

National Indian Health Board



Submitted via email to: HP2030@hhs.gov

January 17, 2019

Alex M. Azar II
Office of the Secretary
U.S. Department of Health and Human Services Attention:
200 Independence Ave S.W.
Washington D.C. 20201

RE: Public Comment for Healthy People 2030

Dear Secretary Azar:

On behalf of the National Indian Health Board (NIHB), and the 573 federally recognized American Indian and Alaska Native (AI/AN) Tribes we serve, I write to submit comments on the U.S. Department of Health and Human Services (HHS) request for comments regarding topic areas and objectives for Healthy People 2030 (HP2030).

Established in 1972, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care and public health services to all AI/ANs. 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 healthcare 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.

NIHB appreciates the opportunity to provide feedback to help ensure HP2030 objectives are inclusive of Tribal public health and healthcare priorities. Tribes and NIHB are committed to working with HHS and the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030 (Secretary's Advisory Committee) to promote objectives that will work to reduce the health disparities AI/AN communities experience across a variety of health conditions.

Background

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 laws and regulations, 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 through the provision of healthcare and public health services to AI/ANs.

Nevertheless, Tribes remain behind other communities in their healthcare and public health infrastructure, capacity, and workforce capabilities, as a result of being largely left behind during the nation's development of its public health infrastructure. These systemic barriers leave many Tribes at

a disadvantage in leveraging public health resources to improve health outcomes for their Peoples. Indeed, AI/AN communities face higher rates of preventable chronic health conditions including obesity, diabetes, substance use disorders, tobacco addiction, and cancer than the national average.

As reported by the Indian Health Service (IHS), AI/AN people born today have a life expectancy that is 4.2 years less than the national average. In some regions of the country, the disparities are much greater. Multiple risk factors explain why life expectancy is lower among AI/ANs, including socioeconomic challenges such as limited access to health education and services, higher rates of poverty and food insecurity, and low federal investment in Indian health and public health.

For example, just under 30% of AI/ANs continued to lack health coverage in 2017 – the highest rate of any group nationwide – and in spite of the federal trust responsibility to deliver health services.¹ Federal appropriations for Indian health amounted to just \$3,332 per capita in FY2017, compared to a national average of \$9,207.² These budget pressures limit the range of health services available for AI/ANs to primarily the most immediate health needs, and constrain efforts to invest in upstream and preventative health services. Higher AI/AN uninsured rates also force greater reliance on emergency care and dramatically increase treatment expenditures for IHS, Tribal, and third party entities.

Cross-cutting considerations

The HP2030 framework identified 41 health topic areas that span a wide spectrum of health priorities. While each of the topic areas certainly impact Tribal health, there are cross-cutting considerations that transcend any one particular area. Tribes and NIHB believe these considerations are critical for HHS and federal agencies to consider as they formulate strategies for implementing the HP2030 objectives. These cross-cutting considerations represent some of the systemic challenges that limit the ability of Tribes to improve health outcomes across multiple health conditions. They are discussed in greater depth below.

1. Lack of IHS and Tribal Representation on the Secretary’s Advisory Committee

Lack of IHS and Tribal representation on the committees and workgroups charged with designing the Healthy People framework contributes to the invisibility of AI/AN health priorities in federal funding and policy decisions. For instance, the Secretary’s Advisory Committee is comprised of individuals from academia, national non-profits and advocacy groups, and state health departments. Because these individuals do not represent Tribes or Tribal organizations, they are unlikely to speak to health issues from the Tribal perspective, and are even less likely to grasp the unique legal landscape of Indian health. Furthermore, neglecting the Tribal perspective makes it more difficult to identify effective pathways to implement the HP2030 objectives in Tribal communities.

In addition, IHS representatives were largely absent from the list of Federal Interagency Workgroup members who are assigned to specific health topic areas – even for health topics wherein AI/AN health disparities are more widely known such as in diabetes, access to health services, substance abuse, and cancer. Based on the list of members available on the Healthy People website, NIHB only found IHS representation on the oral health workgroup. It is essential that IHS employees be included on more of these workgroups so they can speak to how specific health issues uniquely impact Indian Country. Thus, NIHB strongly recommends that HHS consider expanding IHS and Tribal

¹ Georgetown University Health Policy Institute. Coverage Trends for American Indian and Alaska Native Children and Families. Retrieved from <https://ccf.georgetown.edu/wp-content/uploads/2017/07/Amer-Indian-Alaska-Native-Coverage-final-rev.pdf>

² National Tribal Budget Formulation Workgroup. Recommendations on the Indian Health Service Fiscal Year 2020 Budget. Retrieved from <https://www.nihb.org/docs/03012018/TBFWG%20FY%202020%20Recommendations%20Brief.pdf>

representation on its Healthy People committees and workgroups.

2. Need for Indian Country-Specific Topics and Objectives under the Healthy People Framework

Tribal Nations are sovereign governments that share a unique government-to-government relationship with the federal government. Because of the distinct histories, health priorities, and legal status of AI/AN Tribal governments, NIHB strongly recommends that HHS consider developing separate and distinct topic areas and objectives that apply specifically to AI/AN communities. Often times, AI/AN health inequities are overlooked when combined with broader national health issues, which can translate to less prioritization and access to funding. It can also lead to misrepresentation of AI/AN health needs which can exacerbate health disparities in the long-run.

For instance, racial misclassification and undercounting of AI/ANs in state and national disease surveillance systems and registries is a chronic, pervasive issue that disproportionately impacts AI/ANs. Because many disease registries rely on mortality data, misclassification of AI/ANs on death certificates can have the net effect of underestimating population-based disease rates. This in turn can severely impede Tribal, federal, and state efforts towards identifying areas of need for public health education, programming, and delivery of health services. For example, the CDC noted that the actual number of drug overdoses for AI/ANs from 1999 to 2015 might be underestimated by as much as 35% due to racial misclassification.³ Going even further, CDC reported that the proportion of racial misclassification of AI/ANs across multiple causes of death in the National Longitudinal Mortality Study from 1999-2011 was as high as 40%.⁴

This is just one example where an objective and topic area specific to Indian Country is warranted. It is imperative that HHS examine how to best design a framework, topic areas, and objectives that meet the health needs of Tribes and advance the federal government's trust responsibility for health. NIHB strongly encourages HHS to consult with Tribes and Tribal organizations directly to examine how to best frame topic areas and objectives to address the distinct health inequities, challenges, and barriers impacting Indian Country.

3. Need for Tribal Consultation During Development of Healthy People Framework and Objectives

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.⁵ Although we applaud HHS's request for comments on this issue, we believe that the most important and needed recommendations will come from open dialogue with Tribes directly. Therefore, NIHB encourages HHS to engage with Tribal Nations directly and gain their input on how best to meet the needs AI/ANs as it develops the Healthy People framework and objectives.

NIHB has prepared comments based on specific topic areas and objectives. Comments on health topic areas are designed to provide HHS with the Tribal perspective on the impacts of those topics

³ Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *MMWR Surveill Summ* 2017;66(No. SS-19):1–12. DOI: <http://dx.doi.org/10.15585/mmwr.ss6619a1>

⁴ CDC. The validity of race and Hispanic-origin reporting on death certificates in the United States: an update. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2016. https://www.cdc.gov/nchs/data/series/sr_02/sr02_172.pdf

⁵ 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>.

in AI/AN communities, and to share strategies for mitigating health disparities in Indian Country. NIHB has also provided targeted feedback on a few objectives in order to make them more inclusive of, and applicable to, the health needs of Tribal communities.

Access to Health Services

The IHS, Indian tribes, tribal organizations, and urban Indian organizations (collectively I/T/Us) supply essential health services to approximately 2.3 million AI/ANs on/near reservations in thirty-five states.⁶ An additional 46,000 AI/ANs who do not have access to reservation-based programs receive medical and public health services from thirty four urban Indian organizations supported by Federal funds. On the whole, the I/T/U system serves one of the poorest and most medically underserved populations in the United States.

This is worsened by the drastic underfunding of the Indian health system: the National Tribal Budget Formulation Workgroup estimates that the IHS budget requires close to an additional \$32 billion to achieve health parity between AI/ANs and the general American population.⁷ The Office of Inspector General has noted that funding for certain Indian health programs “has failed to keep pace with inflation, resulting in curtailed services to IHS beneficiaries.”⁸ While Tribal health programs attempt to make up funding gaps by billing Medicare, Medicaid, third party insurance, etc., AI/ANs are comparatively less likely to enroll in a government or private insurer than members of the general population.

This is because the United State owes a special trust responsibility and legal obligation to ensure the highest possible health status for American Indians and Alaska Natives, including the provision of health care at no charge to the individual. Many AI/ANs prefer to receive the government-funded Indian health services to which they are entitled rather than enroll in a third party insurer, making third party collection difficult. Because neither IHS nor Tribal health programs charge AI/ANs for services, this often leaves Tribal health programs at the fiscal mercy of a system that simply cannot support AI/ AN health and public health needs.

Core Objectives –

AHS-2030-01: Increase the proportion of persons with medical insurance

The Patient Protection and Affordable Care Act provided special opportunities for AI/AN to enroll in Medicaid insurance coverage through the Federally Facilitated Marketplace resulting an increase of 17% for AI/AN health insurance coverage.⁹ Thanks to increased insurance coverage the number uninsured dropped by 340,000 or 31% since 2012. However, American Indians and Alaska Natives with access to IHS-funded health programs saw much smaller decreases (16%) in uninsured, than those without access to IHS (43% decrease). The reason for this variation is likely that the very fact of having access to health care services at an IHS funded health program diminishes the likelihood

⁶ U.S. Department of Health and Human Services, Indian Health Service, *Fact Sheet: IHS Profile* (January 2019), https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf

⁷ National Tribal Budget Formulation Workgroup, *Honoring the Federal Trust Responsibility: A New Partnership to Provide Quality Healthcare to America's First Citizens: Recommendations on the Indian Health Service Fiscal Year 2019 Budget*, Mar. 2017, at 10 <https://www.nihb.org/docs/04032017/TBFWG%20Testimony%20FY%202019%20FINAL.pdf>

⁸ "Review of the Indian Health Service's Contract Health Services Program," Office of Inspector General (A-15-97-50001)

⁹ "50 States Health Insurance Coverage for American Indians and Alaska Natives: The Impact of the Affordable Care Act 2012-2016," National Indian Health Board (January 2019), <https://www.nihb.org/tribalhealthreform/cihpr/state-insurance-reports/>

that a patient would purchase health insurance or seek out Medicaid coverage. Thus, increased outreach effort is needed to promote enrollment of AI/AN in medical insurance.

AHS-2030-05: Reduce the proportion of persons who are unable to obtain or delay obtaining necessary medical care

Most primary care to AI/AN is delivered through IHS and Tribal health programs which consists of 46 hospitals, 344 health centers, 105 health stations, and 150 Alaska villages.¹⁰ When services are not available by IHS or Tribal health programs, IHS can pay for services provided by outside providers through the Purchased/Referred Care (PRC) program. Types of services purchased from private health care providers by IHS under PRC include essential hospital and outpatient care; emergency care; transportation; laboratory; pharmacy; and physical therapy services, among others. Most IHS-operated Purchased/Referred Care programs are only able to purchase services at the Priority I level which is emergency care for the preservation of life and limb.¹¹

According to the IHS National Tribal Budget Formulation Workgroup, this leads to many Tribal citizens being denied preventative and specialty health care service referrals, leading to “worse health outcomes and increased long-term costs” for the Native health care system.¹² PRC funds are essential for care needed to treat specialized health issues like heart disease, cancer, and injuries, all of which are prevalent in Indian Country and are considered leading causes of death amongst American Indians and Alaska Natives. As a result more funding is needed for the Indian health system to ensure adequate specialized care.

AHS-2030-09: Reduce the proportion of all hospital emergency department visits in which the wait time to see an emergency department clinician exceeds the recommended timeframe

Shortly after the U.S. Government Accountability Office released its report on “Indian Health Service, Actions Needed to Improve Patient Wait Times”¹³, in March, 2016, the IHS launched its 2016-2017 Quality Framework. The framework describes processes and goals to improve the delivery of quality care at IHS facilities and improve patient safety.¹⁴ Amongst the objectives in the framework include “improving patient wait times for appointments, cycle time during appointments, and emergency department wait times, by reviewing and leveraging best practices from service units and the health care industry.”¹⁵ This is in response from a finding by the GAO that IHS had not done any systematic oversight of the timeliness of primary care provided at its facilities. The GAO report also found that there were no agreed upon standards for patient times. In addition, the report found that while some staff measured patient wait times, an aging electronic health record system posed challenges in their ability to share that information.¹⁶ It is recommended that standard wait times are established by the Indian health service in order to monitor and enforce compliance, ensuring quality health care delivery and patient safety.

¹⁰ U.S. Department of Health and Human Services, Indian Health Service, *Fact Sheet: IHS Profile* (January 2019), https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf

¹¹ National Tribal Budget Formulation Workgroup, *Honoring the Federal Trust Responsibility: A New Partnership to Provide Quality Healthcare to America’s First Citizens: Recommendations on the Indian Health Service Fiscal Year 2019 Budget*, Mar. 2017, at 21

¹² Tribal Budget Workgroup, *Recommendations on the IHS FY 2017 Budget*, *supra* note 50, at 28.

¹³ U.S. Government Accountability Office, *Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times* (March 2016), <https://www.gao.gov/assets/680/676120.pdf>

¹⁴ Indian Health Service, 2016-2017 Quality Framework, (November 2016), https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/IHS_2016-2017_QualityFramework.PDF

¹⁵ *Id* at 4

¹⁶ U.S. Government Accountability Office, *Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times* (March 2016), <https://www.gao.gov/assets/680/676120.pdf> at 2.

Cancer

There is a significant cancer burden in Indian Country. Specifically, breast cancer is the most frequently diagnosed cancer AND the leading cause of death among AI/AN women.¹⁷ Although rates for cervical cancer have dramatically decreased nationally, the cervical cancer incidence rate for AI/AN women is 9.7 per 100,000, compared to only 7 per 100,000 for White women.¹⁸ Adding to the cancer burden in Tribal communities, AI/ANs are also less likely to participate in and have access to preventive cancer-related services such as cervical Pap smears and mammograms.¹⁹

Because AI/AN populations face significant inequities when it comes to certain cancer mortality rates, NIHB submits that it is not enough for HHS 2030 to aim for general reductions in cancer mortality rates across the population overall. In addition to that general target, NIHB recommends a specific, targeted focus for AI /AN populations to better understand public health interventions that will succeed in Tribal communities, and to expand screening that can decrease cancer mortality rates and reduce disparities seen in AI AN populations with regards to cancer.

Chronic Kidney Disease

Until 2000, AI/ANs had the highest rate of end-stage renal disease (ESRD) of any ethnic group. However, due to the Special Diabetes Program for Indians (SDPI), a direct care approach organized around a public health model, the ESRD rate decreased by 54% between 1996 and 2013- the largest decrease among any population. By 2013, the incidence of ESRD related to diabetes among AI/AN was the same as in whites²⁰.

Diabetes prevention efforts must continue in AI/AN communities, including support for SDPI, which has led to drastic improvements in preventing diabetes in Indian Country. AI/ANs are still diagnosed with diabetes at the highest prevalence rates among demographic in the United States, and about two-thirds of ESRD cases in AI/AN are caused by diabetes. SDPI may also be a useful model for managing diabetes in other populations, particularly those at high risk.

CKD-2030-02: Increase the proportion of adults with chronic kidney disease who know they have reduced kidney function.

Kidney testing in AI/ANs 65 and older was 50% higher compared to the Medicare diabetes population. Current interventions for diabetes prevention and treatment in Indian Country are working, and can serve as a paradigm for other populations.

CKD-2030-05: Increase the proportion of adults with diabetes and chronic kidney disease who receive recommended medical treatment with angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs)

According to the CDC Morbidity and Mortality Weekly report, audit data shows that prescription of ACE inhibitors and ARBs for AI/AN patients with diabetes increased from 42% in 1997 to the range

¹⁷ CDC. (2017). United States Cancer Statistics (USCS). Retrieved from <https://nccd.cdc.gov/uscs/cancersbyraceandethnicity.aspx>

¹⁸ ACS. (2017). Cancer Facts and Figures 2017. Retrieved from <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2017.html>

¹⁹ Holm, J. E., Vogeltanz-Holm, N., Poltavski, D., and McDonald, L. (2010). Assessing health status, behavioral risks, and health disparities in American Indians living on the northern plains of the U.S. *Public Health Reports*, 125(1), 68-78.

²⁰ Centers for Disease Control and Prevention. (2017). Native Americans with Diabetes. *Vital Signs*. Retrieved 1/13/19 from <https://www.cdc.gov/vitalsigns/aian-diabetes/index.html>

of 68% to 73% from 2002 to 2015. “Furthermore in 2014, among AI/AN with diabetes, 76% were prescribed ACE inhibitors or ARBs, compared with 56% of adults with diabetes in the general U.S. population during 2009–2014.²¹” Continued funding towards SDPI may continue to promote this successful progress.

CKD-2030-06: Reduce the proportion of adults with chronic kidney disease who have elevated blood pressure

Kidney failure can be delayed or prevented by controlling blood pressure. Blood pressure in Native Americans with hypertension since SDPI was implemented was well-controlled (133/76 mmHg)¹.

Diabetes

According to the CDC National Diabetes Statistics Report (2017), AI/AN adults have the highest prevalence of diabetes among racial/ethnic groups and are 2 times more likely to have diagnosed diabetes compared with non-Hispanic whites. Additionally, the death rate due to diabetes for AI/ANs is 1.8 times higher than the general U.S. population. While the burden of diabetes is clearly disproportionate for AI/ANs, successes in combatting diabetes risk factors and complications in this population are worth noting. Since 1997, which also marks the beginning of the federal investment in diabetes prevention and treatment in Indian Country through the Special Diabetes Program for Indians (SDPI), AI/AN blood sugar levels have decreased, risk factors of cardiovascular disease have been reduced, diabetes-related kidney disease has been cut by more than half, and primary prevention and weight management programs for Native youth have increased. This success is because communities design and implement diabetes interventions that address locally identified community needs.

Proposed Core Objective

DIABETES –

Increase the number of federally –recognized Tribes implementing a Special Diabetes Program for Indians (SDPI) program.

DIABETES- Increase the number of eligible individuals participating in a Special Diabetes program for Indians.

Per comment submission guidance, NIHB suggests that potential data sources for these *proposed* core objectives may be found in the Indian Health Service Division of Diabetes and Prevention grant records.

SDPI has been prominent program in AI/AN Tribal communities for 20 years and in those 20 years, impressive positive outcomes in diabetes complications such as a 54% reduction in end stage renal disease and over 50% reduction in eye disease have been realized. A reduction in risk factors such as a decreased in blood sugar levels and a decline in blood cholesterol are likewise impressive. As noted in the 2014 Report to Congress, “there is strong evidence that the SDPI is helping change the trajectory of the diabetes epidemic.” The report also states that “nothing else has impacted diabetes resources across the Indian health system as much as the SDPI over the past 17 years.” However, not every Tribal nation community is implementing a SDPI program. To continue the positive trajectory in diabetes outcomes and increase the potential for this population that is overburdened by

²¹ Bullock, A., Burrows, N.R., Narva, A., Sheff, K., Hora, I., Lekiachvili, A., Cain, H., Espey, D. (2017, January 13). Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease Among American Indians/Alaska Natives- United States, 1996-2013. *Morbidity and Mortality Weekly Report*. Retrieved 1/13/19 from <https://www.cdc.gov/mmwr/volumes/66/wr/mm6601e1.htm>.

this disease, it is imperative that more AIANs and more AIAN communities have access to the SDPI program and that more individuals can participate in local SDPI programs.

Developmental Objectives

DIABETES – D-2030-D01: Increase the proportion of eligible individuals completing CDC-recognized lifestyle change programs.

Tribal communities implement lifestyle change programs based on the same landmark research²² that the National DPP is based on, and, in some instances, use the same curriculum that the CDC recognizes. In other instances, Tribal programs have adapted the DPP lifestyle change curriculum to meet the needs and cultural considerations of the local community and a few of these curriculums have been reviewed and are recognized by the CDC. As CDC recognition is becoming more significant as it is now tied to Medicare reimbursement through the Medicare Diabetes Prevention Program, it is important that those who are already implementing an evidence-based lifestyle change program be able to seamlessly achieve recognition.

However, as Tribal leaders have expressed in formal comments to both the Centers for Medicare and Medicaid as well as to the CDC, there are barriers to Tribes seeking CDC recognition for their lifestyle change programs; one is the unnecessary burden for Tribes to coordinate with and report to an additional federal agency. The support for the Tribal lifestyle change programs is already channeled through another federal agency – the IHS. Secondly, a majority of Tribal health care programs are unaware of the process, the criteria, and the period of time it takes programs to become CDC-recognized.²³ It is necessary for the barriers to be addressed to ensure that Tribal lifestyle change programs do not have additional steps to accomplish in the CDC-recognition process, thus making the process itself a barrier. Therefore, NIHB is recommending the following additional developmental objective to complement **D-2030-D01:**

NIHB Proposed Developmental Objectives

Increase the number of Tribally-managed lifestyle change programs that are CDC recognized, including programs supported through the Special Diabetes Program for Indians.

Environmental Health

AI/AN communities are often first affected and particularly vulnerable to harmful environmental health effects. This disparity occurs due to factors such as: already existing health and socioeconomic disparities in Tribal communities; environmental damage to traditional and subsistence foods; harms to community, spiritual, and cultural practices as well as other holistic, non-physiologic indicators of health and wellbeing; and heightened risk due to reasons such as poor quality housing and additional time outdoors for spiritual or subsistence purposes. These impacts are all compounded by an underfunded Indian health care system and the poverty and geographic isolation that many Tribes experience. Although many of the proposed objectives are directly or indirectly important for Tribal

²² IHS SDPI Report to Congress 2011; IHS SDPI Report to Congress 2014.

The landmark study led by the National Institutes of Health of the Health-led Diabetes Prevention Program (NIH DPP) included a subset of American Indians, and due to its remarkable results in reducing the incidence of Type II diabetes in the intervention group, was the basis for the CDC Diabetes Prevention (DP) recognition program as well as the SDPI DP program. For over ten years, AI/AN communities have been implementing the SDPI DP program and continue to achieve similar results as the NIH DPP lifestyle intervention group.

²³ RE: Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Proposed Expansion of Medicare Diabetes Prevention Program Model (CMS-1654-P) Comment. September 6, 2016. Lester Secetero, Chairman, National Indian Health Board: <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2016/09/TTAG-Comment-Medicare-DPP-Expansion.pdf>

communities, NIHB has provided comments below in response to specific objectives that are particularly relevant for Tribes and Tribal communities.

Core Objectives -

Environmental Health: Air Quality

Many Tribal people rely in some capacity on a traditional lifestyle and subsistence diets which are more closely linked to the physical environment- making them uniquely susceptible to environmental exposures at rates different than the general population. Because of this, standard models of measuring exposure may not necessarily be applicable to Tribal communities, given each Tribe's unique culture, history, food sources, and dwellings. Many Tribal Nations have an interest in long-term air quality effects on the health of Tribal members and lands. And many Tribal leaders have a concern about air pollution and its effect on natural resources.

EH-2030-01: Reduce the number of days people are exposed to unhealthy air

The EPA should work with Tribal governments to meet the criteria to administer Clean Air Act programs. Monitoring air quality and reducing exposure in Tribal communities must be a priority in environmental health.

EH – 2030-06: Minimize the risks to human health and the environment posed by hazardous sites

Hazardous sites often fall on Tribal lands. For example, more than 500 uranium mines were abandoned on Navajo lands after 30 million tons of uranium were extracted between 1944-1986; although the mines have been closed now for more than two decades, radiation is still high in homes and water sources, leading to possible health consequences such as lung cancer from breathing radioactive particles and bone cancer or kidney damage due to radionuclides found in sources of drinking water²⁴ among other health concerns. Uranium mining has led to poor health outcomes for Navajo community members, both those who worked in the mines and others. Moreover, with over 160,000 abandoned mines in the Western US, Navajo Nation is not the only Tribe experiencing issues with mines – nor are past mines the only issue today, as Navajo was again pressured to open new mines in the early 2000s²⁵. These types of health impacts disproportionately affect minority communities, which generally face other risk factors compounding potential problems – such as underfunding and low access to healthcare. AI/AN communities face additional challenges when Tribal lands and sovereignty are not respected.

EH – 2030-07: Reduce the amount of toxic pollutants released into the environment

Related to concerns about hazardous sites (EH-2030-06), Tribes often face challenges with toxic pollutants that affect safe drinking water, air quality, fish, support for animals and plants, and a living link to the people's spirituality and culture. Pollutants and contaminants, including ozone and smog, also affect health, and these toxicants are disproportionately released on Tribal lands or near already-vulnerable AI/AN communities.

Education and Community Based Programs

Community-based programming has been an outstanding tool used by health professionals to form partnerships with Tribal populations to reduce health disparities. Education and community programming are present in many aspects of prevention, but they are considered to be most important

²⁴ <https://www.epa.gov/navajo-nation-uranium-cleanup/cleaning-abandoned-uranium-mines>

²⁵ <https://link.springer.com/article/10.1007%2Fs40572-017-0140-5>

at the primary prevention level. We need reliable data sources for AI/AN. Without reliable data it will be difficult to measure change in these indicators over time.

ECBP-2030-D05: Increase the proportion of worksites that are covered by indoor worksite policies that prohibit smoking

In some Tribal communities, Tribal casinos are the main employer for the area. Some casinos have open smoking policies, but with quality education programs based on promising lessons learned, Tribes might follow the path of other Tribal communities that have successfully instituted limited or complete smoking bans. It is important to note that Tribal Nations are sovereign governments, and have the right and responsibility to set, review, and change public policy for the health and public health of Tribal citizens and those within their jurisdictions.

ECBP-2030-D06: Increase the number of community-based organizations providing population-based primary prevention services

Community-based /community-driven programs acknowledge that communities are in the best position to identify and address public health issues. Furthermore, the history between health research and the negative image that has been created from research conducted in the past makes community driven processes even more imperative. Many Tribes have their own IRB's and research protocols, and are situated to include health professionals who can provide primary prevention. Community direction, along with respect and acknowledgement of culture and history, are key components to successful design and delivery of primary prevention services.

Health Information Technology

The information systems that support quality health care delivery are critical elements of the operational infrastructure of hospitals and clinics. The current IHS health information system is called the Resource and Patient Management System (RPMS), and is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most tribal facilities, from patient registration to billing. The explosion of Health Information Technology (HIT) capabilities in recent years, driven in large part by federal regulation, has caused the IHS health information system to outgrow the agency's capacity to maintain, support and enhance it. In addition, RPMS is dependent on an aging broadband infrastructure that is in dire need of upgrade and expansion. A comprehensive, bold, plan to improve health IT infrastructure in Indian Country is needed.

HC/HIT-2030-04: Increase proportion of persons who use health information technology (HIT) to track health care data or communicate with providers

The lack of broadband in Indian Country, along with an oftentimes inadequate EHR system, negatively impacts Indian health system healthcare providers' ability to utilize electronic communications with patients, and the system's overall ability to support telehealth and telemedicine. These factors and others also inhibit a patient's ability to research his/her own health. For 1.5 million people living on Tribal Lands, searching the internet for symptoms, doctors or insurance benefits is simply not an option. While 90% of Americans enjoy the benefits of high speed internet, 68% of Americans living on Tribal Lands do not. Multiple offices at the federal level need to work together to tackle these infrastructure needs.

HC/HIT-2030-05: Increase the proportion of persons with broadband access to the Internet

Over 1.5 million people living on Tribal Lands lack access to broadband. According to the Federal

Communication Commission's (FCC) 2016 Broadband Progress Report, 41% of Americans living on Tribal Lands and 68% of people living in rural Tribal Lands lack access to high speed internet, compared to the national average of 10%. In addition, approximately 75% of IHS sites are located in areas defined as 'rural' by the FCC. These rural sites pay a higher percentage of their operating budget than urban locations on monthly circuit costs. When bandwidth upgrades are required, rural IHS sites are frequently asked to fund the capital costs of these upgrades, which in turn puts additional strains on an already underfunded system.

Heart Disease and Stroke

As with many populations, heart disease is the leading cause of death in American Indians and Alaska Natives (AI/AN), with stroke as the seventh leading cause of death. The most recent data shows that AI/AN are 20% more likely to die of heart disease and 14% more likely to die from stroke than the general population²⁶. In general, health disparities have reduced the life expectancy for AI/AN by 5.5 years compared to the general population²⁷. In addition, AI/AN die from heart disease younger than other populations- 36% percent of those who die of heart disease die before age 65²⁸.

HDS-2030-01: Increase overall cardiovascular health in U.S. adults

Lifestyle and dietary changes can substantially reduce heart disease and increase heart health. A major risk factor for cardiovascular disease (CVD) is smoking. While the proportion of smokers has decreased in the USA, AI/AN have the highest smoking rates of any race/ethnicity at 31.8%²⁹. Any efforts to improve heart health should include measures to reduce smoking in high risk groups, including AI/AN.

Diabetes is also an important risk factor for heart CVD for AI/AN. AI/AN are still diagnosed with diabetes at the highest prevalence rates among any racial/ethnic group in the United States, however have seen remarkable improvement since the implementation of the Special Diabetes Program for Indians (SDPI), and several risk factors of heart disease were reduced through this program, particularly through the Healthy Heart Initiative³⁰. SDPI funds local level activities that support healthy eating, physical activity, and screening for disease. Continued support for this program is vital for improving CVD outcomes for AI/AN.

HIV

AI/AN communities have been disproportionately impacted by the HIV epidemic since its inception – with disparities reflected in prevention and treatment data. The rate of HIV infection among AI/ANs in 2016 was 10.2 per 100,000 – the fourth highest among other racial/ethnic groups.³¹

²⁶ Great Lakes Inter-Tribal Council, Inc. (2015). Burden of Cardiovascular Disease among American Indians and Alaska Natives in Wisconsin. *Lac du Flambeau, WI: Great Lakes Inter-Tribal Epidemiology Center, Great Lakes Inter-Tribal Council, Inc.* Retrieved 1/13/19 from http://www.glitc.org/forms/glitc/gliet_cvd_report_online.pdf.

²⁷ Indian Health Service. (2018). Disparities. Retrieved 1.13/19 from <https://www.ihs.gov/newsroom/factsheets/disparities/>.

²⁸ Centers for Disease Control and Prevention. (2016). American Indian and Alaska Native Heart Disease and Stroke Fact Sheet. Retrieved 1/14/19 from https://www.cdc.gov/dhdsdp/data_statistics/fact_sheets/fs_aian.htm.

²⁹ Centers for Disease Control and Prevention. (2018). Current Cigarette Smoking Among Adults in the United States. Retrieved 1/14/19 from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm.

³⁰ Indian Health Services. (2014). Changing the Course of Diabetes: Turning Hope into Reality, 2014 Report to Congress. Retrieved 1/14/19 from https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/RepCong_2016/SDPI_2014_Report_to_Congress.pdf.

³¹ Baugher, A.R., Beer, L., Bradley, H.M., Evans, M.E., Luo, Q., & Shouse, R.L. (January 4, 2019). Behavioral and clinical characteristics of American Indian/Alaska Native adults in HIV Care – medical monitoring project,

Furthermore, the number of diagnoses of HIV infection among AI/AN persons continues to rise. There was an overall increase of 70% in the rate HIV infection among all reported AI/AN (from 143 in 2011 to 243 in 2016),³² and a 54% increase in HIV diagnoses among gay and bisexual AI/AN men from 2011 to 2015 – the highest such increase in the country.³³ AI/ANs have one of the lowest survival rates after an AIDS diagnosis among all groups, and one of the lowest rates of viral suppression in the country.³⁴ While Tribes and other AI/AN communities experience poorer health outcomes after an diagnosis, and exhibit higher rates of new infections, there have been little to no targeted prevention efforts for AI/AN communities, and funding is not provided directly to Tribes. NIHB has provided comments below in response to specific objectives that may have a potential impact on Tribes and the manner in which they approach their HIV prevention and treatment efforts.

Core Objectives –

HIV - 2030-03: Reduce the number of new HIV diagnoses among persons of all ages

This objective is the bedrock of all HIV prevention efforts, and encompasses all manner of prevention interventions, strategies and activities that have been implemented over the past 36 years. Regrettably, these efforts have not been focused on one of the most vulnerable populations in our country – American Indians and Alaska Natives. The AI/AN population is one of the few communities that has seen a rise in the rate of new diagnoses over recent years, however, there is very little funding that is directed to Tribally-based prevention or capacity building efforts. Materials and campaigns created very rarely are inclusive of AI/AN communities, and are not reflective of the cultural and social realities of AI/AN communities. Funding allocated and directed by the federal and state governments rarely make it to Tribal programs, and programs that do exist and supported by the federal government have been neither developed for nor researched with AI/AN communities. This leaves Tribes to rely upon their own, limited, funding resources to design, implement, and evaluate their own programs – further distancing AI/AN communities from the prevention plan of the rest of the country, and preventing AI AN populations from reaping the benefits of the latest prevention science.

HIV – 2030-04: Increase the percentage of persons 13 years and older with newly diagnosed HIV infection linked to HIV medical care within one month.

Linkage to care has been proven to be one of the most effective and simple interventions that can be undertaken with a person newly diagnosed with HIV or a person that has fallen out of care. The concept is simple, but the execution can be more complicated – especially in Indian Country with fundamental infrastructure challenges create barriers to linkage to care. There are only a handful of providers that are trained to provide HIV specialty care across the entire IHS/Tribal/Urban healthcare system for American Indians and Alaska Natives. These providers are geographically scattered across the country. Therefore, many AI/ANs are required to rely upon referral care to providers outside the Indian health system, and outside of their own communities – often requiring extensive travel to appointments. These providers, while technically knowledgeable, may not have experience or the cultural knowledge to be able to provide comprehensive, competent care to AI/AN people living with HIV. The lack of local providers, distance to HIV specialists, and lack of culturally competent care, serve as deterrents for many AI/AN to seek ongoing care and monitoring

United States, 2011–2015. *Morbidity and Mortality Weekly Report 2019*; 67:1405–1409. DOI: <http://dx.doi.org/10.15585/mmwr.mm675152a1>

³² Ibid.

³³ Centers for Disease Control and Prevention. (2018). HIV among American Indians and Alaska Natives in the United States. Retrieved from <https://www.cdc.gov/hiv/group/raciaethnic/aian/index.html>

³⁴ Ibid.

Developmental Objectives –

Data-driven decision making has been the rallying cry of the federal government for over a decade, and a reliance upon epidemiological and program evaluation data has crafted the current state of prevention and treatment efforts – with certain geographies and populations receiving increased resources and support. However, there has been well-documented cases of widespread and commonplace misclassification of racial identities of American Indian and Alaska Native people across large periods of time and in all realms of health care.^{35 36 37 38} If data is to inform decision-making, then further research and intervention should be conducted to mitigate this keystone issue. HP 2030 would benefit from a development objective to reduce the number of racially misclassified individuals within the HIV testing, linkage, and treatment spheres.

Research Objectives –

A recent publication by the CDC stressed the disparities in the social determinants of health experience by AI/ANs currently in HIV care.³⁹ The article clearly states that AI/AN in HIV care have higher levels of poverty, that viral suppression is suboptimal, and rates of exposure to other significant risk factors are higher. “... 51% of AI/AN patients with HIV infection had incomes at or below the U.S. Department of Health and Human Services’ annual poverty limit, 27% had symptoms of depression, 78% reported internalized HIV-related stigma, and 20% reported binge drinking in the past 30 days.”⁴⁰ Further research should be conducted on interventions to address disparities within key social determinants of health (e.g. poverty, education, access to healthcare services, and access to food) and corresponding risk factors (e.g., alcohol use, drug use, behavioral health) in order to mitigate the impact on HIV outcomes.

LGBT (Lesbian, Gay, Bisexual, and Transgender Health)

Many AI/AN communities have traditionally held views on sexual orientation and gender identity which differ from current, non-Tribal views in the United States. For example, some AI/AN individuals identify as “Two Spirit” or terminology unique to individual Tribes. Many Tribal communities historically recognize third (and at times a fourth) gender with unique identities, roles, and relationships.

Additionally, LGBT AI/AN people, like LGBT members of the general population, are likely to experience discrimination and health disparities at a higher rate. These disparities range from increased rates of tobacco and drug usage and mental health challenges to increased barriers to access

³⁵ Jim, M. A., Arias, E., Seneca, D. S., Hoopes, M. J., Jim, C. C., Johnson, N. J., & Wiggins, C. L. (2014). Racial misclassification of American Indians and Alaska Natives by Indian Health Service contract health service delivery area. *American Journal of Public Health, 104*(S3), S295-S302.

³⁶ Lieb, L. E., Conway, G. A., Hedderman, M., Yao, J., & Kerndt, P. R. (1992). Racial misclassification of American Indians with AIDS in Los Angeles County. *Journal of Acquired Immune Deficiency Syndromes, 5*(11), 1137-1141.

³⁶ Stehr-Green, P., Bettles, J., & Robertson, L. D. (2002). Effect of racial/ethnic misclassification of American Indians and Alaskan Natives on Washington State death certificates, 1989–1997. *American Journal of Public Health, 92*(3), 443-444.

³⁷ Sugarman, J. R., & Lawson, L. (1993). The effect of racial misclassification on estimates of end-stage renal disease among American Indians and Alaska Natives in the Pacific Northwest, 1988 through 1990. *American journal of kidney diseases, 21*(4), 383-386.

³⁸ Lieb, L. E., Conway, G. A., Hedderman, M., Yao, J., & Kerndt, P. R. (1992). Racial misclassification of American Indians with AIDS in Los Angeles County. *Journal of Acquired Immune Deficiency Syndromes, 5*(11), 1137-1141.

³⁹ Baugher, A.R., Beer, L., Bradley, H.M., Evans, M.E., Luo, Q., & Shouse, R.L. (January 4, 2019). Behavioral and clinical characteristics of American Indian/Alaska Native adults in HIV Care – medical monitoring project, United States, 2011–2015. *Morbidity and Mortality Weekly Report 2019; 67*:1405–1409. DOI: <http://dx.doi.org/10.15585/mmwr.mm675152a1>

⁴⁰ Ibid.

to healthcare due to actual or feared discrimination or other issues. As members of an already underserved and vulnerable minority, the intersection between both identities can lead to heightened challenges and risk. NIHB has provided comments below in response to specific objectives that are particularly important for Tribes and Tribal communities.

Core Objectives -

LGBT – 2030-04: Increase the number of states, territories, and the District of Columbia that use the standard module on sexual orientation and gender identity in the Behavioral Risk Factor Surveillance System (BRFSS)

It is important for research purposes that correct and validated language is used consistently, and critical that research includes and identifies LGBT individuals. However, the language in the BRFSS can be unintentionally exclusive of AI/AN individuals whose identities may fall outside of those categories expressed by the standard language used. Including special AI/AN terminology, such as “Two Spirit” could be more inclusive and result in better and more accurate data consideration. (This could also be more inclusive of other global cultures with similar identities.) Although “Two Spirit” individuals may also identify as LGBT, “Two Spirit” is a specific identity with added meaning and unique considerations.

Recommended change to LGBT – 2030-04: Rather than using language from the current version BRFSS, and in order to ensure inclusiveness and more accurate data collection, consider revising language to more inclusive terminology for diverse cultural views of gender expression.

LGBT – 2030-06: Reduce suicidal ideation among sexual minority high school students, including those who seriously considered suicide, made a plan, or made an attempt in the past year

AI/AN communities have been disproportionately impacted by suicide, as well as many other behavioral health challenges. Although suicide rate may vary by region and Tribe, consistent disparities exist. AI/AN people may be at particular risk for suicide due to various factors including historical trauma; existing disparities such as poverty, drug and alcohol abuse, and community violence; challenges accessing care due to an overburdened health system, geographic isolation and limited funds and transportation; and a lack of culturally-competent providers. AI/AN youth are at particular risk.

The Suicide Prevention Resource Center (SPRC) (2013) indicates that only 10-35% of AI youth/young adults accessed professional help healthcare when struggling with suicidality, and that suicide was the second leading cause of death among young adults ages 10-24.⁴¹ Living in communities where suicide is more common may also increase a young person’s willingness to use suicide as a perceived solution. As such, reducing suicidal ideation is a key means of decreasing suicide among AI/AN youth. This could be bolstered by ensuring access to culturally competent, accessible care for Tribal youth.

Mental Health and Mental Disorders (MHMD)

Plentiful research has demonstrated the disproportionate impact of mental health issues such as suicide in AI/AN communities, and especially among youth. According to CDC data under the National Violent Death Reporting System, from 2003 to 2014, suicide rates among AI/ANs across eighteen states were at 21.5 deaths per 100,000 – approximately 3.5 times higher than demographics

⁴¹ <https://www.samhsa.gov/capt/sites/default/files/resources/suicide-ethnic-populations.pdf>

with the lowest rates.⁴² The same report highlighted that 35.7% of these deaths occurred among AI/AN youth between the ages of 10 and 24, compared to 11.1% among White youth in the same age group.

In 2014, AI/ANs were also found to experience significantly higher self-reported feelings of worthlessness, sadness, and hopelessness than non-Hispanic Whites⁴³. According to the CDC, AI/ANs are 1.6 times more likely to self-report feelings of nervousness and 1.5 times more likely to report restlessness than Whites.⁴⁴ Despite higher rates of mental health issues, AI/ANs were reported in 2014 to have less access to mental health treatment or counseling services and also less likely to receive prescription medications to treat mental health illnesses.⁴⁵

Core Objectives –

Under **MHMD-2030-01** through **MHMD-2030-03**, NIHB strongly encourages HHS to develop separate success indicators for AI/AN communities in order to more accurately track progress in achieving the objective within Tribal communities. As reported by the Office of Minority Health, suicide was the second leading cause of death among AI/ANs in 2014⁴⁶, while adolescent AI/AN females are four times as likely to die from suicide than White adolescent females.⁴⁷ In addition, given lower rates of mental health treatment access among AI/ANs, NIHB also recommends that HHS develop Tribally-specific indicators for measuring progress under objectives **MHMD-2030-03** through **MHMD-2030-08**.

MICH (Maternal, Infant, and Child Health)

AI/AN communities also face health disparities related to maternal, infant, and child health. According to the Office of Minority Health⁴⁸, AI/AN people have 1.6 times the mortality rate as Whites, AI/AN babies are twice as likely as White babies to die from SIDS and 70% more likely to die from accidental deaths before their first birthdays, and AI/AN mothers are 2.5 times more likely to obtain late or no prenatal care.

Core Objectives –

MICH – 2030-08: Increase the proportion of pregnant women who receive early and adequate prenatal care

Prenatal care is important for all women to ensure a healthy pregnancy. Due to existing health disparities, AI/AN women may be at particular risk for MICH problems; this is due to factors such as diabetes, obesity, and tobacco/drug/alcohol abuse in AI/AN communities. AI/AN communities often face greater challenges due to an overburdened and underfunded health system, rural areas and

⁴² Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. *MMWR Morb Mortal Wkly Rep* 2018;67:237–242. DOI: <http://dx.doi.org/10.15585/mmwr.mm6708a1>

⁴³ CDC 2016. Summary Health Statistics: National Health Interview Survey: 2014. Table A-7. <http://www.cdc.gov/nchs/nhis/shs/tables.htm>

⁴⁴ Ibid

⁴⁵ SAMHSA, 2015. Results from the 2014 National Survey on Drug Use and Health: Mental Health Detailed Tables. Table 1.26B <https://www.samhsa.gov/data/taxonomy/term/6553>

⁴⁶ CDC. National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). <http://www.cdc.gov/injury/wisqars/index.html>

⁴⁷ Office of Minority Health. (n.d.). Mental Health and American Indians/Alaska Natives. Retrieved from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39>

⁴⁸ <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=38>

poverty or other transportation challenges, and lack of culturally competent providers. Providing special focus to increase the proportion of pregnant AI/AN women who receive accessible and culturally appropriate care could increase the percentage of women receiving prenatal care early adequately and early in their pregnancies.

Nutrition and Weight Status

With 25 percent of all AI/ANs receiving some type of federal food assistance, and in some Tribal communities as high as 60-80 percent, the importance of the Nutrition Title programs in Indian Country cannot be overstated. The Supplemental Nutrition Assistance Program (SNAP) provides benefits to 24 percent of AI/AN households; 276 tribes and 100 inter-tribal organizations administer the Food Distribution Program on Indian Reservations (FDPIR); and AI/ANs make up more than 12 percent of the participants in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), to name a few.

These participation rates hinge on limited meaningful employment opportunities, poor transportation options to food sources or food retail, lack of food retail locations in Tribal communities, the age and population characteristics of the individuals in the communities, and the prevalence of chronic health problems, among other issues. Because the rate of obesity, diabetes, chronic heart diseases, cancer, and other health problems is so high in so many communities in Indian Country, participation rates in the feeding programs coupled with the prevalence of persistent poverty create a fragile system of food access across Indian Country. A consistent, comprehensive, and tribal-led approach that is tailored to Indian Country's needs is paramount.

Core Objectives –

NWS-2030-01: Reduce household food insecurity and in doing so reduce hunger.

NIHB and Tribes remained concerned about any cuts or changes that would reduce direct AI AN participation in programs, or diminish food resources available to Native children, pregnant women, elders, and veterans. No one, especially our most vulnerable tribal citizens, should ever have to go without food. Tribal governments have consistently sought the authority to take over the administration of federal food assistance programs like SNAP, which they currently cannot run, to not only improve food access and efficiency of the programs, but to further tribal self-governance and serve the unique needs of their citizens and communities.

NIHB and Tribes have consistently advocated for the authorization and programmatic supports to allow Tribal governments and Tribal organizations to administer SNAP and all other federal food assistance programs which they are currently not authorized to directly manage. This can be achieved by providing tribes with self-governance contract authority for nutrition programs which exists for Department of the Interior and Indian Health Service programs (Public Law 638) . Allowing Tribes to take over these functions from the federal government will improve efficiency, reduce regulatory burdens, and support tribal self-governance and self-determination.⁴⁹

Opioids

AI/AN communities have been disproportionately impacted by opioid-related fatalities. According to the CDC, AI/AN communities had the second highest opioid-related fatality rate in 2016 at 13.9

⁴⁹ Native Farm Bill Coalition. (2017) Indian Country Priorities and Opportunities for the 2018 Farm Bill Title IV: Nutrition. Retrieved 1/11/19 from: <https://seedsofnativehealth.org/wp-content/uploads/2017/09/Title-IV-Nutrition.pdf>

deaths per 100,000.⁵⁰ Many Tribes lack critical health resources needed to improve overdose and addiction prevention and treatment such as timely access to naloxone; availability of behavioral health providers and culturally-appropriate care; access to medication assisted treatments; accessible treatment facilities; and the staffing capacity to conduct robust overdose surveillance and tracking. NIHB has provided comments below in response to specific objectives that are particularly important for Tribes and Tribal communities.

Core Objectives –

While NIHB does not propose any changes to the core objectives, we do recommend that HHS closely examine how they uniquely impact AI/AN communities. For instance, **OPIOID-2030-04** and **OPIOID-2030-05** are both focused on reducing heroin use. According to the 2017 National Survey on Drug Use and Health, AI/ANs aged 12 and up had the highest percentage rates of lifetime and past year drug use of any demographic at 58.7% and 23.6% respectively.⁵¹ The same report indicated high rates of prescription pain reliever misuse among AI/ANs across the lifetime and in the past month. NIHB strongly encourages HHS to examine the disparate rates of prescription and illicit opioid misuse and overdose in Tribal communities and formulate Tribally-specific strategies and programming to mitigate negative health outcomes.

Developmental Objectives –

OPIOID – 2030-D01: Increase the rate of people with an opioid use disorder receiving medication-assisted treatment

Access to medication-assisted treatments (MAT) are highly limited in Indian Country. In 2018, the IHS identified having only about 70 providers available who are trained and licensed to prescribe MAT drugs like buprenorphine.⁵² In addition, many Tribal clinics do not have the funding, critical infrastructure, or sufficient physician capacity needed to establish and maintain treatment facilities.

While HP2030 did not identify any research objectives for this topic area, NIHB strongly suggests that HHS include the recommended objectives below to better understand how these issues uniquely effect Tribal communities.

1. Explore and analyze how use of traditional healing practices in AI/AN Tribal opioid response programs have impacted rates of opioid-related overdoses among AI/ANs
2. Investigate how gaps in IHS and Tribal public health infrastructure and workforce capacity have impacted rates of opioid-related overdoses among AI/ANs

Oral Health

AI/ANs have disproportionately poor oral health outcomes. AI/AN children ages 2-5 years have an average of 6 decayed teeth, while the same age group in the U.S. population has only one decayed tooth. Furthermore, half of American Indians and Alaska Natives live in what are considered “dental

⁵⁰ 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>

⁵¹ Center for Behavioral Health Statistics and Quality. (2018). 2017 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.

⁵² Statement by RADM Michael E. Toedt, MD, FAAFP; Chief Medical Officer, Indian Health Service, U. S.

Department of Health and Human Services. Testimony before the Committee on Indian Affairs dated March 14, 2018. Retrieved from

<https://www.indian.senate.gov/sites/default/files/upload/HHS%20IHS%20testimony%20Opioids%20Indian%20Country%20SCIA%203-14-18%20revised.pdf>

shortage areas.” The Indian Health Service (IHS), the primary agency by which the federal government fulfills its obligation to provide health care to Tribes, struggles to recruit and retain dentists in rural Tribal communities.

Core Objectives –

OH-2030-01: Reduce the proportion of children and adolescents aged 3 to 19 years with lifetime tooth decay experience in their primary or permanent teeth.

As of 2014, 41% of AI/AN children aged 2-5 suffered from untreated tooth decay, compared to 10% of non-Native population 2-5 year olds. This disparity is due to historical colonialism that interrupted the sustainable way of maintaining oral health that AI/AN people enjoyed for thousands of years. Similar disparities have been found for other ages groups. In 2011-2012, 48% of AI/AN 6-8 year olds had untreated decay in primary teeth compared to 20% of non-AI/ANs in the same age range; and 53% of AI/AN 13-15 year olds had untreated decay compared to 11% of non-AI/ANs in the same age range.

Lack of access to healthful foods, regular services from a dentist, and preventative oral health infrastructure all contribute to this systemic crisis. Congressional underfunding for the IHS’s Dental line item exacerbates the issue.

OH-2030-08: Increase the proportion of children, adolescents, and adults who use the oral health care system.

Because of the severe shortage of oral health professionals in Indian Country, many Tribes struggle with inadequate oral health services. While the national average ration for dentist to patients is 1 to 1,500, the average in Indian Country is 1 to 2,800. High turnover also makes continuity of care a chronic challenge in Indian Country. To address this shortage, Tribes in Alaska have incorporated dental therapists, focused providers who specialize in the most commonly needed oral health procedures, into their oral health provider teams. The dental therapists work under the Community Health Aide Program (CHAP), which is funded by the IHS and serves Alaska Tribes. IHS is in the process of expanding CHAP to Tribes throughout the country. Several Tribes are eager to begin using dental therapy based off the success in Alaska, and IHS’s CHAP expansion will make that attainable for many Tribes.

Cultural competence is another key ingredient to increasing AI/AN use of the oral health care system. Community based providers, like CHAP and DHAT, provide a means to incorporate additional providers with knowledge of and connection to the communities they serve.

Preparedness

AI/AN communities are sovereign nations with the authority to maintain the safety and well-being of their citizens. As sovereign nations that occupy a government-to-government relationship with the US, emergency preparedness and response in these areas may differ from the rest of the population. Tribal governments can declare emergencies on their own land by requesting a Presidential emergency or major disaster or they can seek assistance under a state declaration. Of the 573 federally recognized Tribes the majority reside in rural or isolated areas which can limit response efforts, access to services, and delays in recovery. Planning for, responding to, and recovery from manmade or natural disasters and emergencies in Tribal communities can pose complex and unique challenges. NIHB has provided suggestions and comments below in response to specific objectives that are important to Tribes and Tribal communities and address the challenges they experience.

Recommended Core Objectives

1. Increase the proportion of health clinics especially those in rural areas and Indian health clinics that develop emergency operations plans, policies, and procedures.
2. Increase the number of formal cross-jurisdictional agreements between state, local, and Tribal governments to improve sharing data and information, response personnel, and other disaster and emergency preparedness and response resources and trainings for health clinics and communities.

Developmental Objectives

PREP-2030-D02 - Increase the proportion of adults who engage in preparedness activities for a widespread outbreak of a contagious disease after recently receiving preparedness information on outbreaks

AI/AN communities are disproportionately impacted by the negative outcomes of public health emergencies and disasters. It is important to support preparedness activities with training and education. A report from the Urban Indian Health Institute, Seattle Indian Health Board found that despite the factual knowledge of H1N1 in Tribal communities there was also a lack of clarity in regards to risk and some basic knowledge. There were also concerns over safety, quality of the vaccine, and unequal distribution of the vaccine in communities of color. Consulting with AI/AN communities to develop culturally relevant training and education on contagious diseases and outbreaks can help mitigate concerns and confusion and aid in increasing engagement.

PREP-2030-D03 - Increase the proportion of adults who are aware of their transportation support needs to evacuate in preparation of a hurricane, flood, or wildfire.

Many Tribal communities are in rural or isolated areas that can hinder access to emergency response resources. Improving communication to/ between Tribes and local/state emergency preparedness and response departments through cross-jurisdictional sharing can address this disparity by providing resources for evacuation procedures, access public health services such as transportation, and increase outreach and education resources to AI/AN communities to promote home and family preparedness.

Public Health Infrastructure

As sovereign governments, American Indian and Alaska Native (AI/AN) Tribal Nations have a unique government-to-government relationship with the federal government. Central to this relationship is the federal trust responsibility to deliver quality healthcare and public health services to all AI/ANs. Despite this responsibility, Tribes remain behind states and other localities in their ability to establish foundational public health capabilities, as a result of being largely left behind during the nation's development of its public health infrastructure.

Even currently, Tribal health departments are largely unrecognized such as in Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century, a report released by the Office of the Assistant Secretary of Health and Human Services. However, over 200 Tribal health departments do exist and, while having varying levels of integration with healthcare, many provide essential public health services, and all have inherent authority as sovereign nations to protect and promote the health and welfare of their citizens, using methods most relevant for their communities¹. Many Tribal health departments are actively working on performance improvement activities such as pursuing public health accreditation but, due to reasons stated above, are usually not included in the data collection opportunities, especially those that are organized by jurisdiction, such as through

the Association of State and Territorial Health Officers and the National Association of City and County Health Officials, resulting in a further omission in the national public health system and initiatives based on that data. It is from this context that the following changes (in **Bold**) are suggested to the research objectives

Developmental Objectives

PHI-2030-D06: Increase the proportion of tribal communities that have developed a health improvement plan.

NIHB would like to bring attention to the Public Health in Indian Country Capacity Scan (PHICCS), a data set specific to Tribal health departments, which is currently in progress, but may be a source for data.

Research Objectives

For each of the nine research objectives, NIHB recommends that they be revised to include the phrase **Tribal, territorial, local and state**. Including this phrase will help ensure the research encompasses the varying needs of different types of health departments, including Tribal ones.

STD (SEXUALLY TRANSMITTED INFECTIONS)

It is well documented that AI/ANs are disproportionately impacted by sexually transmitted infections. According to 2017 national surveillance data, the rate of chlamydia infection among AI/ANs (781.2 per 100,000) is second only to African Americans, and 3.7 times the rate of Caucasians. AI/ANs also had the second highest rate of gonorrhea (301.9 per 100,000).⁵³ The greatest increases in rates of primary and secondary syphilis from 2016 and 2017 were observed among AI/ANs (38.8%).⁵⁴ Furthermore, research suggests that American Indian adolescents are more likely to be sexually active, have first intercourse at younger ages, and are less likely to use condoms than their white counterparts.^{55 56} From a prevention perspective, AI/ANs reported lower confidence in abilities to use a condom correctly.⁵⁷ And with the lack of direct funding to AI/AN Tribes, Tribes often do not have the resources to support prevention activities to supplement clinical practices.

Core Objectives –

STD - 2030-01, STD - 2030-02, STD - 2030-03, STD - 2030-05

Four out of the six core objectives name a specific sex as a target of the objectives – whether male or female. This is apparently an indication of the epidemiological data available on the respective infections. However, this language can have unintended consequences. Objectives that just focus on women stress the serious detrimental biological impact that STDs can have on women and unborn children, but could inadvertently treat men as vectors of disease, divert attention from couples and relationship health, and ignore the impact of STDs/STIs on same sex and same gender individuals. Targeted prevention programming based upon culture, sexual orientation, gender identity is wholly

⁵³ Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

⁵⁴ Ibid.

⁵⁵ Rutman, S., Park, A., Castor, M., et al. (2008). Urban American Indian and Alaska Native youth: Youth Risk Behavior Survey 1997-2003. *Maternal and Child Health Journal*, 12, S76–S81.

⁵⁶ De Ravello, L., Jones, S.E., Tulloch, S., et al. (2014). Substance use and sexual risk behaviors among American Indian and Alaska Native high school students. *Journal of School Health*, 84, 25–32.

⁵⁷ Chambers, R., Tingey, L., Mullany, B., Parker, S., Lee, A., & Barlow, A. (2016). Exploring sexual risk taking among American Indian adolescents through protection motivation theory. *AIDS Care*, 28(9), 1089-1096.

appropriate and effective, and those decisions should be made at the state, local, or Tribal level. Ideally, STIs should be eliminated from all both biological sexes, and the objectives should reflect that goal. Should it be decided to maintain sex-distinct objectives, then it is recommended that HP 2030 more accurately use language that reflects the differences between biological sex and gender (as the objective use terms like “women” and “females” synonymously).

STD – 2030-01, STD – 2030-02, STD – 2030-03, STD – 2030-04, STD – 2030-05, STD – 2030-06

All of the core objectives for sexually transmitted infections hinge primarily on same manner of behavior change. Whether it be sexual behavioral risk reduction or clinical practice, none of them will be achieved without the promotion of altering individual or organization practice. American Indians and Alaska Natives experience significantly disproportionately higher rates of most sexually transmitted infections, although very little funding is allocated to the prevention of sexually transmitted infections in Tribal communities. Targeted prevention efforts with populations at higher risk, such as AI/AN communities, that seek to create individual and community-based change that are culturally aligned and achievable for community members are the manner in which the prevention objectives will be attained.

Research Objectives –

With the acknowledged higher rates of STDs among AI/ANs, as well as a distinct focus among the core objectives on increased screening rates and reduced incidence, it is important to direct funding to projects that will uncover innovative efforts for populations at higher risk. HP 2030 would benefit from research objectives that encourage increase access to testing and treatment services for AI/AN communities. Such an objective could promote pilot and demonstration projects, like mobile STD testing, mail in testing and mail out treatment, testing kiosks, expanded expedited partner therapy in communities that would not otherwise receive the benefits of such research.

Although preventing new infections is the optimal way to reduce the prevalence of any sexually transmitted infection, with the growing concern about antibiotic resistance, a research objective on exploring the efficacy of new treatment regimens is recommended.

SDOH (Social Determinants of Health)

AI/ANs experience some of the worst health inequities in the U.S.⁵⁸ These avoidable health inequities are exacerbated further in AI/AN communities by rural isolation, higher rates of poverty, food insecurity, and general lack of access to appropriate health care⁵⁹—items which fall into the realm of social determinants of health (SDOH). Furthermore, things like geographical displacement have had a significant impact on various Tribe’s food systems, leading to increased chronic disease prevalence. Consequently, historical trauma is considered an influential SDOH in Indian Country. Other significant barriers to advancing health equity in Tribal communities include multi-sector collaboration between the health system and other sectors, as well as the lack of access to health care, public health, and other SDOH data.

Core Objectives -

SDOH – 2030-C01: Increase the proportion of children aged 0-17 years living with at least one

⁵⁸ Espey, D.K., Jim, M.A., Cobb, N., Bartholomew, M., Becker, T., Haverkamp, D., and Plescia, M. (2014). Leading causes of death and all-cause mortality in American Indians and Alaska Natives. *American Journal of Public Health*, 104(S3), S303-S311.

⁵⁹ Batliner, T. (2016). American Indian and Alaska Native access to oral health care: A potential solution. *Journal of Health Care for the Poor and Underserved*, 27(1), 1-10.

parent employed year round

In Tribal communities, childrearing responsibilities do not always fall exclusively under the purview of a child's parents but may extend to grandparents as well. Consequently, it is advised that the term "parent" be broadened to include other types of caregivers.

SDOH – 2030-C02: Increase the proportion of high school completers who were enrolled in college the October immediately after completing high school

In the population 25 years and over, less than 10% of AI/ANs had a bachelor's degree in 2016, roughly half of what is for the total population (American Community Survey). Consequently, a specific focus is needed to not just improve college enrollment rates, but also college *completion* rates in Indian Country.

SDOH – 2030-C03: Reduce the proportion of persons living in poverty

AI/ANs have higher poverty and unemployment rates than the national average, with about one-in-four living in poverty (2017 American Community Survey). Consequently, a specific focus is needed to reduce poverty rates in Indian Country.

Substance Use

AI/AN communities continue to face disproportionately higher rates of substance use and addiction including earlier rates of drug use initiation; higher rates of drug overdose deaths; and lower rates of treatment access. In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that 38.7% of AI/AN youth between the ages of 12 to 17 had a prevalence of lifetime illicit drug use, while also reporting that AI/AN adolescents had the highest lifetime reported use of tobacco, marijuana, nonmedical use of pain relievers, and nonmedical use of psychotherapeutics.⁶⁰ In 2018, AI/AN youth were again reported to have the highest lifetime and past-month rates of illicit drug use, with the highest rates occurring among 8th graders.⁶¹ AI/AN youth are also reported to have some of the lowest ages of onset of drug use, further increasing the risk of addiction later in life.⁶²

Core Objectives:

NIHB highly encourages HHS to pay close attention to how the Core Objectives under Substance Use uniquely apply to Tribal communities. For example, **SU-2030-04** through **SU-2030-11** apply specifically to substance use among youth. Given the statistics highlighted above, NIHB recommends that HHS develop separate, Tribally-specific strategies and programming to reduce rates of early onset drug use and significantly improve access to drug use prevention education in Tribal communities.

SU-2030-02: Reduce cirrhosis deaths

In recent years, rates of cirrhosis deaths due to a Hepatitis C (HCV) infection have increased as a result of the ongoing national opioid epidemic. AI/ANs are disproportionately impacted by HCV

⁶⁰ SAMHSA American Indian/Alaska Native Data. Retrieved from https://www.samhsa.gov/sites/default/files/topics/tribal_affairs/ai-an-data-handout.pdf

⁶¹ Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open*. 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

⁶² Stanley LR, Swaim RC. Initiation of alcohol, marijuana, and inhalant use by American-Indian and white youth living on or near reservations. *Drug Alcohol Depend*. 2015;155:90-96.

morbidity and mortality. The AI/AN HCV mortality rate is 10.8 deaths per 100,000, compared to 4.5 per 100,000 nationally.⁶³ From 2015 to 2016, incidence rates of acute HCV among AI/ANs rose from 1.8 to 3.1 cases per 100,000.⁶⁴ In addition, rates of chronic liver disease and cirrhosis deaths are 2.3 times higher among AI/ANs than Whites.⁶⁵ Thus, NIHB strongly recommends that HHS allocate significant resources to alleviating the impact of HCV in Indian Country, which has increased the risk of cirrhosis among the population.

Developmental and Research Objectives:

NIHB also recommends that HHS develop separate research objectives specific to better understanding the root causes behind higher rates of substance use in Indian Country. Suggestions include:

1. Enhance knowledge and research around the impact of historical and intergenerational trauma on rates of substance use in Tribal communities
2. Explore the effectiveness of revitalization of Tribal traditional and cultural practices on drug use initiation among AI/AN youth

Tobacco Use

More than 1 in 4 AI/AN adults smoke cigarettes. At 26%, that's 1.5 times greater than the US smoking rate. Out of the 10 leading causes of death among AI/AN, 6 of them have been linked to smoking. A disproportionate percentage of American Indian and Alaska Natives (AI/AN) use commercial tobacco compared to other ethnic groups in the United States. In 2014, the CDC reported that 26.1% of all AI/AN adults were cigarette smokers. This rate is compared to 19.4% for whites, 18.3% for African Americans, 12.1% for Hispanics and 9.6% for Asians. AI/AN adults also have the highest usage rate for smokeless tobacco and cigars, and for the use of multiple tobacco products. Commercialization and direct marketing using American Indian images have led to an epidemic-level health problem in many tribal communities. Today, the cigarette smoking rate for American Indians is 59 percent – four times that of the general population (14 percent).⁶⁶

TU-2030-01: Reduce current use of any tobacco products among adults

High commercial tobacco use rates among AI/ANs are directly reflected in the disproportionate rates of chronic diseases in AI/AN populations, where six of the top eight causes of death are linked to smoking. The leading cause of cancer death among AI/AN populations is lung cancer.

AI/AN also suffer from much higher rates of asthma than any other ethnic group. The incidence of asthma among AI/AN children is 20% higher than any other ethnic group and AI/AN adults are 60% more likely to be diagnosed with the condition compared to adults in other ethnic groups.

AI/AN Nations have tobacco traditions that were passed down for generations. But those traditions have also been corrupted by the commercial tobacco industry, which today profits off the recreational abuse of plants that were sacred medicines for indigenous people. And still, AI/AN people are working to restore traditional tobacco practices, to reduce commercial tobacco abuse like cigarette smoking, and to prevent secondhand smoke exposure. For example, ClearWay Minnesota collaborated with Minnesota tribes to create Keep Tobacco Sacred, an advertising campaign that

⁶³ Centers for Disease Control and Prevention. Surveillance for Viral Hepatitis: United States, 2016. Retrieved from <https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm>

⁶⁴ Ibid

⁶⁵ Center for Disease Control and Prevention. Deaths: Final Data for 2014. http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf

⁶⁶ Public Health Law Center.(2018). Tribal Commercial Tobacco Control. Retrieved 1/13/2019 from <https://publichealthlawcenter.org/topics/tobacco-control/tribal-commercial-tobacco-control>

reminds and educates about the differences between traditional and commercial tobacco.

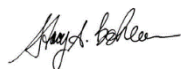
As sovereign nations, Tribes have a critical role to play in addressing the public health problems posed by commercial tobacco. This is particularly true since rates of commercial tobacco use are higher among AI/AN populations than among the general population, a fact reflected in disproportionate rates of chronic disease in AI/AN populations. Yet addressing the death and disease caused by commercial tobacco in Indian Country raises several complex issues, including the need to respect traditional tobacco use and the sovereignty of Tribes, navigate a complex area of law, and acknowledge history and culture. Any efforts should enlist members of Native communities take the lead in tackling the problem of commercial tobacco-related illnesses and cancer disparities.

Conclusion

NIHB Tribes stand ready to work with HHS 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 on HP2030, and look forward to further engagement with HHS on leveraging public health resources to raise the health status of all AI/ANs to the highest level.

Should you have any questions regarding NIHB's comments, or for more information, please contact NIHB Deputy Director and Director of Public Health Policy and Programs, Carolyn Angus-Hornbuckle, at chornbuckle@nihb.org.

Sincerely,



Stacy A. Bohlen
CEO, National Indian Health Board

ⁱ Tribes maintain "inherent powers of limited sovereignty which has never been extinguished." *United States v. Wheeler*, 435 U.S. 313, 322–3 (1978) (quoting F. Cohen, *HANDBOOK OF FEDERAL INDIAN LAW* 122 (1945)). *Wheeler* further explains that "Indian tribes still possess those aspects of sovereignty not withdrawn by treaty or statute, or by implication as a necessary result of their dependent status." *Wheeler*, 435 U.S. at 323. See also, Lawrence O. Gostin, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 5, 8–9 (2nd ed. 2008), which describes governments as not only having the power to promote the health and welfare of its citizens but also the duty and obligation to do so.