



American Indian and Alaska Native Health

STATEMENT OF THE ISSUE

BACKGROUND AND JUSTIFICATION

American Indians and Alaska Natives (AI/AN) are enduring persistent disparities in health services, including high uninsured rates, significant barriers to obtaining health services, and continued decline in health status. AI/ANs have long experienced lower health status when compared with other Americans. Lower life expectancy and disproportionate disease burden exist perhaps because of limited educational opportunities, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. The *Constitution*, treaties, executive orders and laws establish the federal government's responsibility to provide certain rights, protections, and health services to AI/ANs as a government to government relationship.

Members of 567 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS is a federal agency within the Department of Health and Human Services that provides a health service delivery system specifically for AI/ANs. IHS health services are not a type of health insurance. The current health service system is commonly referred to as the IHS, tribes and tribal organizations, and urban Indian programs (ITUs). Tribes may choose to receive health services directly from the IHS or through contracting or compacting agreements (P.L. 93-638), or they may combine these options based on their needs and preferences. This system is funded through discretionary yearly appropriations to the IHS. However, chronic underfunding for IHS and other barriers limit access to services for the population. IHS was established in 1955, and has never been funded at the appropriate level of need for health services. Historically, the range of level of need funding fluctuates between 40% to 60% which can be directly attributed to the continued decline in health status of AI/ANs.

Nationally, the ITU system delivers health services in over 670 IHS and Tribal health service facilities scattered throughout 36 states, mostly in rural and isolated areas. IHS directly operates 31 hospitals (service units), 52 health centers (clinics), 2 school health centers (clinics), and 31 health stations (satellite clinics). Tribes and Tribal organizations, through Title 1 contracting and Title 5 compacting (P.L. 93-638), operate almost 50 percent of the IHS health system. Tribes operate 15 hospitals, 256 health centers, 9 school health centers, and 282 health stations (including 166 Alaska Native village clinics). The IHS, Tribes and Tribal organizations also operate 11 regional youth substance abuse treatment centers. Additionally, the IHS provides funding for Urban Indian health centers in 34 urban areas throughout the country.¹

Not all AI/ANs are officially enrolled in a federally-recognized tribe, some belong to a state-recognized tribe, and others self-identify as AI/ANs but are not enrolled. Tribal membership has important implications for access to benefits. Members and descendants of members of federally recognized tribes have broader access to certain federal benefits and services. Specifically, enrolled tribal members have specific provisions in the *Patient Protection and Affordable Care Act (ACA)*.

There has been a major population shift of AI/ANs from rural to metropolitan areas in the last decade. Throughout the 1990s to 2005 approximately 50 percent of AI/ANs listed their primary residence as rural areas,

primarily reservations or trust lands. As the economic condition worsened there were a considerable number of AI/ANs that were compelled to leave their homes and relocate to urban areas to find employment. Current available data cites that 22 percent live on reservations and 60 percent live in metropolitan areas.² Access to urban Indian facilities are quite limited, there are only 34 IHS funded urban clinics in the Country.

ANALYSIS OF RELEVANT POLICY AND DATA

MISCLASSIFICATION OF DATA

Misclassification of AI/AN's race in mortality data is an ongoing issue that often is severely undercounted. As the majority of the AI/ANs reside in metropolitan areas this misclassification gap is widening. Often AI/ANs choose not to be identified as such due to acts of discrimination, even in 2015. This fact, and the abilities of funeral directors/coroners to accurately identify race on the death certificate from physical features results in gross misclassification.³ From a policy standpoint, this makes development of federal policies difficult with inaccurate mortality data for AI/ANs. In recent years there have been attempts made to improve this data through matching Social Security numbers with individuals that have received services at an IHS facility (IHS only serves AI/ANs) with those choosing to use other health providers' services. This is a tedious task, but has unofficially shown results of misclassification ranging from 40 to 80 percent. This is significant, and needs to be considered for policy development. Other methods are being used that match the all-cause death rate in IHS Contract Health Service Delivery Areas (CHSDA), now referred to as Purchased and Referred Care (PRC), for AI/ANs that do not use ITUs.

HEALTH DISPARITIES

Data from the IHS consistently reports that AI/ANs die at higher rates than other Americans including: Tuberculosis – 600% higher, Vehicle crashes – 229% higher, Alcoholism – 510% higher, Diabetes – 189% higher, Injuries – 152% higher, and Suicide – 62% higher.

A 2014 leading causes of death study⁴ found that AI/ANs did not experience the significant decreases in all-cause mortality seen for Whites. From 1999 to 2009 the all-cause death rate in CHSDA counties for AI/ANs was 46% more than that for Whites. Death rates for AI/ANs varied as much as 50% among regions. Except for heart disease and cancer, subsequent ranking of specific causes of death differed considerably between AI/AN and White persons. This article contains the best available data on deaths among AI/ANs between 1990 and 2009. This study used more accurate racial ascertainment in death records, and showed that the disparity in death rates between AI/AN and non-Hispanic White populations in the United States remains large for most causes of death. A concerted, robust public health effort by federal, tribal, state, and local public health agencies, coupled with attention to social and economic disparities, may help narrow the gap.

LEGAL JUSTIFICATION

The federal promise to provide Indian health services actually predates the *Constitution*.

Once the United States became independent, all branches of the federal government acknowledged the nation's obligation to the tribes and the special trust relationship that exists between the United States and AI/ANs. The federal trust responsibility to AI/ANs is grounded in the *United States Constitution* and the following major Acts: *Snyder Act*, *Indian Self-Determination and Education Assistance Act*, *Indian Health Care Improvement Act*, and

Current Indian Health System

The current Indian health system remains in despair, despite all the federal promises. AI/ANs continue to live sicker lives and die younger than other Americans. AI/ANs experience significantly higher:

- Mortality rates from alcoholism, tuberculosis, suicide, cancer, and influenza⁵
- Infant and maternal mortality rates⁵
- Rates of intimate partner violence⁶
- Levels of dental caries for AI/AN children⁷
- Incidence of drug use disorders⁸

Devastating health risks from historical trauma, poverty and a lack of adequate treatment resources also continue to plague tribal communities.

IHS FUNDING

One of the issues identified by the National Indian Health Board (NIHB) Testimony to the Senate Indian Affairs Committee, on January 28, 2015 discussed the Mandatory Appropriations for the Indian Health Service in 2013, the IHS per capita expenditures for patient health services were just \$2,849, compared to \$7,717 per person for health care spending nationally.⁹ According to NIHB, despite the historic increases that Congress has given to the IHS budget over the last several years, funding discrepancies unambiguously remain. Budgets have not kept up with medical inflation, contract support cost needs, and sequestration cuts. In previous testimony the year before, NIHB testified before the Committee on upcoming budget priorities on March 26, 2014, and noted that for FY 2016 Tribes requested \$5.4 billion for the IHS.¹⁰ Full funding to meet 100 percent of projected need would be \$28.7 billion and is practically achievable in a twelve year phase-in plan.

HEALTH SERVICES ACCESS

From the reservation and rural AI/AN perspective, there are multiple barriers to access routine health services and tremendous issues for culturally considerate and specialized services. In reality, access to primary care services is often a choice of one, and requires an ability to travel in various modes (land, air, and/or telecommunication) for access to basic professional health services. All reservations have an automatic designation of a Health Professional Shortage Area (HPSA), and the entire country, according to the Health Resources Service Administration (HRSA), is designated as a Mental Health Professional Shortage Area (with a few metropolitan exceptions). Given these factors, the ability for AI/ANs to access even minimum health services, requires extra planning, support, reliable transportation, and availability of a culturally appropriate health provider.

Many times patients will forgo their appointments with specialists because the out of pocket costs are prohibitive including: loss of work time, child/elder care, home heating maintenance (freeze-up for those who only have wood as a heating source), livestock care, and home security issues. Currently, there is little literature available that assesses these expenses. These out of pocket costs create an extra

hardship for AI/ANs, who may choose to feed their families and suffer the consequences of postponing their medical appointment until they require extensive and more costly procedures to save their life. Certainly telemedicine has a role in reducing some of these disparities, but there remains a need for more policies and development of arrangements for technology for use in rural areas.

While in the last decade there has been a major shift of AI/ANs from rural to metropolitan areas, there remains a need for improvements in rural health services as the “new” urban AI/ANs often travel back and forth between their cultural ties, including family, located in rural areas. As the economic conditions continue to offer limited employment in rural areas, this migration is expected to continue.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

The ACA offers important opportunities to increase health services and insurance coverage for AI/ANs to reduce longstanding disparities. According to the Kaiser Family Foundation policy report “Health Coverage and Care for American Indians and Alaska Natives” nine in ten (94%) uninsured American Indians and Alaska Natives have incomes in the range to qualify for these coverage expansions.²

This provision has the potential to end rationed Purchased and Referred Care services (previously called Contract Health Services program). Currently, when an AI/AN needs to have a health procedure that is not provided at an ITU, they must request a referral for such services from public or private service providers. This rationed care environment often results in comments such as, “if you need your cataracts removed, knee replaced, or other non-life threatening condition get it done when the new dollars are available at the beginning of the federal fiscal year or wait for another year and pray you are high enough on the list to receive the referral for service.” ACA provides a timely opportunity for AI/ANs to sign up for health insurance, with limited or no cost (94% of AI/ANs currently qualify for Medicaid and/or Medicaid expansion) to receive those previously rationed services at a provider within their health plan.²

However, the *Act* has issues that substantially affect the ability of AI/ANs to participate. One key caveat is the definition of an AI/AN. **The current definition of an AI/AN for Exchanges is: “an enrolled member of a federally recognized tribe”. Non-enrolled AI/ANs are not considered AI/ANs and may apply for a hardship exemption that is available to all people under the ACA. This later group includes beneficiaries of Indian Health Service/Tribal/Urban (I/T/Us) health services. This group is often referred to as IHS or ITU beneficiaries, or they fall under the IHS definition of an Indian.**

Applying the employer mandate to Tribal employers directly undercuts the ACA’s Indian-specific protections in three ways. First, it punishes Tribes for assisting AI/AN enrollment in the Marketplaces, despite the multiple ACA provisions designed specifically to encourage such activities. Second, it can disqualify AI/ANs from eligibility for premium tax credits in Marketplace plans, thus leaving them unaffordable. Third, it ignores the fact that AI/ANs are exempt from the individual mandate and forces Tribal employers to pay for AI/AN insurance plans as a proxy for the individual. None of these outcomes benefit Tribal employers, individual AI/ANs, or the federal government.⁹

The current call centers have proven to be inadequate at answering questions related to the special benefits and protections available to AI/ANs and have often caused greater confusion and application errors. An actual

example of an answer from a call center employee was unbelievable and illegal. The question to the center employee was “how to find her tribe from the list on the application form, it was not listed.” The response was “just pick any tribe.” Needless to say, this is just one example of inappropriate responses. Other problems exist with state sponsored sites, that do not have provisions to inform the applicant about AI/AN special cost provisions. This has resulted in numerous AI/AN applicants who have not enrolled, because of the inaccurate costs that are quoted to the AI/AN. Further and very unfortunately, the image of federal broken promises continues to be fueled by these incompetencies.

There are still thousands of exemption applications that have yet to be processed with no discernible reason as to what the problems are. A large portion of those applications that have been processed, have been processed incorrectly and require prompt resolution so that AI/ANs can be issued exemption certificate numbers. These problems have all contributed to low enrollment, as many AI/AN are still confused about the benefits of the ACA and see no reason to sign up. An AI/AN call center would be one solution, since it would be more culturally sensitive and in certain cases, linguistically equipped to answer calls where the caller only speaks their native language. Tribal leadership has requested this option for over two years, but this proposal has gone unanswered at CMS, despite the fact that the Administration has developed call centers for other minority groups (e.g. native Spanish speakers). This is difficult to understand as the federal government does not have a special trust responsibility towards other minority populations. AI/ANs not only speak languages other than English, but the law applies to them in a completely different way, thereby increasing the need for a native-specific call center.⁹

HEALTH WORKFORCE

Access to a long serving quality workforce is one of the significant barriers to achieving high quality health services at ITUs. Remote and rural locations, lower pay, lengthy hiring processes, and limited equipment at ITU facilities all effect the ability for providers to be recruited and retained within the ITU system. According to a survey of Indian health program facilities 45% of their administrators identified an urgent need for primary care doctors while only 17% of the administrators surveyed reported their facilities are fully staffed.¹¹

The health service needs of AI/ANs have unique qualifications of providers. Consider the historical actions of colonization, genocide, wars, forced relocation, boarding schools, discrimination, broken treaties and promises, economic conditions, and political injustices upon AI/ANs. These actions have resulted in an entire population that has been traumatized and forced to survive in a learned dependency environment. Often this practice environment overwhelms health service professionals, and leads to early burnout or limited years of service.

One solution supported by the IHS and Tribes is making IHS scholarships and student loan repayments for health service professionals tax exempt. This would create parity between IHS and other federal health providers such as the National Health Service Corps. The President’s FY 2015 budget recommendation for the IHS supported this approach noting, “The inability to fund 577 applicants who were not currently working for IHS is a significant challenge for the recruitment efforts of the agency”. The Budget request also noted that “IHS, as a rural health care provider, has difficulty recruiting health care professionals.” There are more than 1,550 vacancies for health care professionals within the IHS system.⁹

BEHAVIORAL HEALTH

There are numerous examples in the literature of mental health disparities. Among AI/AN people, there is a wide range of beliefs concerning illness, healing, and health. The concept of mental illness and beliefs about why and how it develops have many different meanings and interpretations among AI/ANs. Every tribe had their own

cultural traditions that was the foundation of how each tribe maintained their own holistic view and well-being of their citizens. Successful behavioral health services have proven that the use of those traditions to ground their healing practices are the most effective. Often physical complaints and psychological concerns are not distinguished and AI/ANs may express emotional distress in ways that are not consistent with standard diagnostic categories.⁸

The ACA offers significant opportunities to begin to ameliorate the impact of mental illness and drug abuse (here after referred to as “behavioral health” as a summary term) upon the lives of AI/AN. Behavioral health issues have been profoundly underestimated and culturally undefined in the AI/AN population. Most troubling is the fact that much of the personal and societal burden of behavioral health conditions and issues could be prevented or alleviated if people at-risk for experiencing these conditions had access to and received culturally appropriate prevention and treatment.

Behavioral health provisions in the ACA include specific language for government to government relations for tribes and tribal organizations, urban Indian programs, and the Indian Health Service. Additionally, there are public sector sections that would be available, often working with a state, but also directly with federal departments. There are provisions that specifically name tribes: Sections 3502, 4001, 4201, 4202, 5101, 5405, 5507, and 10306; and one (1) Section 5507 that names urban Indian programs.

Public Health Model Adoption

In Indian Country, public health support is virtually non-existent. While much of the U.S. population has access to government-sponsored, accredited health departments, behavioral health facilities, or alcohol and substance abuse treatment facilities, these facilities are rare in Indian Country. Combine this with high rates of poverty, widespread historical trauma, and adverse childhood experiences, and the problems seem insurmountable⁹.

RECOMMENDATIONS FOR NRHA POLICY POSITIONS

Policymakers are encouraged to “first do no harm” to AI/AN health programs. To protect Indian health programs the following provisions are recommended for inclusion in any legislation and regulations. Please note that the first nine are continued from the 2006 Issue Paper.

1. Include “tribes,” “tribal organizations,” and “tribal” when listing governmental entities. Without specific wording, Centers for Medicare and Medicaid Services (CMS) may not give tribes the same consideration as other governments. It is vitally important that this recommendation be followed, history has proven over and over again that the government to government relationship is compromised if not. The appropriate language for policies is: federal, state, tribal, and local governments.
2. As appropriate, include specific wording acknowledging the I/T/U as a special type of provider essential for AI/AN access to Medicaid, Medicare, and SCHIP programs. The wording of such an acknowledgement is necessary based on the legal classification of AI/ANs as dual citizens. (Dual citizens have the choice of using Indian specific and/or public sector programs/services.)
3. State that AI/ANs are entitled to health services on the basis of their enrollment in federally recognized tribes and/or descendants of enrolled members of tribes. Explicitly recognize the special relationship AI/ANs have with the federal government as a political group to establish policies that demonstrate recognition of the government-to-government relationship. AI/ANs are not to be classified as a minority, or a racial group, but as sovereign nations.

4. If new legislation creates special programs to address health disparities, inequities or access to care, include AI/ANs in lists of target groups.
5. Funding should be provided to I/T/Us for implementing new programs and regulations.
6. Explicitly require that CMS and states assess impact on tribes and conduct tribal meaningful consultation prior to issuing regulations, policies or State Medicaid Plans that affect AI/AN.
7. Explicitly require that CMS assess proposed legislative and regulatory changes that impact tribes, and conduct meaningful tribal consultation prior to submitting legislative changes, issuing new regulations, and policies that affect AI/ANs. Numerous Executive Orders from four administrations have supported this. However, there remain some state waiver requests that have been approved by CMS without the required meaningful tribal consultation.
8. Traditional practices and customs must be respected. Respect for cultural beliefs requires blending of traditional practices with a modern medical model and emphasizing public health and community outreach. The CMS should include access to traditional medicine as part of the services available to AI/AN people and fully recognize traditional medicine as an integral component of the Indian health care delivery system.
9. All venues for the use and reimbursement of tele-health technologies should be pursued to relieve the disparity of access to all health services (e.g. home care, specialists, follow-up treatments) including building new collaborations with the Veterans Affairs for tele-health and reimbursement.

RECOMMENDATIONS (NEW)

1. Suicide is catastrophic in Indian Country. Last year (Feb. 2015), there was a state of emergency declared on the Pine Ridge Reservation. It was reported there were five (5) suicides in one month. There needs to be a coordinated, multidisciplinary effort involving federal, state, tribal, and local health officials to address this important public health issue.
2. The AI/AN populations continues to experience much higher death rates than Whites. Patterns of mortality are strongly influenced by the high incidence of diabetes, smoking prevalence, problem drinking, and social determinants. Much of the observed excess mortality can be addressed through known public health interventions.
3. Improve the ability to determine race classification among AI/ANs to strengthen AI/AN mortality data. Also data would be more valid if deaths were analyzed by geographic region to aid in planning, implementation, and evaluation of efforts to reduce health disparities in this population.
4. There needs to be emphasis placed on improving accuracy of all AI/AN health data. Proven methods of matching AI/AN Social Security numbers with health services provided at non-ITUs would have significant benefits for all health policy development. The only delimitation of this policy suggestion is the fact that it would only identify AI/ANs that have used an ITU service sometime in their lifetime, including IHS's CHSDAs now referred to as Purchased and Referred Care (PRC). Improvements in AI/AN accurate data is essential for effective and efficient health policy development.
5. Improvements in education and awareness of cancer screening benefits continue to be needed in rural areas. There needs to be better access to specialists to prevent unnecessary morbidity and premature death as the entire rural population tends to be over represented by the baby-boom generation turning 65 years of age.
6. There needs to be an improved cancer surveillance data policy adjustment for AI/AN communities. This adjustment is a critical need for accurate planning, implementation, and evaluation of more effective cancer controls, and would have an impact on reducing all cancer health disparities in the AI/AN population.
7. Because of the more rapid increase of kidney cancer incidence in AI/ANs and the less favorable mortality trend compared with Whites, additional studies are needed to explain the differences in incidence and mortality that would reduce and eliminate racial disparities for this disease. Continued monitoring of kidney cancer patterns through surveillance is warranted to track progress in eliminating racial disparity in kidney cancer. Given the high prevalence of obesity, smoking, and hypertension, more public health interventions are

needed such as healthy diet and physical activity promotion, tobacco cessation, and early detection and control of hypertension.

8. It is well known that diabetes can affect many parts of the body and is associated with serious complications, such as heart disease and stroke, blindness, kidney failure, and lower-limb amputation. Some complications, especially microvascular (e.g. eye, kidney, and nerve) disease, can be reduced with good glucose control. While current programs in the AI/AN health service system have exemplary programs that have impressive results compared to the public sector, there remains an urgent need for continued persistence for prevention. New innovative approaches are needed for early detection and treatment of complications which can prevent development and progression of this devastating condition for AI/ANs.
9. Proven strategies that reduce alcohol consumption should be considered dependent upon community recommendation and acceptance. These may include: established cultural interventions, early age education, drug courts, increasing alcohol taxes, increased law enforcement. The intervention must be accepted and endorsed by the respective community for best results.
10. Continuing efforts to improve pneumococcal conjugate vaccine coverage among AI/AN children, and increased awareness of the importance of early antiviral treatment of influenza among providers and AI/AN communities is needed. Continuing to strengthen on-going surveillance efforts to better identify the disease burden among AI/AN people at local and regional levels is essential to increase public health action to address disparities. Although progress has been made in reducing pneumonia and influenza mortality, disparities between AI/ANs and Whites persist. Strategies to improve vaccination coverage and address risk factors that contribute to pneumonia and influenza mortality are needed.
11. The decrease in death rates from HIV and TB was greater among Whites, but death rates remained significantly higher among AI/AN individuals. Public health interventions need to be prioritized to reduce the HIV and TB burden and mortality in AI/AN populations.
12. AI/ANs have consistently higher unintentional accident death rates than Whites. This disparity in overall rates coupled with recent increases in unintentional poisoning deaths requires that injury prevention be a major priority for improving health and preventing death among AI/AN populations.
13. The American Psychiatric Association, (2010) recommends the following responses and approaches to address the barriers to mental health services for AI/ANs:
 - Increase awareness of mental health and chronic disease connections, e.g. diabetes
 - Conduct stigma awareness training with gatekeepers
 - Educate providers about unique mental health issues
 - Increase presence of AI/ANs in research (researchers and subjects)
 - Advocate for policies that promote social justice, equity, and equality
 - Advocate for comprehensive, (including mental health and substance use disorders), affordable, health insurance coverage for all
 - Focus on prevention, early intervention
 - Develop systems that endorse integration of traditional healing and spiritual practices
 - Increase use of technologies (e.g. telepsychiatry) to better serve remote populations
 - Increase person-centered care and respect for the role of the family¹²
14. There are still thousands of ACA hardship exemption applications that have yet to be processed, including those that have been processed incorrectly. These problems have all contributed to low enrollment, as many AI/AN are still confused about the benefits of the ACA and see no reason to sign up. As there seems to be no acute solution for the near future, there is one way to dramatically improve AI/AN enrollment. There needs to be an establishment of an AI/AN call center that would be more culturally sensitive, know the special AI/AN provisions, and in certain cases be linguistically equipped to answer calls where the caller only speaks their native language.

15. At this time the ACA impact for AI/ANs is unclear, but there is potential for innovative, far reaching treatment and prevention programs, an emergency demonstration project, education and trainings, school based centers, leadership development, work force development, research, data base development, loan repayment, and reimbursement improvement for behavioral health services. Every opportunity from the ACA needs to be supported by all policy developers.

CONCLUSIONS/SUMMARY

The health delivery system remains critically challenging for all rural Americans. This challenge is basic, there needs to be policy, support, and advocacy to maintain at the very least a minimum threshold of services. This minimum is being challenged from the ACA and resulting policy; the closing and potential closing of more Critical Access Hospitals is a prime example. The lack of access for rural residents to basic emergency services, primary and mental health services, and reasonable local inpatient services will cost lives.

We still live in an environment where rural residents (especially elders) feel an urgency to move to town when they retire so they will have access to health services. It is unfortunate in our great country elders feel the necessity to literally move from their lifelong residence in order to access health services. Further, those who cannot afford to relocate simply go without services. The likely potential for access to health services in small towns being eliminated, negates even this option for access to services, resulting in driving extra distances on secondary roads and in challenging climates. If this trend continues, all of our rural residents will be disproportionately negatively affected to access basic primary care services. Action needs to be taken in concert with NRHA to advocate for continued access to services in rural areas.

History and current health statistics remain especially alarming for AI/ANs. Addressing health equity continues to be a complex undertaking for the 567 federally recognized tribes, with varied cultures, infrastructures, and environments. There continues to be barriers, including poverty, alcohol use, unintentional injuries and deaths, and complexity of tribal structures and jurisdictions.

When Congress passed the ACA, it also permanently reauthorized the *Indian Health Care Improvement Act* (IHCIA). The IHCIA provides new authorities for AI/AN health services, however, additional actions are needed to fully implement the ACA. Specifically, more needs to be done on behalf of the IHS and Congress to take advantage of these new authorities that have the potential to start to reduce the health inequities for AI/ANs. The battle for IHCIA renewal was over ten years in the making. When this historic law was signed, Indian Country was elated by the promise of a new and more efficient health service delivery system for AI/AN people. However, five years later many of the provisions of the ACA remain unfunded or not implemented, and in many ways, represent yet another broken promise for AI/ANs.

It is incredibly painful to continue to report that the health system is broken not only in Indian Country but for all of our rural residents. There remain substantial differences of health equity for AI/ANs and a critical need for continued advocacy from NRHA. The relationship between NRHA and AI/AN policy support has been extremely beneficial. As rural AI/ANs continue to literally fight for their lives, advocacy and collaboration from NRHA is a key asset in these efforts.

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Policy paper approved February 2016 by the Rural Health Congress.

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