. Next, the priorities identified will be used to guide the development of a written, Tribally-driven, national Tribal Public Health Policy Plan and Action Agenda. Then, this draft written document will be presented back to the Tribal leadership during the NIHB 2013 Annual Consumer Conference. NIHB believes this work presents an opportunity to speak with One Voice on the issues that matter most to the Tribes and our people.

The weeks and months ahead demand our best efforts, strong partnerships, creative problem-solving, and positive energy. I hope your lives and work are filled with these blessings.

Yours in Health,

Cathy Abramson

Chairperson, National Indian Health Board

**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., on Capitol Hill, 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.

## SDPI Renewal Signed into Law: A Significant Accomplishment for Tribal Health Care

On January 2, 2013, President Barack Obama signed into law H.R. 8 – *The American Taxpayer Relief Act of 2012* – a bipartisan bill that included the one-year reauthorization of the Special Diabetes Program for Indians (SDPI) at the current funding level of \$150 million per year. The renewal of SDPI marks a significant accomplishment for Tribal health care. With this extension, SDPI programs can continue to make a real difference in the fight against diabetes in Indian Country through September 2014.

Indian Country demonstrated tremendous dedication and spent countless hours connecting with Congress on SDPI renewal to win this important victory. Throughout the past year, the National Indian Health Board (NIHB) engaged in a diverse range of SDPI renewal activities. In December 2012, NIHB co-hosted an SDPI symposium in Washington D.C. titled, “*The Special Diabetes Program for Indians: Impact beyond Indian Country.*” The symposium highlighted the connection between SDPI and the nearly 30% decline in the incidence rate of end stage renal disease (ESRD) for American Indians and Alaska Natives (AI/ANs) since 1996.

Last December, while Congress was in the process of selecting programs to renew, NIHB identified key congressional members and then galvanized a multi-faceted and comprehensive campaign to demonstrate Indian Country’s support for SDPI.

NIHB conducted extensive outreach to Tribal leaders, national Tribal organizations, and other interested stakeholders with a goal of generating a critical mass of SDPI Tribal support letters. As a result, NIHB staff conducted numerous congressional visits, and hand-delivered over 80 SDPI Tribal support letters to congressional members and leadership.

In Washington’s current challenging budgetary and political environment, Indian Country must stay involved if SDPI funding is to continue beyond September 2014. NIHB encourages you to join us in our next SDPI campaign.

### Next Steps and Actions Items

SDPI renewal remains a top legislative priority for NIHB. Because SDPI is not a permanently funded program, Congress will need to renew SDPI again before September 2014 to ensure that established SDPI programs throughout Indian Country continue to receive the resources needed to fight diabetes and its related complications.

With that priority in mind, NIHB will re-launch the SDPI reauthorization campaign at the NIHB National Annual Tribal Public Health Summit in June. 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 the Congress and disseminate this information on the SDPI Resource Center website at [www.nihb.org/sdpi](http://www.nihb.org/sdpi). 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 is greater. Together, we are beating diabetes for our ancestors, our communities, and future generations.

### What is the Special Diabetes Program for Indians (SDPI)?

The growing epidemic of diabetes represents one of Indian Country’s greatest public health challenges, as AI/ANs have the highest prevalence of diabetes among all U.S. racial and ethnic groups. In response to this epidemic, Congress established the Special Diabetes Program for Indians (SDPI) in 1997. SDPI has provided the funding, tools, training, support, and clinical data to help the Indian health system make tremendous changes to the diabetes landscape in AI/AN communities.

## Upcoming Events

### National Indian Health Board (NIHB) National Tribal Public Health Summit June 17, 2013 - June 19, 2013

Hollywood, FL  
www.nihb.org

### National Congress of American Indians (NCAI) 2013 Mid-Year Conference June 24, 2013 - June 27, 2013

Reno, NV  
www.ncai.org

### 2013 National United National Indian Tribal Youth (UNITY) Conference July 12, 2013 - July 16, 2013

Marriott Warner Center  
Woodland Hills, CA  
www.unityinc.org

### 10th Annual Direct Service Tribal National Meeting (& Tribal Healthcare Reform Training) July 2013

Location - TBD

### Great Plains Tribal Chairmen's Health Summit (& IHS Tribal Consultation, Tribal Healthcare Reform Training)

August 7, 2013 - 1:00 pm - 5:00 pm CDT  
Aberdeen, SD

### NIHB Annual Consumer Conference August 26 - 29, 2013

Traverse City, MI  
www.nihb.org

### NCAI 70th Annual Convention and Marketplace October 13 - 18, 2013

Tulsa, OK  
www.ncai.org

### Medicare and Medicaid Policy Committee (MMPC) - Meetings & Conference Calls:

#### Conference Calls:

August 7, 2013  
September 4, 2013  
October 2, 2013

#### Face to Face Meetings:

July 16, 2013  
Washington, DC

### Centers for Medicare & Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) - Meetings & Conference Calls:

#### Conference Calls:

June 12, 2013  
August 14, 2013  
September 11, 2013  
October 9, 2013

#### Face to Face Meetings:

July 17-18, 2013  
National Museum  
of the American Indian  
Washington, DC

If you are interested in participating on TTAG or MMPC, please contact NIHB Legislative Program Associate, Liz Heintzman at [lheintzman@nihb.org](mailto:lheintzman@nihb.org) or 202-507-4072.

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typically receive three three-fourths of their funds from federal dollars and state and local governments get about a quarter of their funds from the federal government, sequestration has a much bigger impact on Tribal communities.

Throughout that week, NIHB met with lawmakers and their staff to gain support for a legislative exemption from sequestration for the IHS. Fortunately, many in Congress recognize the extent of the problem and are working to find a solution. Despite a divisive political environment in Washington and the difficulties associated with achieving a legislative "fix," NIHB will continue to work with Members of Congress to ensure a restoration of the \$240 million in cuts. Furthermore, NIHB seeks a permanent exception from future sequestration for the IHS.

NIHB requests your help. In order to tell the story of the true human consequences of sequestration, NIHB needs information on how these cuts will affect the people you serve. How many patients will go untreated? What services will you have to deny? Will you have layoffs for health professionals? Will you close any clinics? You can share your story at: [www.nihb.org/tribalhealthreform/sequestration/](http://www.nihb.org/tribalhealthreform/sequestration/)

If you have any questions about sequestration or NIHB's advocacy efforts, please contact NIHB's Manager of Congressional Relations, Caitrin McCarron at 202-507-4085 or [cmccarron@nihb.org](mailto:cmccarron@nihb.org). 

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While not every Tribe receives the SDPI grant, the program has become our nation's most strategic and effective federal effort in combating diabetes in Tribal communities. Today, SDPI provides \$150 million in grant funding to 404 diabetes treatment and prevention programs in thirty-five states. This federal investment in community-driven, culturally appropriate programs has led to significant advances in diabetes education, prevention, and treatment. SDPI makes a real difference in the lives of people who must manage diabetes on a daily basis.



SDPI programs throughout Indian Country demonstrate that the risk of developing diabetes and the risk of developing complications for those with diabetes can be significantly reduced. As a result of intensive SDPI program data collection, sharing, and analysis, SDPI programs can show remarkable outcomes, including a decrease in the average blood sugar level from 9% in 1996 to 8.1% in 2010, a 73% increase in primary prevention, a 56% increase in weight management activities targeting children and youth, and a reduced risk of cardiovascular disease through reduced cholesterol levels. 

# New FEMA Regulations: President Obama Amends Stafford Disaster Relief and Emergency Assistance Act

On Tuesday, January 29, 2013, President Obama signed into law the Sandy Recovery Improvement Act of 2013. The Act contains a provision which amends the Stafford Act and provides federally-recognized Tribes the option to make a request directly to the President for a federal emergency or major disaster declaration. Tribes will still have the option to seek assistance, as they do presently, under a declaration for a state if they decide to forgo making a direct request.<sup>1</sup>

This amendment allows the chief executive of an affected Indian Tribal government to submit a request for a declaration that a major disaster or emergency exists consistent with the requirements listed in the Stafford Act section 401 (major disasters) and 501 (emergencies). The amendment instructs that references to any combination of “state and local” in the Stafford Act should be read to include Indian Tribal governments. The amendment also directs Stafford Act references to “governor” to be read to include the chief executive of Indian Tribal governments.

In March and April, FEMA conducted listening sessions with Tribal leadership, Tribal organizations, first responders and other stakeholders to present information regarding the FEMA programs, the Stafford Act and its amendment, and the declarations process. FEMA solicited comments and input through April to inform the preliminary implementation of this provision.

## Topics to Note

Other issues may stem from the method in which FEMA makes public assistance, individual assistance and hazard mitigation available to eligible areas. Currently, governors must have the following agreements and/or plans:

- In order to receive public assistance, governors must have an approved administration plan. (44 CFR 206.207.)
- In order to receive public assistance categories C-G and hazard mitigation grant program assistance, states must have an approved or approvable state mitigation plan (44 CFR 201.4(1)).
- In order to receive other needs assistance under the individual and household program, governors must choose an administrator to provide the assistance and, depending on the choice, have an approved Other Needs Assistance Administration Plan. (44 CFR 206.120).
- State and local governments must comply with the Uniform Requirements for Grants and Cooperative Agreements to State and Local Governments. (44 CFR Part 13).

FEMA solicited comments on whether there are circumstances that may prevent the chief executive of an Indian Tribal government from complying with these current requirements and processes for declaration requests during the pilot program.

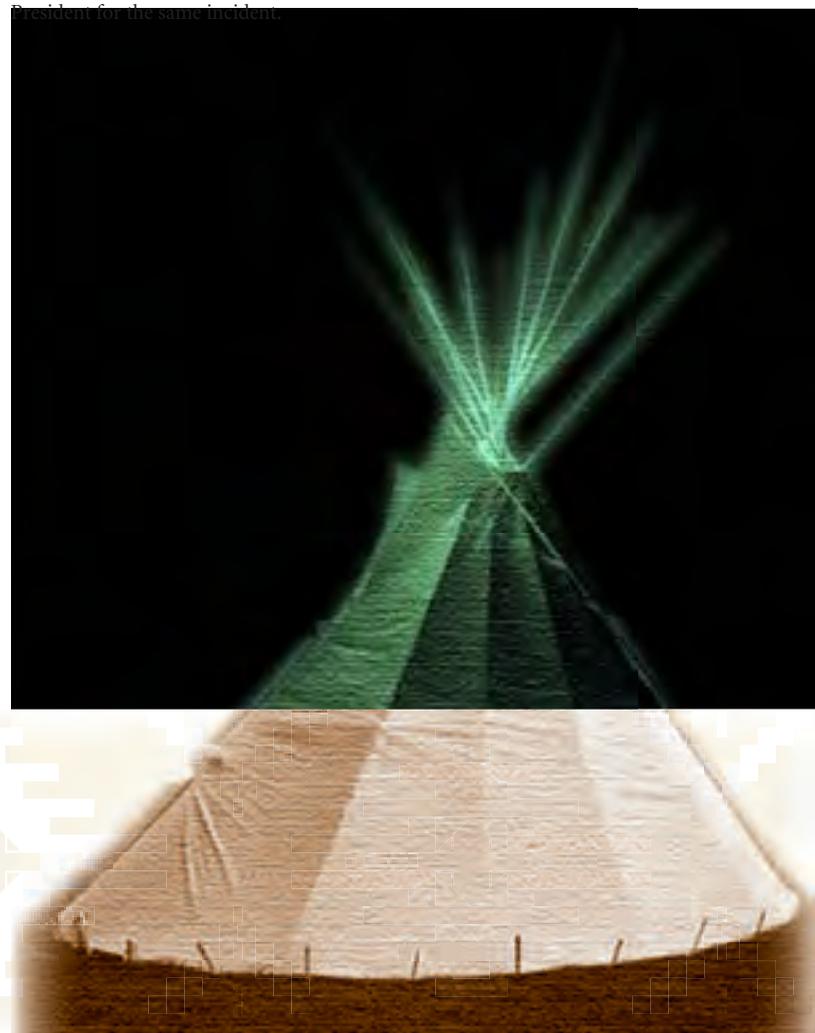
FEMA also solicited comments on the following sections of the Stafford Act: mitigation plan requirement, timelines to submit declaration requests, criterion used for public assistance, criterion used for individual assistance, designating areas eligible for assistance (definition of Tribal lands), appeals, cost share adjustments, notification of state and Tribes, disaster unemployment assistance, and disaster legal services.

To access the agency’s archives of listening sessions and related materials, please visit [www.fema.gov/tribal-consultation#calls\\_schedule](http://www.fema.gov/tribal-consultation#calls_schedule) 

## HIGHLIGHTS: TRIBAL REQUESTS FOR A MAJOR DISASTER OR EMERGENCY DECLARATION UNDER THE STAFFORD ACT

- Amends the Stafford Act to provide for an option for the chief executive of a federally recognized Indian Tribe to make a direct request to the President for a major disaster or emergency declaration. The amendment provides that Tribes may elect to receive assistance under a state’s declaration, provided that the President does not make a declaration for the Tribe for the same incident.
- Authorizes the President to establish criteria to adjust the non-federal cost share for an Indian Tribal government consistent to the extent allowed by current authorities.
- Requires FEMA to consider the unique circumstances of Tribes when it develops regulations to implement the provision.
- Amends the Stafford Act to include federally recognized Indian Tribal governments in numerous references to state and local governments within the Stafford Act.

<sup>1</sup> The amendment stipulates that Tribal governments may be eligible to receive assistance through a declaration made by the President at the request of a state, so long as the Tribal government does not receive a separate declaration from the President for the same incident.



## NIHB Highlights Area Health Boards

### United South and Eastern Tribes, Inc. Health Committee (USET - Health Committee)

United South and Eastern Tribes, Inc. is a non-profit, inter-Tribal organization that collectively represents its member Tribes at the regional and national level.

USET has grown to include twenty-six federally recognized Tribes and operates various workgroups and committees to provide a forum for the exchange of ideas and information amongst Tribes, agencies and governments. Under the authority and guidance of the United South and Eastern Tribes, Inc. (USET) Board of Directors, the USET Health Committee was formed to promote Indian leadership, improvements to the Indian healthcare delivery system, and improvements in the quality of life for American Indians/Alaska Natives. The Health Committee represents the following member Tribes: Eastern Band of Cherokee Indians, Miccosukee Tribe of Indians of Florida, Mississippi Band of Choctaw Indians, Seminole Tribe of Florida, Chitimacha Tribe of Louisiana, Coushatta Tribe of Louisiana, Saint Regis Band of Mohawk Indians, Passamaquoddy Pleasant Point, Passamaquoddy Indian Township, Penobscot Indian Nation, Seneca Nation of Indians, Houlton Band of Maliseet Indians, Poarch Band of Creek Indians, Tunica-Biloxi Tribe of Louisiana, Narragansett Indian Tribe, Mashantucket Pequot Tribe, Cayuga Nation, Wampanoag Tribe of Gay head (Aquinnah), Shinnecock Indian Nation, Alabama-Coushatta Tribe of Texas, Oneida Indian Nation of New York, Aroostook Band of Micmac Indians, Catawba Indian Nation of South Carolina, Jena Band of Choctaw Indians of Louisiana, Mashpee Wampanoag Tribe of Massachusetts, and Mohegan Tribe of Indians of Connecticut.



#### Current USET Health Committee Initiatives Include:

- Prescription Drug Task Force - development of a Prescription Drug Toolkit
- Supporting and promoting the IHS budget formulation initiatives
- Assisting member Tribes with the implementation of the Affordable Care Act, including state health insurance exchange networks
- Promoting initiatives related to improving member Tribes' public health infrastructure
- Promoting and advocating for legislative and best practice initiatives that improve the Indian healthcare delivery system and increased access to quality healthcare services

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### Navajo Nation

The Navajo Nation is the largest Indian reservation and the largest Indian Tribe in the United States. The Navajo Nation is different and unique in terms of geo-physical and demographic characteristics and structures that influence the life style of the entire Navajo population. The culture, language, traditions and other social, economic, education and health characteristics are also unique. "Practice in Beauty Way", "Teachings from Grandparents", belief and influence of "Four Sacred Mountains", "Dine' Language", and "Navajo Code Talkers" ... are some of the few, but major and unique, characteristics of the Navajo people.

The Navajo Nation is a Sovereign Nation situated in three different States: Arizona, New Mexico and Utah and has a total user population of over 250,000. It is a vast rural area located in the Southwest region of the United States extending from 37 degree North latitude and 109.3 west longitudes. The Navajo Nation occupies a total area of about 27,000 square miles. Almost 65% of the total Navajo land area is in northeast Arizona and the remaining 27% of land is in New Mexico, and 7% is in Utah.



#### Navajo Division of Health (NDOH)

Navajo Division of Health, a Tribal governmental health agency, provides and coordinates health care services on the Navajo Nation.

Mission of the Division is "*Dine bi ts'is, bi ni' doo bee ina' ba ahaya.*" (Taking care of Navajo people – body, mind, and life.)

The goal of the division is to increase years of healthy, productive and functional life of Navajo citizens consistent with our culture, values and traditions

#### NDOH ADMINISTERS THE FOLLOWING HEALTH PROGRAMS:

##### NDOH Executive Administration

- Office of the Division Director provides executive oversight to the following offices and programs:
  - Office of the Medical Advisor*
  - Office of Legislative Affairs*
  - Office of Financial Management*
  - Office of Staff Development*
  - Office of Management Information System*
  - Office of Planning, Research and Evaluation*

##### NDOH Health Programs

- Navajo Behavioral Health Service Program
- Navajo Community Health Representative (CHR) Program
- Navajo Area Agency on Aging
- Navajo Women, Infant, and Children (WIC) Program
- Navajo Food Distribution Program
- Navajo Health Education Program
- Navajo Special Diabetes Program
- Navajo Uranium Workers Program
- Navajo Breast and Cervical Cancer Prevention Program
- Navajo Environmental Health and Sanitation Program
- Navajo Public Health Nursing Program
- Navajo New Dawn Program
- Navajo Public Health Emergency (BIOT) Program
- Navajo Epidemiology Center

### NDOH initiatives for 2013

- Upgrade NDOH to a state- like Department of Health
- Develop and implement Navajo Health & Wellness - Ten Year Plan
- Amendment of NDOH Plan of Operation
- Develop and implement Navajo Health Care Financing Agency Plan
- Develop and implement Food and Wellness Policy
- Expand Public health services
- Develop and implement Health Commitment Policy
- Develop and implement HIV Policy
- Establish and operate a Navajo Health Care Improvement Innovation Center
- Youth Health Improvement Project
- Establish and operate a Navajo Health Care Commission
- Veterans Health Improvement Program

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### Oklahoma City Area Inter-Tribal Health Board (OCAITHB)

The Oklahoma City Area Inter-Tribal Health Board (OCAITHB) is a non-profit organization established in 1972 dedicated to improving the health and quality of life of Native American communities through advocacy and education with federal, state and local entities while maintaining Tribal sovereign rights.



OCAITHB provides a unified voice for forty-three federally recognized Tribes located in Kansas, Oklahoma, and Texas, and is governed by twelve representatives, each from the twelve service units in the Indian Health Service (IHS) Oklahoma City Area.

#### Current OCAITHB Programs:

- The Dental Support Center provides technical assistance to Oklahoma City Area Indian Health Service, Tribal/Tribal organization, and urban Indian organization (I/T/U) dental clinics by providing patient education materials, continuing dental education, and increasing access to dental care.
- The Tribal Epidemiology Center offers public health services in epidemiology, data management, and analysis.
- The Public Health Education Assistance Program promotes professional growth and development for regular full-time ITU and OCAITHB employees within the IHS Oklahoma City Service Area by providing public health training center guidelines and reimbursements for tuition.

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## Tribal Consultation Policy: A Tool for Formal Communication between Tribal Nations and the Federal Government

As recognized in the Constitution of the United States, treaties, and federal statutes, Indian Tribes are sovereign nations and, as such, have a unique legal and political relationship with the United States. This government-to-government relationship brings special considerations including the need for distinct communications protocols.

To gain Tribal input on the development of new or amended federal policies, regulations and legislative actions, the federal government uses the formal communications process of Tribal Consultation. Executive Order 13175 of November 6, 2000 (Consultation and Coordination with Indian Tribal Governments) recognized Tribal consultation as a formal federal policy and President Obama's Memorandum on Tribal Consultation, signed on November 5, 2009, affirmed this policy and directed agency heads to submit detailed plans of actions each agency would take to fully implement consultation.

### Tribal Consultation on Indian Health Issues

A Tribal Consultation Policy (TCP) guides interaction between the federal government and the Tribes, and also acknowledges the importance of the partnership between the federal government and Tribal governments in addressing critical issues and policies affecting the lives of American Indians and Alaska Natives. In health matters, a TCP also demonstrates Tribal and federal dedication to improving the health of the American Indian and Alaska Native people.

Since 1997, the U.S. Department of Health and Human Services (HHS) has followed a department-wide TCP. With Tribal input, HHS has reexamined and revised its TCP, most recently in 2010. By frequently reviewing the policy to identify what is working and what can be improved, the department ensures that its TCP remains relevant and meaningful well into the future. Other HHS operating divisions, including the Indian Health Service, Centers for Medicare and Medicaid Services, and Health Resources and Services Administrations, have developed agency-specific TCPs, which complement the HHS TCP. The remaining HHS operating divisions follow the HHS department wide TCP.

The HHS TCP identifies the policies and procedures for consultation. Most importantly however, the HHS TCP sets out federal government actions that trigger the policy and directs the agencies to engage in consultation with the Tribes when federal policies have a significant impact on the Indian health program. The HHS TCP specifies that these communications must be meaningful, rather than perfunctory. Examples of events that trigger consultation, that were identified by Secretary Sebelius in letter to OMB in February 2010, include:

- No Division shall promulgate any regulation that has Tribal implications and imposes costs on Indian Tribes, or that is not required by statute, unless the federal government is paying the costs or formal consultation has taken place with Tribes.
- No Division shall promulgate any regulation that has Tribal implications and that preempts Tribal law unless the Division consulted with Tribes, included a Tribal summary impact statement in the Federal Register, and provides the Secretary with all written communications from Tribes on the issue.
- Each Division should explore and use consensual mechanisms for developing regulations, including negotiated rulemaking.

Tribal consultation provides an effective means for Tribes to share issues with the HHS Operating Divisions and Agencies while those issues are being considered, but consultation can do more. On-going communications, where the department provides feedback to Tribes, and Tribal leaders keep the dialog going, ensure that the concerns raised get addressed. The National Indian Health Board remains committed to this government-to-government process and is available to provide technical assistance to Tribes. 



# What the Affordable Care Act Means for Native People Living with HIV and AIDS

President Barack Obama signed healthcare reform into law on March 23, 2010 to expand the healthcare availability and affordability for all Americans, including American Indians and Alaska Natives (AI/AN). Several of the new benefits have already started. Since 2010, the law prohibits insurance companies from rejecting children with pre-existing conditions, requires new insurance plans to cover certain preventive care services (including cancer and diabetes screenings), and allows young adults to stay on a parent's insurance plan until they turn 26.

In 2014, the Affordable Care Act (ACA) will transform medical care coverage and access for AI/AN people living with HIV and AIDS (PLWHAs) by implementing major health care reform for both private insurance and Medicaid Expansion. Starting on January 1, 2014, insurance companies will no longer be able to deny coverage or charge more for individuals with pre-existing conditions. The law also will require businesses employing more than 50 people to purchase health insurance or face fines.

In states participating in Medicaid expansion, individuals below or at 133% federal poverty level (which is around \$14,000 per year for a single person and \$29,700 for a family of four) will be able to enroll in Medicaid. Currently, childless PLWHAs have to be so sick that they are disabled in order to qualify. In 2014, they can enroll, regardless of health status.

The ACA also increases access to effective prevention, care and treatment for PLWHAs. Starting in 2014, nearly all health insurance plans will be obligated to offer preventive health services without cost-sharing. This includes access to contraception counseling and supplies as well as HIV and sexually transmitted infection screening and counseling.

## Challenges and Questions about Implementation

With these very positive developments, come some very real questions and some challenges as well.

National Native American Aids Prevention Center COE Robert Foley conveyed both his enthusiasm for the new opportunities under the ACA as well as his concerns, stating, "There is a generalized excitement about the ACA and permanent reauthorization of IHCA and what this means for Native people living with HIV. However, it will require people to move to a more traditional insurance-based care – choose an insurance provider, select an approved primary care doctor, receive referrals for HIV and infectious disease specialists, seek out pharmacies that accept the insurance and carry the HIV medicines on their formulary, and so forth. Taking all of these steps will not be easy."

Currently, American Indian patients living with HIV without insurance can access health care through Indian Health Services and the federal Ryan White program. The expanded Medicaid program and new state-operated insurance exchanges will create additional opportunities to access HIV medical care and medication that, by themselves, can cost up to \$20,000 a year. Tribal members on and off the reservation will need help navigating through the exchanges, understanding how the new insurance system will work with existing Indian health care systems, and understanding how urban and Tribal clinics will operate under the new system.

"We hear people asking... 'What is this care going to look like? What will this law mean for us?'" Mr. Foley shared. Over the months and weeks ahead, the National Indian Health Board, along with our national partners, will provide education and outreach to help answer these questions and others for our constituents across Indian Country.

## Other ACA Highlights:

### Vital Investments in Prevention and Wellness

- The ACA requires that insurance plans must offer annual HIV/STI counseling and screening for at-risk people without cost sharing. The ACA also makes significant investments in comprehensive sex education programs.

### Gathering Data and Reducing Disparities

- The law demonstrates a commitment to the President's National HIV/AIDS Strategy to help reduce health disparities and mandates that HHS include sexual orientation and gender identity in its national data collection efforts starting in 2013.

### Insurance Protections and Exchanges

- Insurers can no longer impose a lifetime dollar limit on essential health benefits. People without access to employer-sponsored insurance or Medicaid will be able to use their state insurance exchanges to purchase private insurance. The exchanges are designed to make buying health insurance easier and more affordable.

### More Health Care Providers for Underserved Communities

- The law makes new investments to expand the number of primary care doctors and nurses. The law helps expand the health care workforce through new resources that will boost the number of doctors, nurses and health care providers in AI/AN communities. 

## ACA OUTREACH IN INDIAN COUNTRY

The National Indian Health Outreach and Education Initiative (NIHOE) is a national partnership between Indian Health Service (IHS), the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), and representatives from each of the 12 IHS service areas. The partnership aims to develop effective, streamlined, consumer-oriented materials to assist American Indians and Alaska Natives in understanding their rights and new opportunities under the Affordable Care Act (ACA) and Indian Health Care Improvement Act (IHCIA). Together, the partners will provide local trainings, national marketing tools, and e-resources that clearly explain health reform changes and their impact on Tribal communities. To find out more about trainings and ACA tools contact Tyra Wittenborn at [Tbaer@NIHB.org](mailto:Tbaer@NIHB.org).



## Making the Move to Electronic Health Records

The National Indian Health Board's (NIHB) Regional Extension Center (REC) serves health providers in the Indian Health Service, Tribal, and urban (I/T/U) Indian health facilities by providing training and technical assistance on the implementation of electronic health records, guiding providers as they work toward Meaningful Use stage 1.

The NIHB REC and its partner organizations employ a full complement of IT specialists, pharmacy/nurse/lab clinical consultants and security risk analysis consultants to optimize the successful adoption of electronic health records. All these services are provided free of charge to I/T/U facilities through grant funding from the Office of the National Coordinator for Health Information Technology. Achieving Meaningful Use also makes providers eligible for incentive payments from the Centers for Medicare and Medicaid (CMS).

### Last Call to Physicians

NIHB urges all I/T/U facilities to take advantage of these free services while they are still available! While the program ends in 2014 and services will no longer be provided following April, 2014, the requirement to switch to electronic records will persist.<sup>1</sup> Physicians and facilities will be forced to pay for the same services currently offered to them for free. In addition, providers and facilities who fail to sign-up will lose the opportunity to claim significant incentive payments. NIHB's REC program represents greatly needed funds for Indian Health which, if not utilized, will simply be returned to the United States Treasury.

If you have not already contacted NIHB to sign up with our center, please contact the staff immediately to take advantage of the program before time runs out. The REC's director, Jason Heinecke can be reached at: [jheinecke@nihb.org](mailto:jheinecke@nihb.org)

### Electronic Health Records from the Patient's Perspective

The adoption of electronic health records brings many benefits to patients and can greatly improve quality of care. By going digital, your vital health information is made easily accessible to you, to view at any time. The same electronic health record will also be available at any facility you attend for medical treatment, even if you have never been to a particular facility before.

This change holds the potential to reduce or even eliminate time spent filling out forms every time you go a doctor's office. More importantly, this approach can prevent mistakes caused by the unavailability of basic medical information and medical history (e.g. blood type, allergies, prior surgeries etc.).

Some patients have voiced concerns about privacy and the security of their records. While new systems take getting used to, patients may be interested to know how federal law protects electronically stored health

information. The Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules put many limitations on use and disclosure of your health information.<sup>2</sup> Generally, facilities may only use and disclose (share) protected health information for treatment, payment or health care operations.<sup>3</sup> Facilities and providers also are obligated to secure electronic health information.

Specifically, facilities and providers must ensure the confidentiality, integrity and availability of all electronic protected health information the covered entity or business associate creates, received, maintains or transmits. They also must protect against any reasonably anticipated threats to the security or integrity of such information and ensure compliance by their workforce.

The Department of Health and Human Services (HHS) provides oversight to ensure facilities follow the rules. Violations can result in legal proceedings and heavy fines. At the same time, HHS provides assistance and guidance to help facilities comply with the rules. Altogether, facilities have tremendous incentives to protect patient health information.

With the benefits so great, and strong privacy protections in place, patients can embrace the shift to electronic health records.

For more information on NIHB's REC or issues related to electronic health records, please contact Jason Heinecke, NIHB REC Director at [jheinecke@nihb.org](mailto:jheinecke@nihb.org) or 202-507-4083. 

<sup>2</sup> In January 2013, the Department of Health and Human Services modified the HIPAA Security and Privacy Rules to provide greater protection to individuals and expand much of the rules' coverage beyond "covered entities." Many of the requirements placed on covered entities now extend to business associates of those covered entities.

<sup>3</sup> Facilities/providers may, of course, disclose information to the patient. There are other situations where a provider may use or disclose protected health information. These situations may involve the patient's consent, or the patient's authorization, or may be directed by other legal obligations of facilities or providers. These situations are strictly regulated under the HIPAA Privacy Rule.

<sup>1</sup> Medicare EPs who are not meaningful users will be subject to a payment adjustment (penalty) beginning on January 1, 2015 when billing Medicare.



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