National Indian Health Board

April 6, 2021

The Honorable Raul Grijalva
Chairman, Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Grijalva,

Thank you for providing the opportunity for the National Indian Health Board to testify on March 23, 2021 at the House Natural Resources Subcommittee on Indigenous Peoples of the United States hearing entitled, "A Year in Review: The State of COVID-19 in American Indian, Alaska Native, and Native Hawaiian Communities—Lessons Learned for Future Action."

Please see attached the responses to your follow-up questions for the record. Thank you for your continued leadership in ensuring the Federal Government upholds its treaty and trust obligations for healthcare for all American Indians and Alaska Natives.

Please do not hesitate to contact me with any questions.

Yours in Health,

Stacy A. Bohlen
Chief Executive Officer
National Indian Health Board

Answers to Questions Submitted for the Record by Democrat Members
House Natural Resource Subcommittee on Indigenous Peoples
Oversight Hearing on "A Year in Review: The State of COVID-19 in American Indian, Alaska Native, and Native Hawaiian Communities—Lessons Learned for Future Action
March 23, 2021

Questions from Rep. Raúl M. Grijalva for Hon. William Smith, Chairperson & Alaska Area Representative, National Indian Health Board:

1. **Temporary or permanent closures impacted many tribal communities to health clinics and hospitals throughout the pandemic.**

    a. **Does the National Indian Health Board (NIHB) have an idea of how many tribal health clinics and hospitals experienced shutdowns in the past year?**

Unfortunately, there is currently no reliable data available on the number of tribal health clinics and hospitals that experienced shutdowns this past year. Most shutdowns occurred in March and April of 2020 at the beginning of the pandemic, and several Tribes were forced to shut down again for a couple of weeks in response to a within clinic outbreak. For example, Northwest Indian Treatment Center of the Squaxin Island Tribal is a residential treatment center in Elma, WA that serves Portland Area Tribes. The clinic was forced to closed for two whole months, losing revenue, interrupting treatments, and ultimately losing patients while staff continued to be paid. This story is far from uncommon, given the longstanding staff shortages throughout the Indian Health System.

Along with the devastating human toll, the pandemic upended many aspects of the Indian health care delivery system. As states enforce shelter-in-place orders, it requires health care providers to cancel non-emergent procedures, and social distancing guidelines continue, Indian Health Service (IHS), Tribal Health Programs, and urban Indian organizations (I/T/U) are seeing their patient volumes plummet. Some I/T/U have the capacity to make the transition to telehealth-based service delivery for some routine and non-emergent procedures, but this is not an option for all sites or all procedures. Reduced patient visits and services being offered result in less third-party reimbursements from payers such as Medicare, Medicaid, the Veterans Health Administration (VHA), and private insurance. I/T/U systems depend on the ability to reinvest those reimbursements to bolster availability of health care services and expand care access. As a result of suspended services and stay-at-home orders, Tribal nations have experienced significant reductions in third-party reimbursement—ranging from $800,000 to over $5 million per tribe just in the first 30 days of the pandemic. For some tribes, third-party collections can constitute over half of their operating budgets for health care. Federally-operated IHS facilities are also rely on third-party collections to supplement appropriations. Through only mid-March 2020, UIOs reported an average of $500,000 in lost third-party reimbursements, while larger full ambulatory UIOs reported losses of more than $1.5 million. Fortunately, Congress recognized this need in various relief packages, including a set-aside in the American Rescue Plan specifically for I/T/U

to replenish lost third-party reimbursement dollars. Without this support, I/T/U would have had to further ration health care and the sustainability of some I/T/U would ultimately have been jeopardized.

2. **Your testimony mentions the severe barriers that tribal governments and epidemiology centers have faced throughout this pandemic. Can you please speak further on this issue?**

The COVID-19 pandemic has shed a direct spotlight on the undue challenges faced by Tribes and TECs in exercising their public health authority. During a June 2020 hearing before the House Energy and Commerce Committee, bipartisan members pressed the CDC on media reports that the agency had failed to share data with Tribes and Tribal Epidemiology Centers (TECs). In early July 2020, 26 bipartisan members of the House and Senate sent a letter to CDC Director Redfield demanding answers as to why Tribes have been thwarted in data access.

As sovereign governments, Tribal Nations are inherent public health authorities. Under Section 214 of the Indian Health Care Improvement Act (IHCIA), TECs gained designation as public health authorities. But while state, local and federal public health authorities are able to carry forth their missions largely undeterred, Tribal governments and TECs have faced immense challenges in exercising their public health authority.

There is currently no uniform infectious disease reporting system in the United States. This results in a patchwork system across the country, and poses unique challenges for Tribes and Tribal Epidemiology Centers whose jurisdictions can span multiple state lines. These reporting systems often cannot communicate with each other and exist in a variety of different formats, which makes integrating them into a clear and complete picture much more challenging.

3. **You also highlight the inconsistent nature of tribal COVID-19 related data—specifically, how the Indian Health Service's (IHS) national estimates are likely underrepresenting the impact that COVID-19 has had on tribal communities. Can you please recap why this issue exists?**

These existing capacity and resource shortages meant that the Indian health system was woefully unprepared to prepare, prevent, and respond to the COVID-19 pandemic. Available data on AI/AN COVID-19 health disparities reaffirms this central point. Unfortunately, because of high rates of misclassification and under sampling of AI/AN populations in federal, state, and local public health disease surveillance systems, available data likely significantly underrepresents the scope of the impact in Indian Country. To be clear, misclassification of AI/ANs on disease surveillance systems is not unique to COVID-19.

Previous studies have found significantly higher rates of misclassification outside of IHS Contract Health Service Delivery Areas (CHSDA)[1]; for all-cause mortality rates in states like Oklahoma[2]; for HIV infections among AI/ANs across five states;[3] and on death certificates reported to CDC.[4] However, the issue has taken a new level of urgency given the unprecedented devastation of this pandemic on underserved communities.

a. How have shortages of reliable data affected the pandemic response efforts of tribal governments and health organizations?

Inconsistent data is a common theme across much of Indian Country and contributes to a significant and consistent underestimation of the actual disease burden experienced by AI/ANs. These clear and severe limitations on the current data do not allow for complete pictures of the COVID-19 landscape in Tribal communities. Tribal leaders deserve a clear and accurate depiction of what their communities are experiencing with COVID-19, as well as the Tribal Epidemiology Centers that serve multiple Tribes in their service areas. This is not a new problem caused by COVID-19, but rather an old problem that COVID-19 has amplified.

Available COVID-19 data already highlight significant disparities between AI/ANs and the general population; shockingly, true estimates of disease burden and death resulting from COVID19 in Indian Country are likely much higher. In CDC's own August 2020 report on COVID-19 in Indian Country, the authors noted the following:

This analysis represents an underestimate of the actual COVID-19 incidence among AI/AN persons for several reasons. Reporting of detailed case data to CDC by states is known to be incomplete; therefore, this analysis was restricted to 23 states with more complete reporting of race and ethnicity. As a result, the analysis included only one half of reported laboratory confirmed COVID-19 cases among AI/AN persons nationwide, and the examined states represent approximately one third of the national AI/AN population. In addition, AI/AN persons are commonly misclassified as non-AI/AN races and ethnicities in epidemiologic and administrative data sets, leading to an underestimation of AI/AN morbidity and mortality.

---

[1] 17 Jim, M. A., Arias, E., Seneca, D. S., Hoopes, M. J., Jim, C. C., Johnson, N. J., & Wiggins, C. L. (2014). Racial misclassification of American Indians and Alaska Natives by Indian Health Service Contract Health Service Delivery Area. American journal of public health, 104 Suppl 3(Suppl 3), S295–S302.

[2] Dougherty, Tyler M. MPH, CPH; Janitz, Amanda E. PhD, BSN, RN; Williams, Mary B. PhD; Martinez, Sydney A. PhD; Peercy, Michael T. MPH, MT(ASCP)H; Wharton, David F. MPH, RN; Erb-Alvarez, Julie MPH, CPH; Campbell, Janis E. PhD, GISP Racial Misclassification in Mortality Records Among American Indians/Alaska Natives in Oklahoma From 1991 to 2015, Journal of Public Health Management and Practice: September/October 2019 - Volume 25 - Issue - p S36-S43 doi: 10.1097/PHH.0000000000001019

[3] Bertolli, J., Lee, L. M., Sullivan, P. S., & AI/AN Race /Ethnicity Data Validation Workgroup (2007). Racial misidentification of American Indians/Alaska Natives in the HIV/AIDS Reporting Systems of five states and one urban health jurisdiction, U.S., 1984-2002. Public health reports (Washington, D.C. : 1974), 122(3), 382–392. https://doi.org/10.1177/003335490712200312

[4] Centers for Disease Control and Prevention. 2016. The Validity of Race and Hispanic-Origin Reporting on Death Certificates in the United States: An Update. https://www.cdc.gov/nchs/data/series/sr_02/sr02_172.pdf

Indeed, there are multiple states that still have a significant percentage of COVID-19 cases missing critical demographic data. In California for instance, a whopping 31% of cases are still missing race and ethnicity. The State of New York has failed to report AI/AN data altogether – listing only Hispanic, Black, White, Asian, or Other on their COVID-19 data dashboards.

4. **Despite this recent success, you also mention that the vaccine rollouts had negatively impacted the government-to-government relationship between the federal government and tribal nations. We understand that tribal health facilities could choose to receive their vaccines from the state or through the IHS system. Would this reliance on the state rather than the federal government contradict the federal trust responsibility?**

States are able to directly receive the vaccine from distributors. Tribes should be should receive parity and have direct access to receiving the vaccine as well. The government-to-government relationship relies solely upon the federal government, and diverting federal resources for Tribes through states is an abdication of that responsibility.

We have seen the successes of Tribes when they have control over the distribution of the COVID-19 vaccine. In some states, vaccine administration, or "shots in arms," has been less than ideal. However, Tribal government vaccine rollouts have been far outpacing their state counterparts. Regardless of how a Tribe obtained the vaccines, Tribes were able to get the doses in the arms of their citizens faster and more efficient than most of their surrounding communities and states once they had them in hand. For instance, Alaska had vaccinated 91,000 people at the end of January 2021, and 10,000 of those shots were administered to Tribal patients. Various Tribes in Oklahoma have done so well in vaccinating their citizens, they have recently opened their vaccine efforts to the community, regardless of if they are IHS eligible or not. Anyone in Oklahoma can now receive the vaccine through the Tribe. For the Rosebud Sioux Tribe, they have been vaccinating those in their community nearly double the rate of South Dakota.[5] In an analysis by the AP, federal data showed Native Americans were getting vaccinated at a higher rate than all but five states by the end of February 2021.[6]

5. **Given your experience as the National Indian Health Board's (NIHB) Alaska Area Representative, what unique COVID-19 challenges have Alaska Native communities faced that advocates in the lower 48 might have overlooked?**

Alaska has faced several challenges that are unique to the state. Over 80% of Alaska communities, and a majority of the Alaska Native Villages, are off the road system and dependent on essential air services. Given these communities' remoteness, many of the challenges arose from the transportation of various medicines and lack of basic sanitation infrastructure. With more than 30 communities lacking any water sanitation systems, simple preventative measures such as washing hands with clean water proved difficult. When the vaccines became available, many communities

[5] NPR. Why Native Americans Are Getting COVID-19 Vaccines Faster. https://www.npr.org/2021/02/19/969046248/why-native-americans-are-getting-the-covid-19-vaccines-faster

[6] AP. Native Americans embrace vaccine, virus containment measures. https://apnews.com/article/native-americans-coronavirus-vaccine-9b3101d306442fbc5198333017b4737d

lacked the proper equipment to store the vaccine. Additionally, during the early months of the pandemic, Alaska's most significant regional airline, Ravn, was forced to declare bankruptcy, disrupting commercial air services for months and creating logistics issues for vaccine distribution.

Despite the challenges communities face, the Alaska Native health system continues to outperform many states in vaccine distribution. The key to this success is self-governance. The issues facing the Alaska Native communities are not new, and Alaska Tribal Health System has created a robust system of care in the hub and spoke model, with referral patterns, data, and resource sharing across the system. This system includes an integrated immunization program (that had transport, administration, and reporting processes in place) that has been in existence for decades. With a pre-existing mechanism to disburse vaccines rapidly, Alaska and Alaskan Tribal communities are able to administer the COVID-19 vaccine to their most remote communities effectively.