ASU Indigenous Health Summit

Reimagining Indigenous Health due to COVID-19

College of Health Solutions
Arizona State University

Indigenous Land Acknowledgement

ASU's College of Health Solutions acknowledges the 22 Native nations that have inhabited this land for centuries. Arizona State University's four campuses are located in the Salt River Valley on ancestral territories of Indigenous peoples, including the Akimel O'odham (Pima) and Pee Posh (Maricopa) Indian Communities, whose care and keeping of these lands allows us to be here today. The College of Health Solutions acknowledges the sovereignty of these nations and seeks to foster an environment of success and possibility for Native American students and patrons. As a college, we strive for the incorporation of Indigenous knowledge systems and research methodologies within contemporary health practice. The College of Health Solutions welcomes members of the Akimel O'odham and Pee Posh and all Native nations.

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Arizona State University Indigenous Health Summit Acknowledgements

Executive Leadership Team

John Molina (Pasqual Yaqui/Yavapai Apache), Native Health Urban Indian Clinic Co-Chair

Jacob Moore (Tohono O'odham/Akimel O'odham/ Lakota/Dakota), Arizona State University Co-Chair

Michael Allison (Navajo), Arizona Department of Health Services

Isaiah Belknap (San Carlos Apache), San Carlos Apache Healthcare Corporation

Stephanie Big Crow (Oglala Lakota), Research Consultant

Damon Dixon (Hopi), Phoenix Children's Hospital

Miguel Flores (Pascua Yaqui/Tohono O'odham), Indigenous Wellness Consultant

Gerilene Haskon (Navajo), Blue Cross Blue Shield of Arizona

Chairwoman Gwendena Lee-Gatewood (White Mountain Apache), White Mountain Apache Tribe

Daryl Melvin (Hopi/Navajo), Melvin Consulting PLLC

Kenneth Poocha (Hopi), Arizona Department of Child Safety

Kimberly Yellow Robe (Rosebud Sioux), Banner University Health Plans

Kim Russell (Navajo), Arizona Advisory Council on Indian Health Care

Shawn Sellers (Navajo), United Healthcare Community Plan AZ

Facilitator

Nate Wade, Arizona State University - College of Health Solutions

Report Contributors

Jaxson Jeffery, Medical Student at Mayo Clinic Alix School of Medicine - Arizona

Andrea Preston (Navajo), Arizona State University - College of Health Solutions

Letter From Summit Co-Chairs Dr. John Molina and Jacob Moore

Our heartfelt appreciation goes out to all who gave of their sacred time and efforts to participate in the 2021 Indigenous Health Summit. This event was conceived in light of the perpetual struggle of improving the health status of Indigenous people, and was fueled by the impact of the COVID-19 pandemic. To address such a comprehensive and complex issue as Indigenous healthcare, it became readily apparent that it was critical to engage the expertise of health partners, from various healthcare domains, to engage in meaningful dialogue to explore the possibilities of practical and short-term solutions to improve Indigenous health and wellness. The ideas and recommendations provided by the participants in the breakout sessions not only reflected their wisdom and knowledge within their respective field of healthcare, but more so exhibited a spirit of compassion and humility to improve the health of our most vulnerable population. For indeed, the collective recommendations brought forward by the Indigenous Health Summit, in addressing key focal areas, can contribute to significantly improving the health status of our Indigenous population as well as future generations.

With gratitude,

John Molina, MD, JD
Co-Chair, 2021 Indigenous Health Summit
Corporate Compliance Officer
Native Health

Jacob C. Moore, EMBA
Co-Chair, 2021 Indigenous Health Summit
Associate Vice President of Tribal Relations
Arizona State University

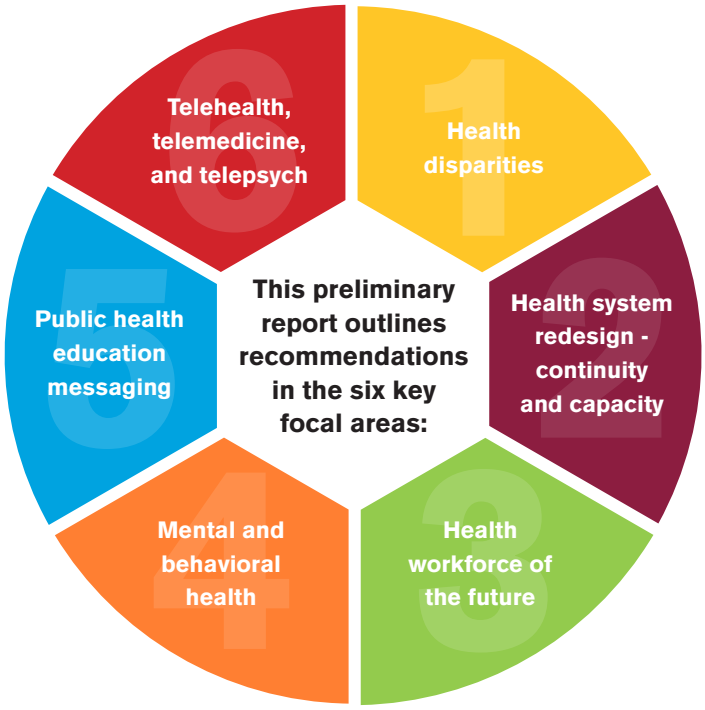

TURN AROUND
STAY HOME
COVID 19
#SAVE THE REZ

Executive Summary

As the COVID-19 pandemic spread throughout the U.S. in 2020, Tribal Nations and Communities experienced a disproportionate burden of illness and death due to the pandemic. Longstanding Indigenous health disparities and inadequate health care delivery infrastructure were exacerbated by the COVID-19 pandemic. To confront the challenge, Arizona State University's (ASU) College of Health Solutions worked with Jacob Moore (ASU) and Dr. John Molina (Native Health Urban Indian Clinic) to bring leaders from across the health care ecosystem to share insights and recommendations on how to best reimagine and rebuild Indigenous wellness and health care systems.

On January 25, 2021, the *Reimagining Indigenous Health due to COVID-19: ASU Indigenous Health Summit* was held virtually. ASU and the leadership group extended an invitation to a select group of thought leaders from government, industry, public health, academia, foundations, NGOs, and clinical care to strengthen Indigenous wellness and health care systems during and after the COVID-19 pandemic.

This health summit was an interactive, engaging, and solutions-oriented event where all participants were encouraged to contribute their ideas, knowledge, and wisdom especially during the summit breakout sessions around the six key focal areas. Breakout teams were asked to develop ideas, recommendations, and solutions to the pressing issues related to Indigenous wellness and health care within tribal communities and share ways in which Arizona State University can strengthen its commitment as a collaborative and trusted partner for Indigenous communities.

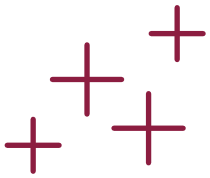


Summit Executive Leadership Recommendation Summary

Create a Summit white paper that includes ideas and recommendations from the summit.

Focus on the Health Workforce of the Future and support programs and infrastructure for K-12, college, and professional or graduate school students.

Encourage a statewide telehealth planning group focused on multiple health professions.



Increase ASU's College of Health Solutions commitment to Indigenous health.

Facilitate conversations and workshops related to data sovereignty for Indigenous communities including but not limited to Indigenous biogenetics.

Identify creative and adaptive solutions to embrace and support traditional health practices.

Reimagining Indigenous Health Due To COVID-19 Summit

The term Indigenous is used to refer to our Native American population. For use in this report Indigenous is defined as a human ethnic culture that has not migrated from its homeland and is not a settler or colonial population. Healthcare for our nation's Indigenous population, Native Americans, has had a turbulent history, beginning with healthcare oversight by the U.S. military during the Indian wars, followed by various governmental agencies and eventually the Indian Health Service (IHS), created in 1955.[1] Historically, the provision of healthcare services for our nation's Indigenous population is based on treaties between the U.S. government and subsequently statutory laws, which is the basis of the trust responsibility between the U.S. government and Native American tribes.[2] Under this legal framework, Indigenous people are the only ethnically and culturally distinct people in the U.S. that have a right to healthcare.

Unfortunately, since colonization, and despite the presence of the Indian Health Service, our Indigenous people continue to suffer high health disparities, due mostly to chronic disease, the Social Determinants of Health, and recently the COVID-19 pandemic.[3] Scholars have noted that this high health disparity is linked to the impact of the intergenerational effects of historical trauma during the period of European colonization. Historical trauma is the result of Indigenous genocide due to deaths from exposure to unfamiliar foreign diseases, wars, and massacres, as well as forced relocations of tribes from their traditional and sacred lands, and the forced placement of Indigenous children into government boarding to schools in efforts to exterminate their culture.[4]

The COVID-19 pandemic has made it even more transparent that the current Indigenous healthcare system is broken. This is evident by the high transmission and COVID-19 infection rates, as well as the high mortality rates of our nation's Indigenous people. To set the stage to reimagine Indigenous healthcare, this summit was staged as an interactive, engaging, and solutions-oriented event. This event convened thought leaders from federal, state, and tribal governments, industry, public health, academia, foundations, NGOs, and clinical care to contribute their ideas, knowledge, and wisdom. Breakout teams developed ideas, recommendations, and solutions to pre-identified issues related to Indigenous health care within tribal communities due to the pandemic.

When planning for strategic change within the Indigenous healthcare environment, it is critical to consider their culture, values, and traditional beliefs. In today's healthcare environment, Indigenous and western base healthcare very frequently intersect, and it is not uncommon for Indigenous people to utilize their traditional practices along with allopathic approaches for healing. Such practices can include spiritual ceremonies and the use of Indigenous herbal remedies, in treatment of disease as well as part of their health and wellbeing.[5] Aligning traditional Indigenous healing practices with western healthcare approaches has the utility of creating a design for a holistic care approach that is embraced by Indigenous communities.

This report presents a summary of the findings of the top challenges presented at the summit and subsequent recommendations to reimagine and rebuild the Indigenous health care system. Rebuilding of the Indigenous healthcare system will ultimately lead to improving health outcomes during future pandemics and other public health crises, but most importantly through creative and strategic partnerships, create a system that is responsive and nimble to the health needs of Indigenous people, thus reducing health disparities and improving their quality of life for current and future generations.

Breakout Session Summaries

ASU sent out a targeted invitation to leaders representing various tribal communities, the teams consisted of healthcare leaders and health professionals, tribal liaisons, tribal nation leaders, directors of workforce development, and traditional healers.

There was a total of six breakout sessions, with an opportunity for attendees to attend one session of their choice.

- Health Disparities
- Health System Redesign - Continuity and Capacity
- Health Workforce of the Future
- Mental and Behavioral Health
- Public Health Education Messaging
- Telehealth, Telemedicine, and Telepsych

Process

Each breakout session was facilitated by a member of the leadership team, and three questions were developed for each of the 75-minute breakout groups. In addition to pre-assigned facilitators, a notetaker was also assigned to each breakout group. Due to the virtual nature of the health summit, the breakout room function was utilized within the Zoom platform.

Each session began with an introduction to the topic and the facilitators directed participants to the guided questions. The notetaker captured the discussion and ideas in response to the questions as well as recommendations. The breakout sessions were interactive, engaging, and solutions-oriented and resulted in short-term and long-term recommendations. Below is a summary of the breakout session outcomes and recommendations as identified by the participants.

Health Disparities

This breakout session was facilitated by Kimberly Yellow Robe (Rosebud Sioux) from Banner Health and focused on the health disparities in Indian Country amidst COVID-19. The health disparities breakout group included 16 tribal and healthcare leaders and health professionals.

American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist due to numerous factors including but not limited to inadequate education, disproportionate poverty, access to utilities and health care, discrimination experienced in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.[6]

Historically, westward expansion accompanied by governmental policies attributed to numerous health differences among Indigenous populations compared to the general population.[7] Today, it is important to understand the key factors which contribute to enormous health disparities persisting today. Native Americans have a national poverty level of 25% with the median income of $29,000 for individuals living on the reservation.[8] Poverty, which influences stress levels, food choices, healthcare quality, education, and housing, is considered to be the most significant social influencer of health outcomes.[9]

As we understand these factors and discrepancies experienced by Indigenous communities, increased sensitivity surrounding their needs is crucial for closing the extensive gap in health status. The effects of the current pandemic have only exacerbated health disparities which is evidenced by the disproportionate rates of COVID-19 related to incidence, mortality, and age among American Indian and Alaskan Native communities.[10]

Framework Questions:

- What is the main cause of death and/or disability among Native Americans?
- What is the main contributor to Health Disparities among Native Americans?
- How can we change our current health system in Arizona to improve the health of Native Americans?
- What investments are most critical to advance data-driven planning through prioritizing investments in population health to build a more equitable future?

Breakout Session Recommendations:

- To develop a coalition from the Summit to start taking holistic action. Summit Coalition stakeholders identified are Indigenous community leaders, Intertribal government relations, health care systems, and academic institutions.
- Identify available funding and technical support to assist tribal communities with Community Needs Assessments (CNAs) and develop a plan to help complete them when an assessment has not been identified. Indigenous community leaders, Intertribal government relations, health care systems, academic institutions, and National Indian Health Board are the stakeholders in this area.
- Identify technical assistance that academic institutions can contribute, such as a Grant Procurement Officer geared towards assisting tribes in identifying funding sources for initiatives addressing the needs identified in the Community Needs Assessment.

Group Discussion Notes:

The term "social influencers" is preferred rather than "social determinants of health" because they are factors that can change and do not have to determine one's fate. Food insecurity also plays a role in an individual's ability to manage a chronic disease. Telehealth has been implemented, but how do Elders access it with limited access to broadband in rural areas? The group would like to see more of a connection to traditional healing, without placing the traditional healers at risk. Continuing COVID-19 education to help understand what is happening and when you go into a hospital does not necessarily mean you will not come out. There is a shortage of health professionals and community health workers.

Assessing data-driven decisions, 85% of maternal mortality was preventable. Capacity is different among different tribes by size and economics. Tribes closer to Phoenix have collaborative relationships with community partners. We need to have a proper understanding of true population health to determine what investments are best. All investments go from reactive (symptomatic) to proactive (wellbeing).

Investments in data-driven planning require a focus on equitability. Patient data outcomes for minority groups are less than what would be typical for the majority, so we must clearly assess the model. The focus is overall wellbeing with an emphasis on individual chronic disease management while focusing on social influencers. The investment in resources for communities should be based on community needs assessment. An investment that is most critical to be data-driven is data that requires a clear review and not accepting bias as meeting a marker of success.

Strong Systems, Stronger Communities (2018) is a funding opportunity provided by the National Indian Health Board (NIHB) and supported by the CDC. This opportunity builds on a former project-NIHB's Tribal Accreditation Support Initiative (ASI). It continues NIHB's commitment to strengthening Tribal public health systems by offering support and technical assistance specifically to Tribal public health systems by providing support and technically assistances as they complete projects to improve their performance, meet national public health accreditation standards, and promote interconnection across the public health system to improve population health: https://www.nihb.org/tribalasi/index.php.

Health System Redesign – Continuity and Capacity

This breakout session was facilitated by Daryl Melvin (Hopi/Navajo) from Melvin Consulting PLLC and included 16 tribal and healthcare leaders and health professionals representing 7 tribes and 9 healthcare organizations plus numerous allies all tasked to address three questions to develop recommendations. The questions prompted robust discussion with numerous thoughts and ideas distilled into recommendation areas with a focus on priorities to implement within the next 6 months.

The health care of Indigenous people has been implemented federally with a three-division system including the Indian Health Service (IHS), contracted Tribal programs, and urban health.

The United States government enacted Public Law 93-638 also known as Indian Self-Determination and Education Assistance Act (IDSEAA) in 1975. This act was meant to empower Tribal governments to take direction and control of implementation and funding of federally funded programs such as IHS. More specifically, it would give Tribes the option to make a contract where they assume administrative powers of a federal programmed providing services to Tribal members.[11] Additionally, Urban health services are an avenue for urban located Native Indian and Alaskan Native communities to be provided culturally competent health care in a variety of ways.[12]

Educating and encouraging Tribal leaders to take advantage of these acts while redesigning their health systems would improve the health disparities experienced by Indigenous communities. This would include increased traditional and cultural awareness among health facilities, ability to meet tribal needs, and enhanced services.[13]

As the health system infrastructure is improved, continuity of care is also an important factor to be considered. Health outcomes are improved as medical teams can work together in order to provide coherent multidisciplinary care for patients. This is especially important for Indigenous communities which battle increased rates of chronic illness.[14]

Framework Questions with Responses:

Think about a time you personally experienced healthcare services that exceeded patient expectations by receiving excellent customer service? How can we work towards more of these types of positive experiences for Native people at healthcare facilities?

- More training and cultural competencies.
- We want babies born in our facilities with a traditional water blessing.
- Mentoring programs in our facilities to mentor your local health professionals to become administrators and future leaders.
- Transition facilities into 638 (tribally operated) status.
- Shift paradigm from science-based system only to incorporate native medicine belief systems as well. Native medicine should be seen as a strength.
- Facility ambassadors to greet patients at the door and help with health system navigation.

Health System Redesign – Continuity and Capacity

What do you see as tribally operated or Indian Health Service (IHS) operated health systems' top needs in the near-term future? Note that to effect change when addressing systemic inequalities, we need to look at root causes. How do we move from a band-aid approach to addressing the root causes of healthcare inequalities?

- The new IHS director needs to have experience working with Native people and understand the culture and have historical knowledge. It would be best to be a Native American to give us a voice.
- The IHS Director needs to be a strong supporter of 638 (tribal contracting) and have knowledge of how the government works.
- We should focus on patient-centered care.
- The federal government must build trust with ALL tribal communities.
- Prepare tribes to shift to 638 (tribal contracting) facilities.
- Better data sharing systems.
- Better education of tribes on healthcare processes in their native language.

If you could wave a magic wand and fix infrastructure issues in the healthcare system, what would your top 2 priorities be and why? For example, describe a single significant contribution that technology currently makes to the healthcare system for Indian people. What investments are most critical to advancing technology or data-driven planning in health systems for all Indian people that build a more equitable future?

- Buildings are very old and lack information technology (IT) capacity. Improve buildings with better IT capacity.
- The resource patient management system (RPMS) is archaic and doesn't work well with 638 (tribally contracted) facilities. Update facilities to meet 638 (tribally contracted) capacity needs and provide a better information exchange system to improve connectivity.
- Recognize Tribal Practice-based Evidence vs. western Evidence-based Practice. Example, the Hopi 20-day Baby Ceremony strengthens the mother's bond with the child which leads to better health outcomes. Other tribes have examples too.
- Data drives decisions. Need to gather and share data in a way that builds trust while respecting culture.

At the end of the day what would you like to hear people in Arizona say about their health care system? What immediate steps would move us in that direction

- Feeling comfortable going to a Native American facility. Not feeling like you are just a number.
- At Native American facilities, you are with people with similar experiences and backgrounds.
- Native American facilities are an extension of your family.
- We have attentive Community Health Representatives.

Breakout Session Recommendations:

- Work on adaptive solutions (vs. technical solutions) for leadership and management system-wide across primarily IHS and to a lesser extent tribal systems. This includes policies. e.g., Integration of traditional wellness concepts, respect for practices, support for Indigenous ways of knowing.

Develop a recommendation paper

- Renewed training for healthcare/IHS professionals on culture and competencies.
- Renewal of national direction and support vs leaving it to a local unfounded and regional initiative. Consistency in training areas and rollout is required.

Recommendation to IHS

- Mandate Integration of native health practices into whole-patient healing constructs. Formally recognition that native medicine is a strength, including tribal specific or region-specific language. Advocate for the inclusion of traditional practices in reimbursements. (Develop a recommendation paper and submit to IHS)
- Recommend support for Tribes to operate their health systems, while stressing the importance of meeting tribes where they are at, in their journey to operate their health systems. A Health care system is inclusive of primary care, ambulatory care, inpatient, tertiary care, contract care, Behavioral/mental health, EMS, substance abuse, and associated wrap-around services. Request IHS change its Mission Statement to add language that requires support for tribes to control and manage their healthcare resources through 638-contracting. (Develop a recommendation paper and submit to IHS)
- Formal recommendation on appointment of a new IHS Director. The nominees have direct experience working in a local capacity with tribes and that they demonstrate they are rooted in native culture and the collective history of Indian people. Finally, they must advocate for changes to Indian Health through transformational change.
- Recommend creating healthcare Ambassadors in health settings to greet all patients. Also to create executive leadership mentoring/shadowing programs to grow our own Native healthcare leaders. (Develop a recommendation paper and submit to IHS)
- Increase and improve Information Technology infrastructure by creating data sharing agreements between Tribes/State/IHS for improved healthcare decision-making. All agreements must legally enforce that tribes own and control their health data.
- Improve electronic health records connectivity and data-sharing across ITUs for continuity of health for individual Indian people.

Health Workforce of the Future

This breakout session was facilitated by Jacob Moore (Tohono O'odham/Akimel O'odham/Lakota/Dakota) from Arizona State University.

In exchange for vast tracts of ancestral lands and the establishment of reservation boundaries, the U.S. federal government promised tribal nations and people access to health, education, and welfare in perpetuity. Federal agencies continue to maintain a role in providing agreed-upon services and support to individual tribal nations and communities.

In the early 1970's, many tribes started to take greater control of, and maintain a more direct role in, healthcare delivery systems through Indian Self-Determination contracts and Self-Governance compacts. Individual tribes either have IHS operated or tribally operated health systems, or a combination of both. Certain services are also provided by states, private providers, and other entities.

Indian Health Service (IHS) has shown that there is a large deficit in clinical care providers among its service areas across the United States. These clinical positions include medical doctors, nurses, nurse practitioners, physician assistants, pharmacists, and dentists. According to the IHS, the rate of vacancy among these clinical positions amounted to 25% cumulatively and with the highest rate of 31% vacancy in some areas.[15] These values shed light on the need for healthcare professionals across a wide range of clinical positions, especially for more than 300,000 Native individuals considered medically underserved.[16] Additionally, American Indian and Alaskan Natives are significantly underrepresented in medicine, making up only 0.56% of all active physicians according to the AAMC.[17] Increasing Indigenous representation in medicine will not only alleviate vacancies but can facilitate the important understanding of traditional and cultural beliefs which is crucial for Native care.[18]

Furthermore, as job security becomes unsure among sectors such as energy and industry, the healthcare workforce offers a promising future in employment for Indigenous people. Estimates show there will be 2.4 million healthcare jobs added nationally by 2029. This would be a 15% growth from 2019 to 2029. A large portion of these jobs include technical and support capacities which also allow for workforce retraining. Encouraging and facilitating the increase of American Indian and Alaskan Natives into the Indigenous health workforce would result in multifaceted benefits extending to health outcomes, healthcare delivery, education, and employment.

In this dynamic and fluid environment, what does the Indigenous health workforce of the future look like?

Framework Questions with Responses:

What self- determination and self-governance; redesign authority to align with the needs. It's challenging to empower, and it's overwhelming because there is a need everywhere.

- This is a priority of both tribal leadership and healthcare boards. It has been a struggle but we're moving in a positive direction. Looking at ways to get community members into higher positions within healthcare. Leverage programs for those with higher level degrees (Masters and above) and bring them in to gain that experience and mentorship from other healthcare leaders. Looking at younger community members (as early as elementary school agers and youth council) to entice them into looking into healthcare careers at all levels. Covid-19 has forced them to recruit and engage community members remotely.
- Some of these federal programs don't fit our needs; therefore, we have to look at them for modifications. It's important for tribes to work in tandem with the healthcare system to address the community needs. Complexity of tribal health and Indian health – how do we fit those together? We need more education, education at a grassroots level, and working with the youth to recognize the benefit to their communities.
- From the biomedical research perspective, it's been shown that fostering an education pipeline during the early stages of young people's careers leads to success later in their careers. This is especially true for American Indian/Alaska Native (AI/AN) students who face the highest attrition rates. In the healthcare system, there are skill sets that can be tapped into based on individual interests (e.g. Communications, primary care, IT, laboratory, etc.). Perhaps further outreach in relation to training and mentorship (e.g. summer programs) might be fruitful in the future.
- Creating a sixth Arizona AHEC (area health education center) Regional Center would allow tribes to be at the table with state/federal agencies.
- Not all tribes have tribal colleges – how do we assist higher ed to assist with health career degrees/certificates. Recommendations of who to look to 1) Provide support and more incentives to existing community Health rep workforce (first responders) to continue education, 2) Military/veterans, and 3) retention of the current workforce (training, incentive, & etc.).
- Create a culture where students want to continue in their program – what other resources can we access to encourage this?

How does the health workforce of the past differ from the health workforce of the past differ from the health workforce of the future?

- Current design and management of a healthcare system has been working on a western standard of healthcare delivery – how can we modify this system?
- From an epi-genetic perspective, we need to look at the effects of historical and generational trauma. What is NIH currently doing? We want to emphasize cultural preservation.

What are the Indigenous healthcare priorities in the future and the workforce needed to address the priorities?

- Bills SB 1301 HB2494 and plan for a workforce summit in the new year.
- Working with tribes and their healthcare facilities – what are their current needs? Encourage communities to be good stewards and encourage them to build relationships with colleges.
- Continue collective work amongst tribes, partners, state and federal agencies.

Breakout Session Recommendations:

The next six-months

- Supporting and tracking SB 1301 and HB 2494, and possibly plan another workforce summit in the new year.
- Work with tribes and their healthcare facilities – what are their current needs?
- Encouraging communities to be good stewards and encourage them to build relationships with local colleges.
- Continue to work collectively (tribal/partners/state/federal).

Overall

- Reach out and engage with the younger community members to consider health careers, given the impact of COVID-19 on their communities. Catch them early, fostering an education pipeline during the early stages of young people's careers leads to success later in their careers.
- Not all tribal communities have access to the same resources. How do we find equity (resources) across tribal communities?
- When working with partners, align with the needs of the communities served.
- Look at current/past programs – what worked, what didn't work?
- Tribal colleges/TCU's – how do we assist higher ed to assist with health career degrees/certificates.
- Arizona AHEC (Area Health Education Center) Regional Center, allowing for tribes to be at the table with state/federal. Would like to be part of the GME conversations.
- Provide support and more incentives to existing community health rep workforce (first responders and others) and military/veterans to continue education in the health field.
- Higher ed - Creating a culture where students want to continue in their program – what other resources can we access to encourage this?
- Current design and management of a healthcare system has been working on a western standard of healthcare delivery – how can we modify this system?
- From an epi-genetic perspective, we need to look at the effects of historical and generational trauma. What is NIH currently doing? We want to emphasize cultural preservation (tribal healers and traditional medicine).

Mental and Behavioral Health

This breakout session was facilitated by Ken Poocha (Hopi) from Arizona Department of Child Safety.

In recent years before the beginning of the COVID-19 pandemic, mental and behavioral health continued to grow in seriousness and awareness. Mental illness, which is defined by the DSM as mental, behavior, or emotional disorders, was shown to affect about 20% of the general American population in 2019.[20] Mental and behavioral health disparities among Indigenous communities have once again resulted in disproportionate rates.

The state of mental and behavioral health among American Indian and Alaskan Natives is disproportionately affected by many of the factors that have been mentioned during the summit including social influencers, cultural understanding, and other health disparities such as increased rates of chronic illness.[21] Research has shown that Indigenous people are having significantly lower mental health status, higher death rates to suicide (especially among youth), and less services or prescriptions for mental health care.[22] Additionally, substance abuse of alcohol and drugs occur at paramount rates while also starting at younger ages in comparison to all other ethnicities.[23]

COVID-19 has again exacerbated the health disparities among Native Americans concerning negative mental and behavioral health outcomes. Indigenous communities have shown that 6 in 10 individuals have experienced worsened mental health with Native women also being unevenly affected.[24]

Framework Questions:

- What are the current challenges/barriers to mental health during this COVID crisis/past year? Who and how has it affected our communities? What are the ramifications for mental health on our communities from this past year?
- If there were no barriers or challenges to addressing these previously defined challenges and barriers, how would you address these issues?
- What are the challenges/barriers to actually implementing your solutions? How do we develop a plan to make these a reality in the next 6 months? Year? Who is driving this? How?

Breakout Session Recommendations:

- Provide community support quickly with 24-hour availability.
- Keep students safe by providing rapid testing and isolation in dorms.
- Get funders to fund efforts in a way that is directed by the partners and community.
- Provide aid for ceremonies.
- Bring funding coalitions together.

Group Discussion Notes:

- Ceremonies are important to people. Not being able to participate in ceremonies affects all. Being able to participate in ceremonies brings individuals back into balance and provides a holistic way of seeing the world. Being unable to practice has affected people and they have a void. It lacks balance, a lot of grieving going on, not being able to do ceremonies in the way they usually do, additionally social distancing is not doing things right. Adaptations have been made, but it is important to help the spirit of relatives move on. Students experience the same thing. Used to be able to gather for discussions, virtual is just not the same. Traditional medicines discussions are held, but emotions can't be seen through Zoom; smells of medicine can't be done through Zoom; feelings cannot be expressed via Zoom. Being quarantined and isolated has affected students who have not coping skills, depression has gone up. How do we provide services in a way that we keep everyone safe while following guidelines? There are many different layers. Additionally, how it affects them physically, not being able to go outside and take walks; body, mind and spirit are important to us. We need to figure out a way to have social interactions in a way that is safe and provide services and treatments that people need. Not being able to participate in these ceremonies has affected the elders as some experience depression. Ceremonies anchor recovery programs. All of our staff members have been affected by COVID. Recognizing the effects on trauma on top of trauma (experience another trauma before having sufficient time to heal from the first trauma).
- We have learned that the exposure to risky environments and drugs increases the risk for overdose. During an interview with people in Arizona, the importance of having more treatment available became apparent. Community support is needed quickly; provide 24-hour availability. While tracking substance abuse, it has been pretty steady. For a period of time there were less people reporting.
- Members of the phone and telehealth teams are helpful. There was an increase in needs and this was addressed by mobilizing to meet most of the needs via telepsychiatry.
- We can't forget about the care of the providers. There is so much concern and discussion about patients and clients, but providers need to be ok as well.
- Continue to provide a place for homeless individuals. Our essential service organizations never closed. The discussion regarding direct service providers and discussion about front line employees is appreciated.
- Often people do not have a safe place to live, isolate or quarantine in affordable housing – this is extremely important. There is much worry about paying rent (which can cause mental health issues), as well as the loss of income and food. The digital divide is something that many families face, as some families have kids in three different classrooms. These are stressful things, in addition to family members who must go to work and who have kids who attend remote schooling. These are all contributors to higher substance abuse and domestic violence.


SUN DEVIL
NATION
SUN DEVIL
ATHLETICS
ARIZONA STATE
BASKETBALL

- With regards to behavioral health and residential treatment – we must have protocols in place to help keep people safe. This includes making rapid COVID testing and isolation dorms available to those who need them. Because of the needs of the community, we did not feel like we could close the residential treatment centers as people still needed a variety of services, including MAP services.
- If the information is not provided in the appropriate vernacular it is really distant to the hearer. Pragmatic measures and ways to get this information to the people is necessary. Creative writers could be impactful in this area. Bring the message home to the everyday level of communication so that people will understand the impact.
- There is an immediate need to get information to the community and address particular issues for both youth and the elders. Invite a panel of leaders to discuss the lessons learned through the pandemic, so that we can all share the valuable lessons learned.
- Unsure if the right people are at the table or have a voice in funding. There are a lot of COVID dollars available, but they come with myriad restrictions to the utilization of funds. It is important to be at the table to identify where the funds are needed and how to find resources. Create programs to meet funding needs.
- A lot can be learned from story-telling. The stories should be recorded and made available to the community. As a protective factor and a bit of nostalgia, there are old instruction booklets for the ceremonies, and how they filled us up. This goes back to the idea of knowledge sharing and the importance of story-telling. These are instances where we are using the resources that we already have.
- A global network that includes elders who have knowledge to share.
- Our knowledge and culture need to be protected. It is important to protect traditional knowledge when receiving funding. Efforts are being made to change the policy so that we can have dialogue about receiving funding while maintaining the sacredness of our ceremonies. It would be great to do this across the board without governance, along with the ability to apply for funding for our community in ways that we know what to do. The elders are knowledge keepers who will not divulge information. Tribes can change with the new administration who might have different values, but knowledge goes on forever and does not change. We need processes in place to protect our knowledge and people so that we are not exploited as history tells us.

Public Health Education Messaging

This breakout session was facilitated by Michael Allison (Dine' Navajo) from Arizona Department of Health Services.

Strong evidence supports that public health communication holds a pivotal role in helping community members make important decisions about their family's and individual health. These decisions about health, in turn, can have far-reaching implications and result in major outcomes such as what has been seen in campaigns aimed at decreasing tobacco use.[26] As health misinformation continues to spread and becomes more readily available, it is imperative that Indigenous health leaders engage in effective communication strategies surrounding COVID-19.

One successful example of public health communication has been with the Navajo Nation. In April 2021, over 80% of eligible members had received the first vaccination versus a much lower 42% of the country's population.[27] Some of the reasons attributed to this success could be from bridging cultural understanding, addressing misinformation circulating in communities, and clearly outlining safety guidelines.[28]

Public health communication will continue to play an important role in COVID-19 and improving the health ofIndigenous people in the future. There are important factors that have been suggested for consideration when creating these messages such as individualizing communication to the communities' values, empowering tribal members, and supporting mental and spiritual health.[29]

Framework Questions with Responses:

What communications media worked in keeping your reservation and urban communities informed about the status of the Covid-19 pandemic, including patient care information? What improvements are needed, if any?

- Social media and press releases – meet with other tribes to ensure messaging is consistent.
- Electronic records (dashboard) assistance from CDC.
- Improvements - work with tribal communities to ensure messaging is consistent.
- Facebook and Instagram - public health education weekly, biweekly updates.
- Incorporate town halls.
- Medical director answers questions on the radio.
- Don't realize until it happens to them – reeducation.
- Communicating via outside sources is difficult. Staff at a local nonprofit called each and every client - and follow-up every month to ensure they are receiving the most accurate and up-to-date information.

Did your tribal and urban leadership have up-to-date and accurate Covid-19 data to make pandemic messaging decisions? if not, why? What improvements are needed?

- Dependent on CDC and for implementing contact tracing. Communicate to the public as often as needed as news progresses.
- We had some data about our testing because we are doing it on the reservation, but couldn't account for those who tested off the reservation in another area. Data lagged and it took a while to coordinate agreements.

- Our COVID Incident Command committee met 2X a week to (1) discuss CDC and World Health Org data/ recommendations (2) discuss COVID policy updates as needed (3) plan for community messaging regarding COVID. We worked directly with our partners for further information as necessary. Messaging can be found on social media, electronic newsletter, website, emails and on paper in COVID-safe distribution events in partnership with other organizations.
- Add resource from tribal leadership to meet with Phoenix partnerships to ensure the most up-to-date information is being shared and
- IHS is able to collect information based on reservation address
- Ensure positive data continues to be shared back with tribes.

What have been lessons learned thus far on the roll out of Covid-19 vaccines to tribal and urban communities? What changes or improvements are needed, if any?

- How is the rollout of vaccines working?
- Limited number of vaccines to distribute with the plan including employees and elders - we need more. Don't know when we will get more, and how many. Most of our citizens want them, and we don't have enough. There are still people that are apprehensive about it or do not want it; however, most do.
- Improvements needed as teams are in short supply to administer vaccines. Additional workforce to compile data in order to receive additional vaccines.
- Registering is difficult for the transient population and urban tribal members. Plan B list in order to not waste vaccines and staffing.

Breakout Session Recommendations:

- Create and market messages & videos by those who have been directly affected. Powerful personal stories.
- Pay for internet costs, such as the low-income cellular program.
- Templates for all employers to follow to let workers return to work.
- Webinar - COVID Vaccine main rollout. Sharing success and challenges.
- Data transfer back to tribal leadership. MOU, IGA - formal structures needed.

Telehealth, Telemedicine, and Telepsych

This breakout session was facilitated by John Molina (Pasqual Yaqui/Yavapai Apache) from Native Health Urban Indian Clinic.

Indigenous people living on tribal land or rural communities have always had the challenge of access to healthcare from these remote areas.[30] Indeed, much of the health disparity seen with Indigenous health is due to this specific Social Determinant of Health. Telehealth, which is inclusive of telemedicine and tele-psychiatry, has been an option to bring health services to these remote areas when the technology was available at those locations. However, Indigenous people, especially those in remote areas do not have adequate connection to internet services, or the equipment such as a smart phone or laptop, or sufficient broadband connectivity in their home or community to support a video consultation.[31] In Arizona, it has been reported that over 160,000 people living on tribal lands have either "unserved or underserved" telecommunication networks and must resort to using schools, libraries or other community facilities to access internet services.[32] There currently exists a critical Digital Divide between Indigenous communities and the rest of the country.

The COVID-19 pandemic has not only demonstrated the utility of telehealth but has catalyzed the adoption of telehealth across the spectrum of outpatient patient care, at-home care, which has now become the mainstay of improving access to healthcare during this pandemic.[33] This at-home patient care is extremely critical as many of our Indigenous people suffer from chronic illnesses that needs to be managed on a regular basis as an outpatient or provide preventive health services to prevent the onset or advancement of chronic disease.

The breakout group addressing the challenges of telehealth in Indigenous communities focused on three strategic questions.

Framework Questions with Responses:

- What element (administrative/operational) with the use of telehealth/telemedicine can be improved during this pandemic?
- What special consideration should be given to the use of telepsych within Indigenous populations?
- What other considerations with telehealth implementation within Indigenous nations should be focused on over the short term?

What element (administrative/operational) with the use of telehealth/telemedicine can be improved during this pandemic?

- Research the use of Artificial Intelligence (AI) with telehealth to minimize medical errors and misdiagnoses, and enhance diagnostic knowledge.
- Train providers in best practices for proper use of telehealth to enhance patient engagement, examination and assessment/diagnostic skills especially during the COVID-19 pandemic.
- Encourage and support federal and state waivers to have telehealth stay in effect.
- Collaborate with Arizona Telehealth Broadband Action Team (BAT) to strategize solutions to improve broadband capacity in Indigenous communities.
- Research telehealth applications that would be most effective-based in the areas of psychiatry and medication management.
- Consider the "bigger sphere" of telehealth: Train providers on Emotional Intelligence, as it is a crucial element in customer satisfaction. Telehealth must be done in a sensitive way and with compassion.
- Connect to the National Institutes of Health (NIH) for grant funding and training opportunities in telehealth.

- Psych visit to Alaska to learn about their best practices framework on how telemedicine has played a key role in particular communities and as a reference in the traditional way of structuring telemedicine for rural areas.
- Consider exploring the Veteran's Administration (VA) telehealth program for medical care for veterans in Indigenous populations.

What special consideration should be given to the use of telepsych within Indigenous populations?

- Telehealth is very adaptable; assist in creating innovative solutions in Telepsychiatry that can be operationalized.
- Consider boundaries as patients invite the provider into their home. Fine line in being intrusive as providers can view their home in the background.
- Establishing appropriate boundaries and relationships between doctor and activities have been affected by the pandemic due to social distancing.
- Consider the practice of Distant Energy medicine (health) by telehealth.
- Integrated telehealth into Indigenous traditions, culture, and practices.
- Setting up cameras during the ceremonies, blessings and viewing to a larger group (blessing the equipment during the ceremony).
- Blessings and ceremonies can just as easily be demonstrated virtual through telehealth.
- Consider "Care Beyond Walls" with Fitness Trackers that can help providers track the amount of sleep and exercise a patient experiences.
- Providing patients with the virtual self-care resources. Education is key to help patients find the solutions they are seeking.

What oother considerations with telehealth/telemedicine implementation within Indigenous nations should be focused on over short term?

- Start small by incorporating these solutions in our own communities.
- Starting at a small level and implementing at a larger scale.
- Review best practices that have been utilized by tribal nations during the pandemic.
- Educating providers and offering a toolkit on the practice of telehealth.
- Creating the patient relationship with telehealth by educating patients on telemedicine and what to expect.
- Translate education in multiple languages to ensure the information is given in native languages.
- Making the CMS telehealth waiver permanent to extend the use of telehealth services.
- Reimbursement.
- Billing codes.
- Create virtual Support groups (via Zoom etc.).
- Enhance telehealth partnerships to have access to national and global expertise.

Breakout Session Recommendations:

- Patient and provider education on telehealth/ telemedicine as well as Artificial Intelligence (AI).
- Best practices that have been utilized by Tribal Nations.
- Establishing patient/provider relationships through virtual environments.
- Using Zoom features to connect for telehealth, ceremonies etc.

Post-Summit Actions

Following the ASU Indigenous Health Summit, the executive leadership team met three additional times to summarize feedback from the summit's breakout sessions, evaluate survey feedback, and identify and prioritize recommendations to enact from the summit. This section provides actions taken post-summit and the accomplishments to date for meeting the recommendations identified by the executive leadership team.

- ASU Indigenous Health Summit white paper finalized, published, and distributed.
- ASU INSPIRE Summer Camp for American Indian high school students from 9th-12th grades.
  - o Hosted a health track with two sessions:
    - Panel introducing students to Traditional Medicine/ Tribal Healers and Physicians with panelists Miguel Flores Jr., LISAC, Damon Dixon, M.D., and John Molina, M.D., J.D.
    - Session with Dougherty Tsalabutie, MPH, Director for the National Center for American Indian Health Professions at A.T. Still University
- Shared information about the virtual ASU Summer Health Institute with Indigenous Health Summit executive leadership team requesting that they share with American Indian high school students in the 11th grade.
- Engaging with Mayo Clinic Alix School of Medicine - Arizona medical students interested in mentoring ASU American Indian pre-health students.
- Exploring academic partnership to increase capacity within Indigenous health at the Master's, Doctoral, and Post-doctoral levels throughout the western region.
- Arizona Tribal Workforce Forum Planning group held an initial meeting to discuss ways to advance the 6th Tribal AHEC (Arizona Area Health Education Center).
- Utilizing a generous grant from the Tohono O'odham Nation, ASU's College of Health Solutions created an Indigenous Health Ambassadors program. The goal of the program is to convene a group of accomplished Indigenous leaders to advise the College of Health Solutions on ways to strengthen its commitment to Indigenous health.
- ASU's College of Health Solutions is producing a Voices in Health Social Media Campaign for Native American Heritage Month in November 2021.
- ASU's Doing Research in Indigenous Communities 2021 conference will host a session on data sovereignty for Indigenous communities.

Endnotes

[1] Cunningham, P., Healthcare Utilization, Expenditures, and Insurance Coverage for American Indians and Alaska Natives Eligible for the Indian Health Service. Changing Numbers, Changing Needs: American Indian Demography and Public Health, 1996. 13. https://doi.org/10.17226/5355

[2] U.S. National Library of Medicine, "If you knew the conditions…": Health Care to Native Americans. 1994; Available from: https://www.nlm.nih.gov/exhibition/if_you_knew/index.html

[3] Hathaway, E.D., American Indian and Alaska Native People: Social Vulnerability and COVID-19. The Journal of Rural Health, 2021. 37(1): p.256-259. https://doi.org/10.1111/jrh.12505

[4] Warne, D. and S. Wescott, Social Determinants of American Indian Nutritional Health. Current Developments in Nutrition, 2019. 3(Suppl 2): p.12-18. https://doi.org/10.1093/cdn/nzz054

[5] Koithan, M. and C. Farrell, Indigenous Native American Healing Traditions. The Journal of Nurse Practitioners, 2010. 6(6): p. 477-478. https://doi.org/10.1016/j.nurpra.2010.03.016

[6] Indian Health Service, Disparities Fact Sheet. 2019; Available from: https://www.ihs.gov/newsroom/factsheets/disparities/

[7] Baciu, A., et al., Native American Health: Historical and Legal Context. Communities in Action: Pathways to Health Equity, 2017. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425854/

[8] Muhammad, D. C., et al., Racial Wealth Snapshot: American Indian/Native Americans. National Community Reinvestment Coalition. 2019; Available from: https://nativegov.org/indigenized-communication-during-covid-19/

[9] Hyde, S., Income and Health Outcomes. Bureau of Labor Statistics. 2017; Available from: https://www.bls.gov/opub/mlr/2017/beyond-bls/income-and-health-outcomes.htm

[10] Arrazola, J., et al., COVID-19 Mortality Among American Indian and Alaska Native Persons – 14 States, January- June 2020. Centers for Disease Control and Prevention, 2020. 69(49): p. 1853-1856.

[11] Indian Health Service, Office of Direct Service and Contracting Tribes: Title I. 2021; Available from: https://www.ihs.gov/odsct/title1/

[12] Urban Indian Health Institute, About Urban Indian Health Programs. 2021; Available from: https://www.uihi.org/urban-indian-health/about-urban-indian-health-organizations/

[13] Warne, D. and L. B. Frizzell, American Indian Health Policy: Historical Trends and Contemporary Issues. American Public Health Association, 2014. 104: p. 263-267. https://doi.org/10.2105/AJPH.2013.301682

[14] Gulliford, M., et al., What is 'continuity of care'?. Journal of Health Services Research and Policy, 2006. 11(4): p. 248-250. https://doi.org/10.1258/135581906778476490

[15] Indian Health Service, Agency Faces Ongoing Challenges Filling Provider Vacancies Report to Congressional Requesters United States Government Accountability Office. 2018; Available from: https://www.gao.gov/assets/gao-18-580.pdf

[16] US Census Bureau, American Indian and Alaska Native Heritage Month: November 2017. 2017; Available from: https://www.census.gov/newsroom/facts-for-features/2017/aian-month.html

[17] Association of American Medical Colleges, Reshaping the Journey of American Indians and Alaska Natives in Medicine. 2018; Available from: https://store.aamc.org/downloadable/download/sample/sample_id/243/

[18] Bassett, D., "Our Culture Is Medicine": Perspectives of Native Healers on Post Trauma Recovery Among American Indian and Alaska Native Patients. The Permanente Journal, 2012. 16(1). https://doi.org/10.7812/tpp/11-123

[19] U.S. Bureau of Labor Statistics, Healthcare Occupations: Occupational Outlook Handbook. 2021; Available from: https://www.bls.gov/ooh/healthcare/home.htm

[20] National Institute of Mental Health, Mental Health Information: Statistics. 2019; Available from: https://www.nimh.nih.gov/health/statistics/mental-illness

[21] Mental Health America, Native and Indigenous Communities and Mental Health. 2019; Available from https://www.mhanational.org/issues/native-and-indigenous-communities-and-mental-health

[22] U.S. Department of Health and Human Services Office of Minority Health, Mental and Behavioral Health – American Indians/ Alaska Natives. 2019; Available from: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39

[23] American Psychiatric Association, Mental Health Disparities: American Indians and Alaska Natives. 2017; Available from https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf

[24] Arriagada, P., et al., Indigenous People and Mental Health During the COVID-19 Pandemic. Statcan COVID-19: Data to Insights for a Better Canada. 2020; Available from: https://www150.statcan.gc.ca/n1/en/pub/45-28-0001/2020001/article/00035-eng.pdf?st=fi_njpdv

[25] Community Preventive Services Task Force, Health Communication and Social Marketing: Health Communication Campaigns That Include Mass Media and Health-Related Product Distribution. 2011; Available from: https://www.thecommunityguide.org/sites/default/files/assets/Health-Communication-Mass-Media.pdf

[26] Rural Health Information Hub, Health Communication. 2021; Available from: https://www.ruralhealthinfo.org/toolkits/health-promotion/2/strategies/health-communication

[27] Treisman, R., Outpacing the U.S., Hard-Hit Navajo Nation has Vaccinated More than Half of Adults. National Public Radio. 2021; Available from: https://www.npr.org/sections/coronavirus-live-updates/2021/04/26/990884991/outpacing-the-u-s-hard-hit-navajo-nation-has-vaccinated-more-than-half-of-adults

[28] Navajo Department of Health, COVID-19 Resources. 2021; https://www.ndoh.navajo-nsn.gov/covid-19

[29] Native Governance Center, Indigenized Communication During COVID-19. 2021; Available from: https://nativegov.org/indigenized-communication-during-covid-19/

[30] Kruse, C.S., et al., Telemedicine Use in Rural Native American Communities in the Era of the ACA: A Systematic Literature Review. Journal of Medical Systems, 2016. 40(6): p. 145. https://doi.org/10.1007/s10916-016-0503-8

[31] Federal Communications Commission, 2019 Broadband Deployment Report. 2019; Available from: https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf

[32] Cronkite News Arizona PBS, As Providers Turn to Telehealth During COVID-19, Calls Rise for More Resources in Indian Country. 2020; Available from: https://cronkitenews.azpbs.org/2020/08/10/telehealth-pandemic-resources-indian-country/

[33] Wosik, J., et al., Telehealth Transformation: COVID-19 and the Rise of Virtual Care, Journal of the American Medical Information Association, 2020. 27(6): p. 957–962. https://doi.org/10.1093/jamia/ocaa067