

# National Indian Health Board



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November 5, 2018

The Honorable Robert R. Redfield, M.D.  
Director  
U.S. Centers for Disease Control and Prevention  
U.S. Department of Health and Human Services Attention:  
1600 Clifton Road NE, Mail Stop D-28  
Atlanta, GA 30329

**RE: U.S. Centers for Disease Control and Prevention: Surgeon General's Call to Action: "Community Health and Prosperity"; Establishment of a Public Docket; Request for Comments, Docket No. CDC-2018-0082**

Dear Director Redfield:

On behalf of the National Indian Health Board (NIHB), I write to submit comments on the request for comments entitled: Surgeon General's Call to Action: "*Community Health and Prosperity*"; Establishment of a Public Docket.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care and public health to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

We appreciate the opportunity to provide comments and commend the Centers for Disease Control and Prevention (CDC) for their continued dedication to advancing the public health infrastructure and capacity of Tribal Nations. AI/AN communities face some of the starkest disparities in preventable chronic health conditions including obesity, diabetes, substance use disorders, tobacco addiction, and cancer. Increasing investments in upstream, holistic, and culturally appropriate prevention policies and programs can help Tribes turn the tide on many of these debilitating illnesses. Additionally, investing in primary prevention can yield tremendous cost savings in future Tribal or Indian Health Service (IHS) health care expenditures. Indeed, utilizing a preventative public health approach to reducing obesity rates by merely 5% could save nearly \$30 billion within 5 years.<sup>1</sup>

## ***Background***

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<sup>1</sup> Bending the Obesity Cost Curve: Reducing Obesity Rates by Five Percent Could Lead to More than \$29 Billion in Health Care Savings in Five Years. Washington, D.C.: Trust for America's Health, January 2012. Available online at: <http://healthyamericans.org/assets/files/TFAH%202012ObesityBrief06.pdf>

The United States has a unique legal and political relationship with AI/AN Tribal governments. This relationship was established through treaties and affirmed by the United States Constitution, Supreme Court decisions, federal statutes, and presidential executive orders. Central to this relationship is the federal government's trust responsibility to protect the interests of Indian Tribes and communities, including the provision of healthcare and public health services to AI/ANs. Nevertheless, Tribes remain behind many other communities in their public health infrastructure, capacity, and workforce as a result of being largely left behind when the nation was developing its public health infrastructure. These systemic barriers have exacerbated AI/AN health disparities and left many Tribes at a disadvantage in leveraging public health resources to improve health outcomes for their citizens.

While lack of investment in public health in Indian Country has contributed to chronic health disparities, AI/AN communities also face significant challenges across the socioeconomic spectrum. Moreover, higher rates of poverty, lower rates of employment, and limited access to education and healthy foods represent a few of the systemic challenges contributing to negative health outcomes in Tribal communities. With poverty as one of the biggest predictors of poorer health outcomes, it comes as no surprise that lower-income adults are five times more likely to report being in fair or poor health compared to adults with incomes at or above 400% of the federal poverty line.<sup>2</sup>

Despite the fact that over 50% of AI/ANs are under the age of 34, approximately 55% of AI/ANs were unemployed from 2012-2015, with average household incomes roughly 21% less than the national average at \$38,530.<sup>3</sup> Further, while majority AI/AN counties comprise less than 1% of all U.S. counties, nearly 60% of such counties experience higher-than-average food insecurity.<sup>4</sup> In 2016, the U.S. Department of Agriculture (USDA) reported that only 25.6% of reservation residents live within one mile or less of a supermarket, compared to nearly 60% of the U.S. population.<sup>5</sup>

Socioeconomic challenges have been a driving force behind the chronic health problems impacting AI/ANs communities. As reported by IHS, AI/AN people born today have a life expectancy that is 4.2 years less than the national average. AI/ANs are 30% more likely to be obese than non-Hispanic Whites<sup>6</sup>, and continue to experience the highest rates of type 2 diabetes of any specific population in the U.S.<sup>7</sup> Tuberculosis incidence among AI/ANs is 500% higher than the general population<sup>8</sup>, and AI/ANs experience the highest Hepatitis C (HCV) mortality rate at 12.95 deaths per 100,000.<sup>9</sup> In recent years, increases in rates of acute HCV among AI/ANs below the age of 30 can be largely attributed to the national opioid overdose epidemic. And although AI/ANs represent only about 2% of the nation's overall population, they encounter the second highest opioid overdose mortality rate

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<sup>2</sup> Urban Institute. 2015. How Are Income and Wealth Linked to Health and Longevity? Retrieved from <https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf>

<sup>3</sup> U.S. Census Bureau. 2011-2015 American Community Survey 5-year estimates. Retrieved from <https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2015/>

<sup>4</sup> Feeding America. Map the Meal Gap 2015. Retrieved from <https://www.feedingamerica.org/sites/default/files/research/map-the-meal-gap/2013/map-the-meal-gap-2013-exec-summ.pdf>

<sup>5</sup> Jernigan, V., Huyser, K. R., Valdes, J., & Simonds, V. W. (2016). Food Insecurity among American Indians and Alaska Natives: A National Profile using the Current Population Survey-Food Security Supplement. *Journal of hunger & environmental nutrition*, 12(1), 1-10.

<sup>6</sup> CDC 2017. Summary Health Statistics: National Health Interview Survey: 2015. Table A-15

<sup>7</sup> CDC 2016. Summary Health Statistics: National Health Interview Survey: 2014. Table A-4.

<sup>8</sup> Indian Health Service. Available at <http://www.ihs.gov/>. Accessed 4-15-2014.

<sup>9</sup> Reilley, B., & Leston, J. (n.d.). A Tale of Two Epidemics - HCV Treatment among Native Americans and Veterans. *The New England Journal of Medicine*, 377(9), 801-803. <https://doi.org/10.1056/NEJMp1705991>

at 13.9 deaths per 100,000.<sup>10</sup> These startling statistics demonstrate the need for lasting community-based public health investments in Tribal communities to begin to turn the tide on these and other chronic health conditions.

### ***Community Health in Indian Country***

The concept of community health is nothing new for Tribal Nations. In Tribal communities, ensuring good health goes far beyond simply securing access to health care services, to include the health of the larger community in which individuals live, work, play, and serve. Indeed, while this framework of “social determinants of health” - characterized by the social, economic, and environmental conditions that determine health outcomes far more than access to health care alone – is new to mainstream public health circles, it has been the foundation for indigenous definitions of health since time immemorial. Traditional teachings and cultural values have long championed the idea that individual health is inseparable from community health, and that true health requires more than just an absence of disease. For instance, the Traditional Medicine Wheel and Four Directions all convey spiritual, physical, emotional, and mental health as being intricately connected and collectively determined. In other words, an individual's health cannot be defined as “good” so long as the community's health remains poor. Thus for many Tribal communities, improving the status of community health is integral to fostering the health of all Tribal citizens.

Nevertheless, the U.S. health system is almost entirely focused on treatment as opposed to community-based prevention, and on individual health care as opposed to community or population health. In 2014, public health spending accounted for only 2.65% of health care expenditures overall, and is projected to fall to 2.4% by 2023.<sup>11</sup> With per capita health spending in the U.S. already the highest in the world at \$10,348 in 2016<sup>12</sup>, and health care expenditures overall projected to account for roughly 20% of gross domestic product (GDP) by 2026<sup>13</sup>, it is essential that health systems transition from a focus on treatment to community-based health promotion and disease prevention.

As sovereign nations, Tribes are uniquely positioned to lead national efforts in the transition to community-based health programming. Tribal Nations are the most aware of the health issues that impact their communities, and retain the solutions to overcoming health disparities. Indeed, the most successful health promotion programs ever implemented in Tribal communities have been Tribally-designed, developed, and implemented.

Yet, that has not borne out among federal funding mechanisms. Generally speaking, Tribal health systems are simply left out of many funding streams within the U.S. Department of Health and Human Services (HHS). This is partly because federal block grants flow to states, leaving little opportunity for Tribal governments to receive this funding. While Tribes are eligible to apply for many other federal grants that address public health and other issues, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are too under resourced to apply for the grants. To address this gap in access to federal resources, funding should flow through to Tribes on a recurring, formula

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<sup>10</sup> Seth P, Scholl L, Rudd RA, Bacon S. Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. *MMWR Morb Mortal Wkly Rep* 2018;67:349–358.

DOI: <http://dx.doi.org/10.15585/mmwr.mm6712a1>

<sup>11</sup> Himmelstein, D. U., & Woolhandler, S. (2016). Public Health's Falling Share of US Health Spending. *American journal of public health*, 106(1), 56-7.

<sup>12</sup> Kaiser Family Foundation analysis of data from OECD (2017), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database) (Accessed on March 20, 2017).

<sup>13</sup> Office of the Actuary. Centers for Medicare and Medicaid Services. 2018. National Health Expenditure Projections 2017-2026 Forecast Summary. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf>

basis, so that Tribal health programs have funds they can count on from year to year.

### ***Best Practices from Indian Country***

The Special Diabetes Program for Indians (SDPI) – long renowned for its unprecedented success in reducing the burden of type II diabetes among AI/ANs – exemplifies an effective best practice in promoting community health. SDPI blends traditional healing and community-based practices with Western medicine to create a truly robust public health intervention. With over 300 Tribal grantees, SDPI is one of the most important community-based programs at work in Indian Country.

The Yakama Nation, an SDPI grantee, has been successfully running a Health Heart demonstration project for several years. Before the program began, more than 1,200 Yakama citizens living with diabetes were receiving diabetes management from overburdened primary care providers at the local IHS facility. Utilizing clinical pharmacists, the Healthy Heart program now provides diabetes care to more than a third of these patients, thus reducing the burden on understaffed physicians. From 2004 to 2014, the program helped over 30% of patients achieve optimal glucose control, and 73% of patients brought down their “bad” cholesterol levels to under 100. In addition, 64% of patients receive annual foot exams, and 99% of patients get A1C levels tested annually, up from 85% when the program began.

Nationally, SDPI has been largely responsible for a 54% reduction from 1996 to 2013 in incidence rates of End Stage Renal Disease (ESRD) – reducing millions of dollars in Medicare, IHS, and third party billing.<sup>14</sup> Moreover, SDPI has helped AI/AN communities reduce rates of diabetic eye disease by 50%<sup>15</sup>, while obesity and diabetes rates among youth have not increased in over a decade.<sup>16</sup>

Another successful community-based program is the Good Health and Wellness in Indian Country (GHWIC) initiative. Established in 2014 by the National Center for Chronic Disease Prevention and Health Promotion, GHWIC is a 5-year initiative that funds Tribes, Tribal organizations and Tribal Epidemiology Centers (TECs) to improve chronic disease and tobacco prevention and intervention efforts. The initiative currently funds 11 Tribes, 12 Tribal organizations, and all 12 TECs, all of which utilize a combination of evidence-based and traditional programming to address preventable chronic conditions such as obesity and tobacco addiction.

For instance, the Lower Brule Sioux Tribe in Minnesota – one of the 11 Tribal GHWIC grantees – has expanded their diabetes program by enacting policies that promote more Tribal members diagnosed with diabetes to enroll. As a result, 41% of all Tribal members diagnosed with diabetes enrolled in their Diabetes Self-Management Education program, which teaches participants healthy eating and cooking techniques. Further, 70% of program enrollees noted that they are eating healthier as a result of the program.

In Oklahoma, the Citizen Potawatomi Nation has utilized similar community-based initiatives to address the variety of behavioral health issues including mental health, suicide and substance addiction. After completing a community needs assessment and asset map to identify community health challenges and priorities, the Tribe applied the lessons learned from the assessment to develop their Native Connections Plan. The project is currently implementing universal, selective, and indicated prevention strategies for suicide prevention, substance use intervention and treatment, and promotion of mental health. The community has experienced a 50% increase in mental health and

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<sup>14</sup> Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. *MMWR Morb Mortal Wkly Rep* 2017;66:26-32. DOI: <http://dx.doi.org/10.15585/mmwr.mm6601e1>

<sup>15</sup> CDC Vital Signs <https://www.cdc.gov/vitalsigns/aian-diabetes/index.html>

<sup>16</sup> IHS Teleophthalmology Program Data

substance use treatment admissions in the last five years, while suicide remains the second leading cause of death among 12-24 year olds. The program served 200 AI/AN youth in the first year, and intends to serve an average 1,200 youth for the remaining three years of the project, reaching roughly 5,000 youth by the completion of the program.

These initiatives demonstrate the significant impact that community-based programs can have on lowering disease incidence and prevalence, reducing health expenditures, and improving health status and outcomes. Moreover, it is essential to increase direct investments in Tribal public health infrastructure and programming in order to ensure that such initiatives continue to expand, and that the Tribal best practices derived from such programs can be reapplied to create new initiatives addressing other health priorities.

### ***Request for Further Tribal Consultation***

Executive Order 13175 requires all federal agencies to engage in meaningful, robust consultation with Tribes and Tribal organizations prior to enacting policies that may have implications for Indian Country.<sup>17</sup> Although we applaud the CDC's request for comments on this issue, we believe that the most important and needed recommendations will come from open dialogue with Tribes. Therefore, we encourage CDC to engage with Tribal Nations directly and gain their input on how best to meet the needs AI/ANs.

### ***Conclusion***

NIHB Tribes stand ready to work with the CDC to build the public health capacity of Indian Country and reduce health disparities in Tribal communities. We thank you for this opportunity to provide our comments and recommendations for the Surgeon General's Call to Action, and look forward to further engagement with the CDC on leveraging public health resources to raise the health status of all AI/ANs to the highest level.

Sincerely,



Vinton Hawley  
Chairman  
National Indian Health Board

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<sup>17</sup> See, e.g., 25 U.S.C. § 1601 ("Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."); The White House, *Memorandum for Heads of Executive Departments and Agencies re: Tribal Consultation* (Nov. 5, 2009), <https://www.whitehouse.gov/the-press-office/memorandum-Tribal-consultation-signed-president>.