The Secretary's Advisory Committee on
Infant and Maternal Mortality
U.S. Department of Health and Human Services

IN-PERSON MEETING
Mystic Lake Center
2400 Mystic Lake Boulevard NW,
Prior Lake, MN 55372

Wednesday, September 14, 2022
9:00 a.m.

Court Reporter: Christina DeGrande

C O M M I T T E E M E M B E R S

Edward P. Ehlinger, MD, MSPH
ACTING CHAIRPERSON Minneapolis, MN
Term End Date: December 15, 2022

Michael D. Warren, MD, MPH, FAAP
EXECUTIVE SECRETARY
Maternal and Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

Vanessa Lee, MPH
DESIGNATED FEDERAL OFFICIAL
Maternal and Women's Health Branch
Division Healthy Start and Perinatal Services
Maternal and Child Health Bureau
Health Resources and Services Administration
Rockville, MD 29857

MEMBERS
Sherri L. Alderman, MD, MPH, IMH-E, FAAP
Developmental Behavioral Pediatrician
CDC Act Early Ambassador to Oregon
Help Me Grow Physician Champion

Oregon Infant Mental Health Association
Immediate Past President
Portland, OR
Term End Date: March 12, 2025

Steven E. Calvin, MD
Obstetrician-Gynecologist
Minneapolis, MN
Term End Date: December 31, 2024

Charlene H. Collier, MD, MPH, MHS, FACOG
Associate Professor of Obstetrics & Gynecology
University of Mississippi Medical Center
Jackson, MS
Term End Date: March 12, 2026

Tara S. Lee, PhD
Senior Fellow and Director of Life Sciences
Charlotte Lozier Institute
Arlington, VA
Term End Date: December 31, 2024

Colleen A. Malloy, MD
Assistant Professor of Pediatrics (Neonatology)

Ann & Robert H. Lurie
Children's Hospital of Chicago
Chicago, IL
Term End Date: December 15, 2022

M. Kathryn Menard, MD, MPH
Upjohn Distinguished Professor
Department of Obstetrics and Gynecology
Division of Maternal-Fetal Medicine
University of North Carolina School of Medicine
University of North Carolina at Chapel Hill
Chapel Hill, NC
Term End Date: March 12, 2025

Joy M. Neyhart, DO, FAAP
Rainforest Pediatric Care, a member of
Southeast Alaska Regional Health Consortium
Juneau, AK
Term End Date: March 12, 2026

Janelle F. Palacios, PhD, CNM, RN
Nurse Mid-Wife Kaiser
Permanente
Oakland Medical Center Labor & Delivery
Oakland, CA
Term End Date: December 15, 2022

Magda G. Peck, ScD
Founder/Principal, MP3 Health Group
Adjunct Professor of Pediatrics &
Public Health
University of Nebraska Medical Center
Richmond, CA
Term End Date: December 15, 2022

Belinda D. Pettiford, MPH, BS, BA
Women’s Health Branch, Head
North Carolina Division Public Health Women’s
And Children’s Health Section
Raleigh, NC
Term End Date: December 11, 2022
Marie-Elizabeth Ramas, MD, FAAFP
Family Practice Physician
Hollis, NH
Term End Date: March 12, 2026

Phyllis W. Sharps, PhD, RN, FAAN
Professor Emerita
Johns Hopkins School of Nursing
Laurel, MD
Term End Date: March 12, 2025

ShaRhonda Thompson
Consumer/Community Member
St. Louis, MO
Term End Date: March 12, 2025

TABLE OF CONTENTS

P R O C E E D I N G S

DR. ED EHLINGER: I'm glad we didn't tire you out too much. And welcome to all of the people who are joining us virtually, but we'll have a -- a good group here.

Just wanted to highlight the fact, if you have a chance to go over -- Leonard Wabasha mentioned this. Hocokata Ti, the lodge at the camp center gives a -- a -- view of the history of the Mdewakanton -- Shakopee Mdewakanton Sioux Community, which is -- you know, it's about a mile from here. You know, and I -- it will be hard during the -- maybe Thursday, before you -- we leave, you might be able to get over there.

It gives a little different picture than what you get of this tribe from inside the casino. It's a little bit more sacred space. And so I encourage you to -- to stop over there.

But let's first get to the important things, the meeting business that we have to do. I ask for a moval to approve the minutes of our last meeting. Magda,

motions. Is that a second?

MS. BELINDA PETTIFORD: Second.

DR. ED EHLINGER: Belinda.

Any comments on the -- the minutes?

All right. Hearing none, all in favor of approving the minutes say "aye."

UNIDENTIFIED SPEAKER: Aye.

DR. ED EHLINGER: All opposed, same sign. Minutes are approved.

All right. Yesterday was a -- quite an eventful day and -- and lots of important information and important stories. So I'm just curious, just in the time we have here, in the next 15 minutes or so, I'd like to just hear from you about -- from all of what we heard yesterday, what touched your heart? What piqued your interest? What stoked your passion? What stimulated your imagination? What did -- energized your potential for action? And what questions still need to be asked?

Joy?

JOY NEYHART: Why are we separating moms and babies just because a mom is incarcerated and -- and how do we stop doing

this? Because we know how wrong that is for that -- for that baby and for that mom. So can we make this a priority from this committee?

ED EHLINGER: Belinda?

BELINDA PETTIFORD: Good morning. Belinda Pettiford.

I think several things touched my heart, but I especially -- the two young ladies that participated, I think it was Autumn and Lanice and sharing their story and being willing to be so vulnerable in front of us, it made me want to see, are we doing enough with our recommendations? Are we going deep enough with them?

And I know you gave us that as a charge last night, not to go mild, but to spice it up some and definitely move forward.

But I also was struck by the different levels of trust of the Indian Health Service. And depending on who you asked and their relationship with them and wonder are we -- I do think we've done everything we can in many respects to try to get them at the table, but are we being strong enough on

our recommendations? Should we just be asking for more resources or we -- should we really be looking at that system with our recommendations, because the system, obviously, is flawed.

When you hear someone that has the opportunity to utilize the Indian Health Service and they say they wouldn't even send their four-legged pet there, there's something wrong with that system that is deeply ingrained. And I don't know if our recommendations have gotten to that yet. So I think we need to spend some more time and go deeper with those.

ED EHLINGER: ShaRhonda?

SHARHONDA THOMPSON: ShaRhonda Thompson here. For me, it was the -- the disrespect of -- of their beliefs and traditions in many facets, the hospital, the prison, the lack of respect for their beliefs and their traditions is -- it -- the words. I'm at a loss of words for it because it -- it's horrible. It's horrific that we're not taking that into consideration. This is a part of them, and we're stripping that away

from them in any opportunity that we can. And I think that really needs to be rectified.

ED EHLINGER: Thank you.

Kate, it looks like you want to say something. Yeah. We're -- just pop up whenever you would like.

KATHRYN MENARD: There's so many -- so many things that I was struck by and touched by. One thing I know that -- that, you know, last meeting we had this virtual. And I've been thinking a lot about how different it felt and how much more I could absorb and appreciate, you know, when we were in person.

And then it -- it's a bit about apples to oranges because it's different content. But I think there's really tremendous -- I mean, I took pages and pages of notes, you know, which I never do on the video, you know, it -- but, so I'm -- I'm kind of relatively new to the development of the recommendations and that sort of thing.

So there's just a bunch of things that jumped out. But -- but -- at me, but I

think systems is -- is something that Belinda brought up and we've -- we've got a system -- systems in place that aren't working.

And I just cut -- keep going back to that, that there's been efforts to change the people to fit the system instead of changing the system to fit the people. So I hope our recommendations can really highlight that, that the -- that the systems need to change to fit the people.

The -- the -- the -- the -- the issue of respect of traditions is exceedingly important. And -- and I will add that perhaps much of the -- much -- some of that comes from a lack of understanding, you know, lack of knowledge. I put myself two feet in that, you know, of not kind of really having depth of knowledge of what those -- how important those -- what those traditions are and how important they are.

So I think we need to get more knowledge out there among the -- the -- not only the clinical -- clinical care providers, but the -- you know, the broader

public health nationally. I mean, I think we've -- we've got Minnesota public health providers are deep into this, but, you know, in North Carolina, they're not. And I'm telling you. Sorry, Belinda, but yeah.

And we -- and we have, you know, for the east coast, we have a -- a population, it's probably the high -- and I understand it's the highest population of indigenous and native people in -- on the East Coast. And we're not in tune -- I'm not, you know, and -- and many of our -- of my colleagues aren't. So I'll stop there, but lots more ideas.

ED EHLINGER: Thank you. Other thoughts that touched your heart, piqued your interest, stoked your passion, stimulated your imagination?

Phyllis?

PHYLLIS SHARPS: I -- I think for me --

ED EHLINGER: Introduce yourself.

PHYLLIS SHARPS: I'm sorry. I'm Phyllis Sharps, a nurse, a perinatal nurse, who has -- who's spent my career caring for underserved African-American women in urban

settings.

And as I listened to the -- the stories here, the pain and the hurt was very real. And it's not unlike what I hear from the women I care for and the level of distrust of systems that are supposed to help women, that further victimize women and stereotype. And I don't think always give the care that they're entitled to, the best care, the best practices.

And as I think about the recommendations, I -- yeah. I think we need to be bold. But the other thing that kept running to my mind is how do we make sure or how do we build in accountability, because we don't want another set, I'm sure -- I'm new to the committee, so this is my first meeting, but I'm sure you don't want a set of recommendations that people read and nod heads and then they get put away on a shelf and, you know, four or five years from now, we'll -- we'll be back considering some of these same things.

So I think we need to also think about a mechanism and -- and who else outside of

federal agencies and -- and folks that are represented here need -- needs to hear. You know, are there other audiences? Are there other mechanisms and ways to get recommendations out? Because if we certainly have it going to communities that are most infected, that's another level of accountability that -- that might be -- that we might be able to build into the system.

ED EHLINGER: Thank you.

Sherri?

SHERRI ALDERMAN: Sherri Alderman from Oregon. I'm a developmental behavioral pediatrician with infant mental health interests and expertise.

Again, I agree with what everyone has said and the tremendous number of -- of spotlighted issues and questions came up for me as well throughout the whole day that I'm very grateful for.

I -- I -- what I hear is that -- is that it's important that the dominant culture hand over the power for indigenous peoples to create their own system and -- and provide supports that would enable them

to actualize those -- that system that they choose.

The question that I have is to refer to this group of people that we're talking about as indigenous people is -- is a dominant culture bundling of a very diverse group of people. And I wonder -- and -- and that diversity also includes very significant disparities across that group of people.

And so what I wonder is how can our recommendations not only hand over the power for indigenous peoples to create a system that works for them but also cultivates an atmosphere that they create that brings all of the voices, the diverse voices that they have within the indigenous people, to be able to address the disparities and bring all of -- of the people that we're talking about to a level of empowerment that is best for their families, the communities and -- and -- and the babies.

ED EHLINGER: Thank you.

Marie?

MARIE RAMAS: Marie Ramas, family

medicine physician.

Many things struck me. I -- I think two additional thoughts in addition to my colleagues, that I'm considering for today and into tomorrow is what are current systems in place that are working to advance and promote health equity that we already have modeled for us, maybe in other areas, whether that be in commercial payer systems or in certain Medicaid spaces that we can help to translate into this space in particular?

The second area is the concept of workforce and thinking of creative ways to co-create solutions with our priority communities and particularly with our indigenous brothers and sisters.

So how can we elevate those recommendations to encourage and instigate alternative ways of promoting workforce? And I think we have several examples from yesterday that can help us with that.

ED EHLINGER: Great. Thank you.

Magda?

MAGDA PECK: Good morning. Magda Peck,

MP3 Health, University of Nebraska Medical Center, City Match and MCH Champion. I'm glad to be here.

First, I want to acknowledge the power of story. Story comes before data. Stories are data. But we've separated the heart from the -- from the numbers, and when we do so, we become numb.

And so the storification that happened in yesterday's design, the invitation for story, people are eager to tell their stories if they trust that they will be heard.

Second, of interest to unlearn and learn anew that indigenous health is predominantly in many ways or equally an urban issue and that the percentage of folks of in -- of indigenous descent who do not live on reservation, who are living invisibly in America cities, is -- it's just in -- it's an invisible fact.

And I think that we need to recognize the urban Indian health issues uniquely and truly open our hearts and listen to what has been inaudible.

Third, what can I say about passion? I think that anger is really useful. This is not a time for politeness and for anyone to have been with us yesterday, at a minimum, to not walk out and feel outraged, even if it's new for those of us who are white and privileged, the outrage is something we have to continue to stoke that fire, and honor the anger and act. Anything short would be another insult.

So it's not so much the passion. It's -- it's the absolute appropriate and essential anger to -- to keep fires lit.

And last, this is a moment of political will. This is a moment where we have this tiny sliver of attention of Secretary Becerra and HRSA Administrator Carole Johnson. We already have the remarkable ears and hearts and will of our MCHB colleagues. Thank you. And our CDC colleagues. Thank you.

But if we're going to change systems and change policy, it has to happen both in communities but where power resides. And so I just want to acknowledge that we have some

things we can do while we have this open window and to be bold about it.

As a start and a final note, there were some remarkable humans who addressed us and welcomed us into their story, who would be fabulous SACIMM/ACIMM members. And I hope that the place to recruit starts here so that when we -- we meet next again, there is no excuse for not having greater voice and visibility beyond the extraordinary leadership of Dr. Palacios.

If we don't change us, how dare we ask for anything else to change. It starts with that little step right here, right now.

ED EHLINGER: Thank you.

Janelle?

JANELLE PALACIOS: Thank you, everyone, for every -- everything that has been shared because it's exactly what I was hoping to hear reflected back today and that all those stories and comments from yesterday were able to help show the committee just how intense the situation is and how dire the needs are.

In a conversation afterwards I had with

two wonderful colleagues, Dr. Ramas and LaToshia from NICHQ, I would say that my world was turned upside down when they introduced an -- an idea that was right in front of me and that I've lived but I forget because I live in two worlds, and that is a reframing of these recommendations.

If we're to be bold and not be mild, like Secretary Becerra has asked us to be, then I would rename these. Instead of recommendations, these are amends. These are a restitution. This is what is owed to us. We're not asking for these things. This is what is ours. We've already prepaid.

ED EHLINGER: Thank you, Janelle.

From our ex-officios, also any -- any thoughts? It's not just the appointed members. Anybody else? Any other thoughts that you might have?

CHARLAN KROELINGER: Good morning. This is Charlan Kroelinger, CDC. I just wanted to say, we are here, we are present, and we are listening. And we appreciate being invited to the table and given the

opportunity to hear native voices.

Those lived experiences yesterday were very impactful for us, and we hope to contribute significantly in the discussions for the amends.

ED EHLINGER: Thank you.

AMANDA COHN: Good morning. And I'm -- I'm Amanda Cohn, also with CDC.

Just ditto to what was just said. But I think the other thing that struck me and we think about is that this is the tip of the iceberg in some ways, right? And I think that this is -- these stories reflected these lived experiences, but there are so many more.

And, you know, not -- I -- I'm hopeful. I think somebody said yesterday that -- that changes that can be made to amend this population will have benefits for the whole population. And I -- I do see that. And so I'm -- I'm looking forward to -- to hearing the recommendations and the amends from the -- from the committee. Thank you.

ED EHLINGER: Dr. Warren, Lee?

MICHAEL WARREN: Thank you. Michael

Warren, HRSA Maternal and Child Health Bureau.

First of all, thank you all for an incredible day yesterday and for the work that went into organizing this and creating such a powerful agenda and look forward to -- to today and tomorrow as well.

As I was reflecting last night, I was -- I always try to think where have I been implicit or complicit in -- in the system that we have and in the outcomes that we have. And I was thinking about, in particular, the implicit part of that.

And during my time in state public health work, I was in a state where there were not large federally-recognized tribal communities, and I did not know it was my own ignorance about urban Indians.

And so when I would hear national statistics about disparities, it didn't cross my mind that there was work to do. And so I think about that opportunity lost. And that is frustrating on the one hand, but I think about there is a time to learn and relearn, and -- and this is it. So I

appreciate that learning and teaching that we got yesterday.

I also want to comment on the power of the story, and I think it's one of the things -- one of the many things we've been robbed of during COVID. And we figured out a way to meet virtually. We have made do.

But the -- the lack of in-person connection, I think has taken away some of those opportunities to not only hear, because we can -- can hear that virtually, but to see and to feel in the room the -- the palpable pain and sorrow and anger that I think for all of us are so important to feel. So I just -- I want to thank you all for bringing us together in this way.

ED EHLINGER: Thank you.

Lee, do you have any thoughts?

LEE WILSON: Yeah. I have two observations from yesterday that were comments made, one early -- early in the day about when data come out that reveals a problem, many look at the results and say, what's wrong with these people? And I think it is incumbent upon all of us to remember

that when we see and hear data, that we have a filter and a lens that we use for addressing those data and how we choose to interpret our reactions to it. And there is an easy leap that we can make to what could they do better for themselves.

And I'm not saying that that isn't a question that needs to be addressed, but that needs to be addressed by the individuals who are affected by it and not necessarily by us and, therefore, to try to focus on what is the responsibility of whatever chair we're sitting in to address the needs and not filter it through a lens of judgment, a judgment on those individuals.

The other -- and this is just sort of my take -- on and my general approach to life is I tend to look at inconsistencies and say, you know, we're doing it this way, but it doesn't make sense for us to do something different in another place. And one of the points that was raised yesterday afternoon was the fact that we go to these heroic efforts to save these mothers and

these babies through the clinical systems that we have in place, and then we release them afterwards into an environment that may be just as destructive as what they were facing before they had their condition.

And so when we're making our recommendations that we're making fulsome recommendations about the life of the individual and not just an individual intervention because our concern is with the whole person and not just with that particular experience that they're having.

So that's my observation. Thank you.

ED EHLINGER: Thank you all for those -- those comments. Just to acknowledge that we do have some people on -- on Zoom that are joining us; NCHS, CMS, the Office of Minority Health. So they are -- are looking at us on -- on the screen as we speak.

And I wanted to reflect on -- or reiterate what Dr. Warren said. I think just having this meeting in this facility, in this, place at this, time bringing the stories together from the people from where

they live and where they work is -- is really important.

And then just having all of us, as -- as Kate said, around the table, it just changes the character of our -- our interaction. So I -- I really appreciate that.

So we're going to move forward into our meeting today. It's also going to be packed, but I want to highlight just two things. You know, I always kind of reflect on the history of things.

It's -- there's two birthdays today, one among many, but I want to highlight Ivan Pavlov, you know, the Nobel Prize winner for physiology. He said, "While you are experimenting, do not remain content with the surface of things. Don't become a mere recorder of facts, but try to penetrate the mystery of their origins."

So I think that's relevant to what -- we've got a lot of facts, a lot of data. So let's just not look at it and admire, as was said yesterday, admire those data, but let's look at and penetrate the mystery of those

things. And that's what I heard people talking about here. They were getting at the mystery or the pain or the -- the substance of that.

The other birthday is Sydney Harris, a journalist. He said, "An idealist believes the short run doesn't count. A cynic believes the long run doesn't matter. A realist believes that what is done or left undone in the short run determines the long run."

That is our charge today. We are here in this time. I don't care. We have to be a realist and say, all right, how can we make this better in the long run? This -- which is not going to end with our work tomorrow. It's going to continue. And we need the partnerships. We need the data. We need the passion. We need the support. We need the partnerships. So let us think about that as we move forward.

So now I'm going to turn it over to Joanna Bryant, who you heard yesterday who did the tribal welcome. She's going to update us on -- on what's going on with the

Shakopee Mdewakanton Sioux Community.

I realize that if we're here, we should learn a little bit about what they want. And I -- I particularly really wanted to have this meeting at the Shakopee Mdewakanton Sioux Community because oftentimes, when you look at indigenous folks and American Indians, Alaskan Natives, we always look at deficits.

And certainly, Shakopee Mdewakanton Sioux has lots of -- of resilience and lots of -- of positive things going on. And so I wanted to highlight some of those. And we've heard it from some of the other presenters, but this would be a good time to -- to -- to do that.

So, Joanna, I turn it over to you.

JOANNA BRYANT: Thank you.

Good morning, everyone. I'll admit, you know, hearing your guys' reflections is super powerful and very encouraging for me, right? I was not able to be here yesterday due to our -- we have our general counsel component. It's our required meeting for tribal members and that -- that's where I

needed to be yesterday, and again, at some point this afternoon.

And I will say, you know, in my spare time last night, I dug up, you know, your charter, and I looked at your last set of recommendations trying to find something that I could make relatable to the SMSC.

I think when Ed first asked me to kind of do this review of SMSC, I'm like, wow. Like, how am I going to make that relate to the rest of the world outside my little bubble here in Prior Lake, Minnesota, right?

So I'm going to share a few things, but the things that I heard this morning were the things that I woke up saying, I hope they're looking at this, right?

So I'm going to try and break it up into getting the overview done and then talking about why I think SMSC and what's led to our ability to make those changes and implement some of the programming that obviously lived in your previous recommendations.

So for those of you that don't know, obviously, SMSC, we have our own health care

system that we operate. And I think the foundation of recognizing how we're able to do that is our self-governance ability as a sovereign nation and our ability to self-govern our federal funding that comes through us and then is just passed to us through the IHS system.

Now, not every community or tribe is able to do that. I know they're trending towards the ability to do that. And I think that that's really crucial in the empowerment of the tribe, the community, to improve and govern their own health, right?

So we are able to -- in the last -- I've been working in my role within the health department for the last 18 years. We have very stable leadership within our community. And so the mission of health care kind of stays focused. It stays right up there in the front of what our community is trying to do.

So we've been able to incorporate a health care system that includes all of the -- all of the good stuff, right? Your primary care, your urgent care, your vision

care, your behavioral health services. We do, you know, chiropractic and physical therapy. You know, we -- we kind of put it all in there in that whole person care model.

And then we ensure within that system that we have collab -- collaboration amongst departments by one unified medical record, right? So information is there and available.

Our dental team, when they're treating a diabetic patient can clearly see what's going on with the -- the diabetes care. Our diabetes educator can look and see, hey, I see you haven't been and gotten your -- your cleaning. Let me help you set that appointment. They can go in and set the appointment, right, and get that -- make those connections and care that need to happen. So I think that addresses that whole issue of fragmented health care and how that really can impact any individual's health when the system is fragmented.

I'm sure you all have had experiences in a health care system where you're showing

up and you've been referred and the very first thing is they don't know who you are. Sometimes they don't know why you're there. You're filling out the same paperwork you filled out at the previous place, and you would have thought that, you know, the records were going to be sent over. And you're starting over at ground zero every single time you engage with a new person in your health care journey. And I think that that can be super disruptive.

And again, so I feel like you guys have talked about, right, what really impacts or what -- what can impact an individual's ability to receive medical care. The opportunity, you know, is the care available? Can they get there? Can they get to where they need to get the care from in a reasonable method, in a reasonable amount of time? The environment, where is the care being provided?

And then I think barriers, you know, everyone has a unique set of barriers, and you really don't know what those are until you ask. And I think we've learned in even

serving -- our clinics and services are available for our tribal members. And we also serve our -- what we call our area natives. So natives who are not members of our tribe, but live within Scott County, have eligibility to get direct care services from our community.

And even with -- within those populations, you know, our providers, when they first come on board, we have to explain to them, you know, you may have a -- a well child check on your schedule. Our minimum appointment length is 30 minutes. We want our providers to spend time. But don't be surprised when mom shows up, she's going to have the child on the schedule, and she may have two or three in tow. So it's not just about treating the one child that's on the schedule, right? It's about having the ability and the flexibility within the health care system to treat the family when they're there, when they are in front of you and making that connection.

And that's not really realistic in the way in which our health care system runs

today, right? Super quick, fast-paced. In my opinion, health care has become a business, and it's not about the business of providing -- taking care of people's health. It's a money revenue-generating system.

Now, if you guys can fix that, I -- it would be astounding, right? Like, it's -- it's a big-picture problem.

And so, again, like I said, I -- I think that there's -- there's two -- two pieces that I'd like to share today of -- of why I think that we, as a community, using our self-governance capabilities and what that leads us to be able to do with -- with partnerships and then how -- how important I think that is.

I heard some reflections here about empowerment. How do we empower the individuals who need the care? And this will be a contrary statement to, I think, anything I've even ever heard myself. So I'm really surprised that it's rolling around in my head.

As a committee, in this particular instance, if you are truly looking for the

ability to impact indigenous women and children, these -- that population is probably your lowest hanging fruit if you really want to make an impact. And there's ways in which to do that.

Where -- where are you -- where are your policies or recommendations guiding for funding to go to? I think that federally-recognized tribes have the ability to take and receive that money and implement their own programs to ensure that their communities are healthy, right? Check one off your box. Give them the opportunity to rise to what they need to do and take care of their own people and determine their own policy.

I did read several of your recommendations. I think 167 pages, I didn't get to page 167. Kind of rested in the first 10, 15 pages with the recap. And what struck me -- and I've seen it everywhere I've looked before, but I think I was looking at it through a different lens last night.

Recommendations, you guys have

recommended everything, right? We're recommending doula care. We're recommending alternative options. We're trying to get people there. We're doing all these things. And then somewhere in the paragraph to providing evident -- evidence-based care. So you're creating an amazing recommendation, but we're also putting a barrier right into the language of the recommendation. I fully understand the need for evidence-based care and the research and everyone's favorite word is data.

Unless you have personally been in a situation where your health care potentially is being impacted because someone doesn't have enough numbers on a piece of paper or something, a checkbox isn't done, it's a very, I would say humbling, but I'm going to change that to devastating place to be.

When you're -- when you -- when you -- I'd -- I'd ask you to look through the same lens of any other individual who may not be part of a -- of a class who is suffering or having a health disparity. I don't know that they need to prove the need or the

outcome for them to get the care that we're talking about here today. I don't know that the same factors apply.

You can -- if they -- if they have that ability to go out and get their private insurance, they can go to the doctor. They can do all these things. There doesn't have to be data coming back saying that that's an appropriate use of the fund -- of the money. And I think that's the lens that we're kind of missing here today as well.

And so for -- and here's an example of kind of something we were able to do with those things, right? I mean, under our ability to manage and create our -- our own components. Not to say that, you know, we go from where the funding goes to IHS. And, you know, IHS, kind of, you know sometimes they put little and we need to do this and you need to give us names and -- you know, there's challenges there. But we pretty much are able to create these culturally-based programs that -- that we know work with -- within our community.

We have a program that we call -- it's

a care coordination program. We call it Oyate Care. And the navigation concept in and of itself is really showing to help us connect, right?

We have services, but we don't have all the services, right? There's always going to be a need for our members to go outside the boundaries of our reservation and plug into a system, a system that can be very challenging.

And so what our care provider does, we have a nurse who then ensures that the appointment's made, the records are sent over, all of the information, that it's in the hands of the other place that we're referring to.

We not only do that, but we also send another copy with the patient so when they get there and the facility says, "Oh, we don't have your records, it must have -- we must have never gotten them," "Well, here's another copy. Here's my last lab test. This is why I'm being referred."

In certain situations, when we're talking about large -- large issues or very

challenging health conditions, we will either send our nurse or our -- our provider. We use PAs and nurse practitioners within our clinic settings. They'll go with them and be that -- that medical person there to help them navigate that care.

When you think of a concept of someone getting a challenging diagnosis, we've seen it happen before. You go in and someone's told they have cancer, right? Once you hear the word "cancer," I think everything else intuitively shuts off in your mindset.

And then they want to rattle off 14 pages of options and treatments and considerations and all these things you need to do. And I don't know that people are hearing that.

I assume that would be the same thing very similar to a mother going in and hearing that there's something wrong, right? There's a challenge with her pregnancy. Natural body response is you -- you first need to -- you're going to shut down. You need to process.

And so by having that other individual there that not only knows their past history, can understand the diagnosis, take notes, be able to relay that back, help coordinate future care appointments, and I think most importantly, ensure that we're not getting a duplication of services.

Like I said, right, when you go from referral to referral, everybody wants their own lab work, and they think they need to use their X-ray machine to get an X-ray of the same thing you just had X-rayed, and I don't know that that always necessarily makes sense, in some cases, maybe so. But I think that duplication of care and that care navigation has been super important with -- within our community. And so that's a good example, right?

Now, could -- could I provide statistics and data on that? Yeah, I could go dig and we could -- we could make it -- we could get it all out and pull it over to our system because we have the benefit of having a resource to put those statistics in, but it's -- it's not the primary driver.

We -- we look at the outcome. If at the end of the year, we can say that we reached a success where we had no incidences or we didn't have any mothers or children passing away from complications, then I would deem that a success for that year. And we would move forward trying to improve and -- and move on other topics that -- that could be impacting that from other ways, right? Because it's not -- it's not a singular. You guys have demonstrated that already with what I heard you say this morning and -- and kind of everything that I read that I -- I could get my hands on, you know, last night catching up on everything that you guys have been doing.

Another example I think of is what I call kind of the blending of services, right? So when we look at our community, we have a childcare facility that does a lot of the primary childcare from, you know, infants all the way up through school age, and it even goes a little bit past that.

But when we went to address for, say, the social and emotional development of our

youth, we go to where the children are, right? We go to where the potential to make impact is there. We don't necessarily make them come to us. So by infusing a childcare -- or a model that -- called Conscious Discipline, by training our staff and infusing that staff into the childcare environment, we are able to identify challenges in very, very young children with emotional needs or coping skills, or whatever it is, and impact them on a daily basis with consistency more so than not five days a week. That's primarily where they are and then extending that education into the home to the parents.

And when we say we bring a concept like that on, it's not just the staff at the -- at the Playworks facility that we engage in that training. These children are also going to cross over into our education department. So we train the staff in the education department on the same model.

They're going to end up in our health clinics. And so we ensure that our providers are also aware of this very unique

method and the benefits of doing that. And so it's, again, integration campus-wide, throughout our health system to ensure that everyone who has the ability to impact these individuals is doing so in a consistent manner.

So that's another one of my favorite programs. So it's relatively young in its development. I think we've been working conceptually for about three years. And this last year, in 2022, we were able to get a designated classroom off and complete lots of training.

And in October coming up, we have a whole week that we're actually closing the facility, bringing all of our staff together and doing a training across the board. So does that create challenges? It does, but we're -- we'll figure out our way through it to get -- to get that training done.

You know, and again, like I said, I think some of the other things -- and -- and that philosophy, I think, carries over to things even outside the Health and Wellness Department, although they're closely

related.

If you've done any research or know anything about the community, if you talk about any particular issue. Nutrition, we have an organic farm. Our farm then provides produce to our store that's across the street over in the -- in the -- by the convenience stores, behind that. Mazopiya, right? It's -- it's an avenue for us to have our -- our produce and fresh stuff out there and available to our membership, right? So I think that that -- conceptually the way in which we address issues is that full-scale approach in -- in all the little pieces that -- that we touch.

And I think the most important thing that -- that I would say that I heard this morning in the reflections and that I saw in some of the recommendations is I would really encourage you guys to look at the systems, right, that you're relying on to deliver your recommendations.

I saw the word "Medicaid" a lot of times in the recommendation as the -- what appeared to me to be the arm that was going

to deliver the -- these recommendations and -- and care or -- or carry out your vision. I think if, as a group, you -- if you've never tried to fill out a Medicaid application, it's -- you know, it's a good time.

Collaborating between, in Indian country, the -- the policy that they have, the insurance that they have and -- and first and secondary and who paid benefits, I -- I can't have a tribal -- an elder tribal member waiting 17 days to get a wheelchair because they're worried about who's paying first and who's paying second. And Medicaid can't do this because this hasn't done this. I mean, it's that internal flow that's -- that's broken.

Had they been on a private-paying policy, they'd plop their card down, and a wheelchair would automatically be delivered, like, same day. I mean, sometimes people aren't -- they can't go home until they have these things, the home outfitted, the home health care stuff.

So I think you guys are right on cue

with saying -- all recommendations have been amazing. I mean, can they be improved? Sure. But where -- where's the roadblock? Where's the barrier in what you're trying to do? Just like you look at with health care, I think that your systems is going to be the place where I would think you could make the most impact, but...

And conceptually, that -- that's really all I -- I had to share this morning with you guys. Ed wanted me to be sure to leave time for questions, in case there was any -- any questions in regards to something that SMSC is doing that I could potentially answer.

ED EHLINGER: Joanna, thank you very much.

Questions? Yeah, ShaRhonda?

SHARHONDA THOMPSON: ShaRhonda Thompson.

Thank you, Joanna. I appreciate what you were saying. I just want to kind of clarify some of the thoughts that I had in my head based on what you said.

JOANNA BRYANT: Uh-huh.

SHARHONDA THOMPSON: So the way that you all are set up, you're a federally-recognized tribe, so you get the funds directly and have the ability to govern the funds in your health care.

So what I was thinking you were saying, correct me if I'm wrong --

JOANNA BRYANT: Uh-huh.

SHARHONDA THOMPSON: -- is that if we can increase the funds to the federally-recognized tribes, they would be able to incorporate the other tribes that do not have that ability to govern themselves and their health care that are near them like you do with the other natives that are near you but not part of your tribe?

JOANNA BRYANT: Yeah. You know, I -- that -- again, I can't speak for all communities. I mean, again, in my experience, if we talk about -- so Minnesota, right? I'm obviously very familiar with Minnesota, because this is where I live.

I mean, the 11 tribes that are here in Minnesota, they do work together and -- and

collaborate, you know, in regards to how those things are going to be done.

But the first part of your question, yes. I think that if you want to impact the indigenous population, you need to recognize that they have the ability, will, and drive, and I think the knowledge that you're searching for to improve the health of their own people.

And so instead of running that funding through any other gatekeeper, you need to allow the tribes that funding and give them their money to improve their health, right? Because they're the only ones who can really truly do it.

And yes, I mean, I do think that having the ability -- again, that on site. When we add or create a service within our direct care clinic, it obviously immediately benefits our population that may not be enrolled in our tribe that have access to the clinic.

Your urban question on the urban population is where you might need to consider how would you fund or give the

tribe the opportunity themselves to support their urban population, right? There's a lot of dynamics that go into play about an individual who -- who may be enrolled in a federally-recognized tribe that's living in an urban setting, but you also have to -- there's probably urbans that are not enrolled in a federally-recognized tribe that also live within that city population.

But again, that -- that barrier to when the funding is provided, it's for services that they normally provide with on -- within the reservation bounds. So if those -- that individual is displaced to have to go work and do -- provide a living for their family, their ability for the -- to go back and forth to get that care is -- is challenging.

But maybe some type of direct allotment that allows them to care for their -- for their urban population could potentially improve the outcome.

ED EHLINGER: Joanna, I'm -- I'm curious, you know, the Shakopee Mdewakanton Sioux is -- is a -- a major player in Minnesota. I mean, you are a -- you have an

influence in -- throughout the state, you know, particularly in the Twin Cities, with the University, with, you know, some hotels in St. Paul and -- and lots of not-for-profit organizations.

How -- how do you imbed sort of your culture and -- and your learnings into your more community outreach activities? How -- how do you try to influence the broader population that you are influencing --

JOANNA BRYANT: Yeah.

ED EHLINGER: -- because of who you are and -- and what is your strategy and how do you make that happen?

JOANNA BRYANT: Yeah. That's a great question. I mean, I think that ultimately, you know, yes, we have that ability to -- to engage in conversation. But, again, it -- it comes down to -- I think it comes down to a lot of hard work by a lot of the people who -- who are part of our team, our employees, the people who we bring on, as -- as, we'll say, experts, you know, that are providing our health care.

So, for example, when we talked about

that care navigation program, right? And I heard you guys talk about, you know, how to ensure that it's to address the lack of respect or it's really education, right? You really have to get out there and you have to educate the -- the people surrounding us that are providing care to my members when it's not within my own clinics, right?

So we partnered with, for instance, St. Francis. They're probably the closest hospital to us, a couple of miles down the road. So we went in, and the tribe, we used our -- our staff to do, like, cultural training. And the year that we did that, we -- we ran every -- they ran everyone through the program and we -- we engaged with over 500 medical care providers within their system and talked about all of these great things, you know, understanding things.

We helped -- we have a smudging policy in play at St. Francis. It's also at another facility. It's with one of our youth behavioral health care partners, which

is Prairie Care. They -- they've -- they've taken on and made that part of their policy.

And, again, I think most times it's like, well -- well, how do you do that? Like, what do we have to do, and what does it have to look like? And I think, you know, allowing the individuals to bring in their -- their -- what they deem is culturally appropriate in any situation. I mean, they'll direct you.

You know, I think the policy really even wasn't that complicated. And, I was like, number one, you know, get a cover for your smoke detector. That's it. Like, it's that simple. Either, you know, cover it so the smoke doesn't set it off, and then the individuals can go ahead and do whatever traditional component of their -- their -- their -- that they want.

So I think it's -- it's a lot of education. It's a lot of reaching out, making yourself available, showing up to the table for the conversations and just trying to infuse.

And I -- I think we try to do it by

example as well, right? Like, some of our missions and what we put out there when we were focusing on nutrition, the seeds of native health, right? And we -- we helped develop that campaign and partner with the U of M.

So there -- there is a lot of partnership that needs to go on. And that's not always the easiest thing when you're talking about Indian Country, because not -- relationships with outside cities and government structures that surround a -- a tribe or -- or reservation land, those are not always, you know, the healthiest and/or most positive relationships.

And so -- but I do think that that's where the hard work has to come in on both parts. They have to come to the table realizing that if we're going to actually make an improvement, we have to find a way to interface with and exist within that system that lives outside of our walls and -- and make it work to our benefit. Yes.

ED EHLINGER: Okay.

UNIDENTIFIED SPEAKER: Couple questions. I -- I -- you know, we're trying to think big. We're trying think do bold. We're going to try to put recommendations out that'll incite change. When we think big and think bold, then we kind of have to think practical, too, in terms of recommendations. So this is the kind of background for my question.

I need to learn a little more about the -- the -- the pass-through sit- -- you know, that -- that you have. Is that -- is that something that you negotiate with Indian Health Service? How does it happen that -- that tribes --

JOANNA BRYANT: Uh-huh.

UNIDENTIFIED SPEAKER: -- get that pass-through? And -- and is it -- is it practical for most tribes to be able to do that or are small tribes going to be -- not be able to manage that? And -- and, you know, would it be constructed, then, at the state level? I mean, how can you make that concept really practical? Because it sounds really good.

JOANNA BRYANT: Yeah. You know, again, I don't know the statistics in regards to how many tribes within Minnesota or -- or within the region are at -- where someone -- where are we?

60 percent of the tribes are already utilizing a self-governance contract. So where they're not, it -- it -- again, that would be a good question. Why are -- why are they not able or choosing not to use that self-governance contract? It -- it's -- it's a choice. I mean, you have a choice. Again, there's a process, I mean, that you have to contract basically. You have to have an agreement.

And there's some -- you know, obviously, I'm trying to think off the top of my head. It's been a long time since I looked at ours, because it's been in place for so long.

You know, the ability, you have to show the ability to maintain the financial component, so there has to be some proof of some stability and whatnot. And there's some audits required, you know. Of course,

there's always red tape, right? There's always pieces that they have to do.

So and I think that number continues to grow. At least I know that the -- the tribes that -- that we come in contact with or that we're talking with, that's something that we're always sharing.

I mean, we -- we're always going out when we're asked -- and we get a lot of tribes that come and visit us, and we're like, hey, look at -- look at your option for self-governance, right, so that that -- those funds can be directed directly to you.

And I think, just a follow-up on your component. Yes. I -- I love the -- the dream -- the dream big, you know, the going bold type thing. I don't really have a practical. My -- no, you know, like -- like -- it's -- it's so hard to blend those two together. It's very, very hard.

Yeah. I mean. Yeah. You -- there's always a way. I'm a firm believer that there is always a way to get -- to get to the end of the road. But at the same time, how do you -- how do you -- again, it's all

going to -- allow those -- allow the individuals who are -- who are capable and -- and can do that to -- to start doing that themselves.

ED EHLINGER: We have time for one more question, and Dr. Warren has it.

MICHAEL WARREN: Good morning.

JOANNA BRYANT: Good morning.

MICHAEL WARREN: Thank you so much for being here.

I was struck by your comments a few moments ago about the relationship with -- with other city or state governments and some of the challenges there. And at HRSA, we've been trying to work to look where we've got the opportunity to expand our eligibility for grant programs directly to tribal communities to do that.

Some of them, the way the laws are written, it -- the -- the grants go to states. And so are there -- are there ways that we can think about those programs and support those interactions with tribal communities within states or experiences that you've had that make that work better,

that we could take back to -- to that grant funding?

JOANNA BRYANT: That's a good question. Well, I mean, my first thing, well, change the language. Don't limit it to just states. But that could be, you know -- sounds simple -- simple -- simple but extremely problematic, right?

You know, I think that -- again, I -- I think it would be in -- in how -- how you're going to allow them to deliver that, right? So, again, it's all about these systems that you want to use. You want to -- how -- we're -- we're saying there's funding available, but we want to run it through a system that has inherent barriers in the system.

And so I don't know how to solve that problem unless, really, and I think maybe jokingly, I was serious, you have to change the language. You have to change it at the -- at the beginning in order to say -- to make that impact, right?

If -- if -- if you're going -- if you're going to give funding to a state,

why -- why would you not give it directly to a federally-recognized tribe? I -- I don't know.

But -- so I -- that would be my question is, why is -- why is the policy what it is? I mean, again, when you -- when you look at a state system, any public health system with any state, I mean, they have a huge job on their hands.

And I'm saying, again, if there's a -- is a community that happens to reside in there that has a sovereign status and has the ability to facilitate their own, why would you not want to direct that care, let them improve it, and let the -- and reduce the -- the amount of scope that the state has to have?

ED EHLINGER: Joanna, thank you very, very much for -- well, for hosting us here --

JOANNA BRYANT: Yeah. Absolutely.

ED EHLINGER: -- and for your -- your presentation. I hope you -- you're going to hang around for a little bit during the course of the day. I know you've got other

things going on --

JOANNA BRYANT: Yeah.

ED EHLINGER: -- but I'm sure that people may have some -- some questions --

JOANNA BRYANT: Absolutely. I have to step out for a little bit --

ED EHLINGER: Yeah.

JOANNA BRYANT: -- but I'm -- I'll be back this afternoon.

ED EHLINGER: Wonderful. Thank you.

JOANNA BRYANT: Okay. Good. Well, good luck, and have a great day.

ED EHLINGER: All right. Let's now move on to our next panel. So if we have Meredith Raimondi and Patrice Kunesh. Come on up and -- and sit at the -- the table up here.

And I know we have Stacy Bohlen on -- we don't have this quite yet, but it's -- that's going to be the next presentation is the swearing in of this.

But we're -- there's another big thing that happened today. Your money is now going to have a signature of an American Indian woman, Chief Lynn Malerba. And I say

that because one of our panel members, Patrice Kunesh, was interviewed by NPR's Marketplace Report, I believe. And so as I'm driving in today, Patrice, I heard her voice on the -- on the radio.

And -- all right. So we've got -- we're going to be talking about policy and program considerations to improve indigenous health. And I've got Meredith Raimondi, vice president of Public Policy, National Council of Urban Indian Health.

MEREDITH RAIMONDI: Good morning. Thank you. I think we have a slide show as well.

ED EHLINGER: Okay. Okay. Good.

MEREDITH RAIMONDI: I'll let them get that --

ED EHLINGER: Because -- yes. Yeah. No, this is fine. Mary Owen had talked about this -- this historic day, so --

MEREDITH RAIMONDI: Yeah.

ED EHLINGER: So we've got to -- it's going to be marked a couple of times.

MEREDITH RAIMONDI: All good to go, Emma? All right. Thank you.

EMMA ALLEN: Yes, we are. Apologies.

MEREDITH RAIMONDI: All right. Thank you.

Good morning. My name is Meredith Raimondi, and I am the vice president of public policy at the National Council of Urban Indian Health.

I'd like to thank the Advisory Committee for the invitation and the opportunity to present today and talk about recommendations regarding the health of American Indian and Alaskan Native infants, children, and mothers living in urban areas.

Thank you to the Shakopee Mdewakanton Sioux Community for hosting us for this very important meeting.

NCUIH also thanks this committee for its commitment to improving the health of indigenous mothers and babies.

I'd also like to thank Joni Buffalohead and the Indian Health Board of Minneapolis, which has been providing health care to Native people in Minnesota in urban -- in urban communities since 1971.

Native communities throughout the

country experience maternal and infant health disparities compared to the general population, something you have heard over and over the past few days.

While there is not a one-size-fits-all solution to address these alarming disparities, we have prepared some recommendations for the committee today.

Next slide. Like many of you, we have been working in this space for far too long without seeing results that have remove -- improved health outcomes for mothers and babies.

As we begin, I'd like to highlight some recent work on this topic. In March of this year, we submitted comments to this committee, and last month we, submitted comments to HRSA's Maternal and Child Health Bureau regarding the Pediatric Health Care Access Program.

In our comments, we have continued to stress the critical importance of including Urban Native populations in HRSA's overall efforts of improving health outcomes for all Native people. I will cover some of our

policy recommendations in the following slides.

Next slide. I just wanted to share a little bit about NCUIH, the National Council of Urban Indian Health. We are a national nonprofit organization devoted to the support and development of quality, accessible, culturally competent health and public services for American Indians and Alaska Natives in urban areas.

We advocate for the health of urban native communities, and we provide critically needed technical assistance, training, policy support, and other services to urban native communities located throughout the United States.

Next slide, please. So you've heard a lot about urban Indian organizations and urban Indian health over the past few days. And I just wanted to break that down a little bit further. One thing that we heard about is, you know, federally-recognized tribes and federally-recognized tribal members.

In addition, urban Indians are defined

in statute to also include descendants and state-recognized tribal members. So these individuals may also receive services through the Urban Indian Health Program.

And then "Urban Indian Organization" is a technical term used in the Indian Health Care Improvement Act to convey the health clinics that are run by urban Indians to provide health care to urban Indians.

I'd like to recognize that Minnesota is a historic site for the hosting the first meeting on tribal land because the Twin Cities and Seattle, as you heard from Socia yesterday, were among the first official urban Indian organizations in the country.

These programs were first established as pilot projects created by the communities, beginning with the Indian Health Board right here in our backyard of Minneapolis.

51 years ago, in 1971, Representative Julia Butler Hansen of Washington, who ran the Appropriations Committee serving Indian health, said, "The problem arises when Indians leave a reservation on their own and

are clustered in cities such as Minneapolis-Saint Paul." She also stated that "Improving the health of mothers and children has always had the highest priority in the Indian Health Service."

This was 51 years ago, and here we are today, and we are hearing the exact same issues over and over and over again. And I would just like to point out that this -- even the language of the colonizer is -- is apparent here when it says that Indians left the reservation on their own. We heard again over and over how people were relocated, displaced, and terminated. This is by the country, and these are the systems that we are talking about.

But I would also like to highlight that urban Indian organizations are a shining light and a place within the system that is working when it isn't able to do so.

Congress first established urban Indian health clinics in 1976 officially, when only 40 percent of native people were residing in cities. Again, 50 years later, the budget for Indian health service for Urban Indian

programs is 1 percent of all Indian health care.

There are 41 urban Indian health clinics with 77 facilities, and they are growing at a rapid pace, yet they cannot keep up with the growth that they're experiencing due to lack of investment and funding.

Next slide, please. So this just explains the Indian health system. Like we said, a lot of systems are being discussed today. There is the Indian Health Service, which runs federally-run facilities. Then there are tribal contract or compact facilities. And then there are urban Indian organizations.

Next slide, please.

You heard a lot about the services provided by these clinics. And I would like to also note that the Oklahoma City Indian Clinic is opening a first-ever urban Indian maternal health clinic in the coming year.

As providers of culturally-focused health care, we have heard that term over and over again, and you have seen from the

discrimination that people have experienced why it is so important to be able to go to a provider they can trust. At least 23 of the clinics provide maternal-infant health and prenatal and/or family planning.

Again, as Socia mentioned yesterday, because there is no dedicated funding for urban Indian health in maternal -- in the maternal area, they have to do with what they can with the funding they have.

They also provide pediatric services and participate in the maternal-child programs such as WIC and HRSA's Maternal, Infant, and Early Childhood Home Visiting Program.

Next slide, please. We'll make sure these slides are available. These show where the different clinics are located throughout the country.

Next slide, please. And this is where all of the different types of IHS facilities are located throughout the country.

Now, as you know, there are native people everywhere, and there are not dots everywhere. So that is something we can

change.

Next slide, please. Okay. So significant disparities persist, and there are many statistics on the coming slides. And again, we will make these available.

Next slide, please. So we have a handout that we have shared with you, and we hope that this will be helpful as you make your recommendations going forward.

Next slide, please. Again, we went through some of the factors that you heard about, cost being a major component and a barrier. Again, filling out Medicaid applications and the discrimination and lack of cultural competency.

Next slide, please. We also wanted to highlight that Native infants and mothers living on tribal land and reservations, along with urban native infants and mothers, experience significant disparities.

This chart here is from 1989 to 1991. The -- the location we're in is number one for inadequate prenatal care for American Indians and Alaska Natives.

Thankfully, the areas of

Minneapolis-Saint Paul; New York City, Bakersfield, California; Baltimore, Maryland; Billings, Great Falls, Montana have all done incredible work to improve Urban Native populations and access to resources. However, significant disparities continue to remain.

Next slide, please. Another thing we've heard about a lot over the past few days is the federal government's trust responsibility. And so I wanted to outline what that is and why it's important. This is a sacred promise that the United States made to American Indians and Alaska Natives to provide health care.

So when we talk about a return on investment, there is no return on investment. This is a prepaid health care plan, and it is the United States government's responsibility to provide the highest health status, highest possible health status, and to provide all the resources.

How is the system going to be successful if you do not set it up for

success by providing the resources that this law says that you are supposed to do?

Well, our UIOs do carry out the trust responsibility to provide health care for natives in urban areas. In fact, recently, through the COVID-19 pandemic, when you heard that there was an influx of resources to the system, the highest percentage of -- of population receiving COVID-19 vaccines is the native community. And that's what happens when resources are provided and made available. The health care is accessed, and it is received.

Next slide, please. Unfortunately, despite the critical importance of the Indian Health System, the United States has not met its promise. This underfunding is particularly troubling to urban Indians.

According to the U.S. Commission on Civil Rights, below funding federally appropriated for urban Indian health care is concerning and likely falls -- fails to meet the obligations of the federal government under the trust responsibility.

Over half of the UIOs provide maternal

health care, but due to chronic underfunding, many health centers only have the capacity to carry out these services for the early stages of pregnancy.

Despite the desire to do so and the community-based need, many urban Indian health clinics cannot expand their services due to underfunding. Often, expecting mothers who wish to visit urban Indian health clinics have to be referred to hospitals and non-UIO clinics for continued care. And in yesterday's example, you saw how the transfer of care resulted in the death of a mother and her children.

Next slide, please. We support the committee's recommendation to reauthorize the Maternal, Infant Educate -- let's see, Maternal, Infant, and Early Childhood Home Visiting Program, MIECHV, as it's called.

Earlier this year, we signed on to a letter to support doubling the tribal set-aside. Again, when you're talking about the set-aside, that -- that's an additional amount of funding allocated in different bills by Congress for tribal and native

communities. So if any bill touches any part of the HHS, it is the goal of tribes and urban Indian organizations that it have a set-aside, and that is how it can get infused into the system. That is how you can have funding that isn't -- isn't grant-based, but it actually goes directly to the people who need it.

Next slide, please. Another thing we've talked about is the lack of data. One of our UIO leaders has said, "Data is dollars." So the stories are incredibly important and moving and critically important to understanding the issues, but we also need to invest in the ability to provide data. Without data, there is gaps in care that are inevitable and unwanted health outcomes will continue.

Data concerning native and maternal infant -- maternal and infant health and mortality is not collected or extremely limited. A report by the South Dakota Advisory Committee on Civil Rights said there is a lack of consistent, comprehensive data available regarding maternal health of

American Indian populations. And this lack of data makes it difficult to develop explanations for the present maternal health disparities.

Now, there have been many reports, and there have been countless studies done, but we can continue to provide and investigate and work with tribes and tribal organizations to collect and apply their own data in the way that they would like to see it done.

Our next recommendation -- sorry. Next slide, please. Our next recommendation is also the establishment of a confer policy with the Health and Human Services. Native American representation is extremely important. And we would like to see all of the Health and Human Services truly understand and appreciate that their responsibility extend to native people.

I've heard a lot about how IHS is not able to succeed, but without being a stakeholder at HHS, they will not be able to have success. We support elevating the position of the IHS director to the

assistant secretary role so that they may better work with HHS as a collaborator at the table instead of an agency that doesn't have the resources it needs to be successful.

We also support encouraging HHS to work with all native people and urban Indians through a confer process so that they are hearing from native people about the health care needs they have.

Finally -- next slide, please. We'd like to reiterate the importance of Native American representation at the table on committees. We appreciate that there is an ex-officio member from IHS, and we also recommend that there be appointed an urban Indian provider and tribal provider added to this committee.

Again, we've heard over and over about how important it is to have representation, and -- and that's why you need to hear directly from the people whose services and health care you're going to be affecting.

Finally, before I conclude, I would like to say that "equity" is a buzzword that

we're hearing every day, especially in the space of health care delivery. But if there is not native representation at the table making decisions about their health care and the policies that affect them, then you are not doing justice to the conversation of equity.

Over and over again in Washington, I find that I attend meetings or coalitions where there is not one native voice or native organization represented. So I would like to encourage you to contact many of the people here today, or myself, if you are establishing or working on any equity project that doesn't include a native voice. If you are, thank you. Please continue to do so and know that that is meaningful.

This is an urgent need, and we have outlined many recommendations today.

I would also like to truly thank all of the people who spoke. The stories will resonate with me for a long time to come, and I know they will resonate with the people here today. I hope that the administration will hear the stories, lift

you up, and begin to create lasting policy considerations.

Thank you.

ED EHLINGER: Ms. Raimondi, thank you very, very much. Very helpful information. And I'm sure there will be lots of questions when we're -- when we're done with the three presentations --

MEREDITH RAIMONDI: Okay.

ED EHLINGER: -- so thank you.

MEREDITH RAIMONDI: Thank you.

ED EHLINGER: Let us now turn to Stacy Bohlen from the Sault Ste. Marie Tribe of Chippewa. She's chief executive officer of the National Indian Health Board. And she's going to be joining us virtually. And Elisha Sneddy, the NIHB Maternal and Child Health Project Coordinator is here in person, so we can follow up with her.

But Ms. Bohlen, I turn it over to you.

STACY BOHLEN: (Speaking indigenous language.)

Good morning. My indigenous native name is Turtle Woman. And with that name comes responsibility to speak the truth for

all the people. I am a citizen of the Sault Ste. Marie Tribe of Chippewa Indians in the Upper Peninsula of Michigan. And I'm the chief executive officer for the National Indian Health Board. It is a pleasure to be with you today.

I've been listening to the deliberations and the discussions and the presentations by folks from our community who have had notable experiences, let's put it that way, that really need the attention of policymakers. So thank you all for your service. And I'm delighted, as I said, to be here.

Next slide, please. The National Indian Health Board represents and serves all 574 federally-recognized American Indian and Alaskan Native tribal governments. We are the consolidated, unified voice for Indian country in the United States from the federally-recognized tribal perspective.

We were created in 1972 -- this is our 50th anniversary this year for the express purpose of advancing the voice of federally-recognized American Indian and

Alaskan native tribes to ensure that tribal sovereignty is reinforced, strengthening tribal health systems, securing resources, and building capacity to achieve the highest level of health and well-being for our people. That's the work that we do, and it can often be summed up in the word "advocacy."

Next slide, please. I wanted to share with you some terminology concerns that we have and, perhaps, offer some helpful input from the tribal perspective. I've heard a lot of talk from this committee about indigenous populations and serving indigenous populations, but there is -- there is a correction that the tribes would like to see, and that is the American Indian and Alaskan Native term. Those are legal terms and they portend a legal status of our people in the United States of America.

These are the correct terms to use when discussing federal policy as it pertains to the sovereign nations and their citizens. This is found in the United States Constitution and the U.S. federal

government, because of treaties and our special relationship, again codified in law Supreme Court cases and the constitution, the United States government has a special trust and treaty obligation to the tribes it attaches to the 574 federally-recognized tribal nations.

And we know that the word "indigenous" -- yes, we are indigenous to these lands, but when working on policy and discussing American Indian/Alaskan Native in any kind of a policy-making environment, those are the correct terms to use, because they are the legal terms of art and expressions of our people, and they respect our political status that our people have in this country.

Next slide, please. Each of the issues that we'll bring before you today are examples of structural policy practice and funding priorities contributing to the ongoing harm to American Indian and Alaskan Native health and public health.

Many of the policies that we're going to discuss today, or that we're going to

point out or the statistics that we will use are a result of paternalistic policymaking cultural barriers, or the great hand of colonization that began 600 years ago and seems to continue to operate invisibly in the policymaking arena.

The good news is that the requested and suggestions advanced here will put -- if put into practice, would set the path for long-term improvement in American Indian and Alaskan Native health.

I also just want to quickly give a shout out to my Alaska -- I mean, my Native Hawaiian brothers and sisters. This -- what I've described here in terms of nomenclature does not im- -- imply in any way a lack of respect or recognition of the colonization, the suffering, and the histories, and the current status of our Native Hawaiian brothers and sisters. I'm simply pointing out the legal status that is very, very different for American Indians and Alaska Natives.

Next slide, please. So I want to frame this discussion today in the context of the

August 31st issued CDC life expectancy report. Life expectancy in the United States has dropped for the second year in a row in 2021. That's the largest two-year drop since 1922-'23.

While .9 year -- there's been a .9-year drop for all Americans in the aggregate, American Indian and Alaskan Native life expectancy dropped 6.6 years in 2021. That puts our people down to 1944 levels for all Americans. This is unacceptable. And if these facts do not portend an emergency, they are not the canary in the mine shaft that is laying on the bottom of the cage, I don't know what will get the attention of policymakers and how change will be made, because we're tired of winning the race to the bottom. And we're so glad that you are here and listening and committed to making change that is better for all of us.

And of course, our American Indian/ Alaskan Native women, our mothers and children, child and maternal health is -- is captured in this number.

Next slide, please. The report is, as

I said, a bellwether for years of structural racism that has saturated American policymaking and appropriations practices and left our people with the worst health status systems and outcomes in the nation.

Next slide. So this -- these statistics have been discussed numerous times during this reporting, during your meeting. I'm not going to go into it more. My slides are available to all of you for anything you'll find helpful. You are welcome to them.

Next slide, please. Historical trauma, of course, plays a massive -- as it says here from Maria Yellow Horse Brave Heart, a "Massive cultural trauma across generations, rather than the most limited diagnosis of PTSD is inadequate in capturing the influence and attributes of native trauma."

And I want to contextualize, again, what we're talking about in this way because when we talk about social determinants of health, we really need to develop, and the National Indian Health Board is developing with tribes, a tribal determinants of health

wheel that respects the medicine wheel and respects the fact that when the social determinants of health were developed, they were never intended for our people. Our people were not involved in creating them. Our voices are nowhere.

There are several portions of the social determinants of health that attach to us, but when you're American Indian/Alaskan Native, health is defined by the full health of your mind, body, and your spirit. That lends itself to the cultural integrity of traditional values, traditional healing, and ways of knowing that are necessary for our people to achieve full health. And the social determinants of health simply do not address or capture that.

Next slide, please. So, again, you can look at historical and ongoing oppression and marginalization. We've talked about a lot of this over the last couple of days. I want to call your attention to genocide and the cultural erasure that came through war, boarding school policy, et cetera. Because we believe that if you really want to make a

difference in child and maternal health in Indian country, you have to address the underlying causes and not simply the symptoms.

Next slide, please. So we've done a lot of work in the child and maternal health arena. At NIHB, we initiated an annual National American Indian and Alaskan Native Maternal Mortality Prevention Institute. We partnered with CDC on a number of -- of initiatives. And we have led a child maternity -- we -- we are leading the creation of a child -- I'm sorry, Maternity -- a Maternal Mortality Review Committee. We're involved in the Hear Her campaign and the American Indian/Alaskan Native portions of that campaign.

Please, next slide. So I want to go into some recommendations for the committee, and I -- I offer these, again, from the tribal perspective. And I mean them and we mean them in the best way possible.

First of all, President Biden re-ignited and reaffirmed Executive Order 13175 that requires consultation and

coordination with American Indian/Alaskan Native tribal governments. Chart -- they -- he charged all executive departments and agencies with engaging in regular, meaningful, and robust consultation with tribes in the development of federal policy that have tribal implications.

So we encourage your committee to work through HHS and engage with tribes on any public recommendations you are seeking to advance. Tribal consultation is a very specific thing that occurs, and it is between the federal government in respect to its trust obligations and its legal relationship with tribal nations, with sovereign tribal nations. So we encourage, and really cannot say it affirmatively enough, that your recommendations are developed with tribal consultation and input.

Next slide, please. We recommend, as a practical matter, Medicaid expansion. We recommend that the committee support legislation to eliminate the coverage gap for American Indians and Alaskan Native

women who reside in states that have refused to expand Medicaid or to extend postpartum coverage.

These are absolutely critical life-and-death opportunities through 1115 Waivers, through a number of ways that Medicaid expansion can help and treat our people.

Even though the tribes have a relationship with the federal government, states do not. So an American Indian person who is entitled to health care, because we do have the world's first prepaid health care system, which we paid for with our land, the -- the gold, the iron ore, the oil, the trees, the water, everything that the land has provided and the robust riches of the United States, which are land-based. Those were all our lands. We forfeited those.

And I know that some folks think, well, you know, you were a defeated people. No. We negotiated because we were a terrifying people and we fought as hard as we could with our resources that were not on par with

those of the invaders who came here.

And what we have is a result of negotiations that were entered into, and the Supreme Court of the United States has repeatedly said that the treaties are the supreme law of the land. So even though our people have the right to that health care, through Medicaid, if you're in Arizona, because states control Medicaid and they have a Medicaid expansion, you have access to all that that means. But if you're in South Dakota where there are huge tribal nations, huge populations of American Indian people, and they did not do Medicaid expansion, our mothers, our expectant mothers and their children do not have access in the way that they need to.

So supporting this is extremely important. We have done a great deal of work in this arena. We have a committee called the Medicare/Medicaid Health Care Reform Advisory Committee that is run from the National Indian Health Board. It is a standing committee that advises and provides technical support to the Tribal Technical

Advisory Group to CMS.

And I encourage you to use our resources. Please contact me as a resource. Our web page is www.nihb.org. We have a vast body of work in policy that we have been fighting for and developing over decades.

And during our 50th anniversary celebration at the end of this month, which I shamelessly invite all of you to attend to learn more about tribal health in person, we will be launching a web-based library that will contain the compendium of work that we have done since our founding.

Next slide, please. So recommendation on doulas and midwives. I want to share something with you that might surprise you. Let me pull this up really quickly so I have my document to read from.

This is about the president's budget request. I don't know if you're aware of this, but in the HRSA budget request put forth by the President, there were a very limited number of -- there were 48 students included in the budget who would receive

loans to become certified nurse midwives. 48 was what the president's budget had in the 2023 budget request.

Now, this is an area where this committee could really have some muscle. The National Indian Health Board has noted in official testimony to the agency on behalf of the tribes that this is not even one person per state, not one certified midwife per state, let alone a number sufficient to address the urgent needs of American Indian and Alaskan Native mothers.

The tribes request the president's 2024 budget includes $15 million for scholarships to train 200 nurse midwives to practice specifically in Indian country. And we further request 30 million for a culturally-competent nurse midwife training program to be established at one or more tribal colleges or universities.

If you really want to solve these problems, you go to the -- the heart of the problem and invest where the investment will best provide the return that we all need. I'm getting back to my slides now. Just

give me one second, please.

So, next slide, please. So another recommendation, we support data sovereignty and research capacity. In the Indian Health Care Improvement Act reauthorization of 2010, tribal epidemiological centers or tribal epicenters put in the law as required to be treated as public health authorities for purposes of the Health Insurance Portability and Accountability Act. We have for years and decades not had access to our own data about our tribal citizens, data that is held by CDC, NIH, and others throughout HHS. Tribal nations in epicenters experience uneven data access throughout the federal government.

The Government Accountability Office issued a report earlier this year that affirmed these access issues that the tribes and tribal epicenters have been bringing to the government's attention for years. They put out five recommendations for how this can be addressed. We agree with all of the recommendations, but I also want to point out that we have two pieces of legislation

that NIHB has been collaborating and working with Congress to advance. One is H.R.3841 and one is S.1397. Those are Tribal Data Sovereignty Acts, and they would ensure that tribes have access to the data that was promised to them in the law in 2010, that has yet to come to fruition. If you can, we would love for you to support the passage of those two bills or ask that the Secretary does so.

We have also made that request. We were in Albuquerque last week with the Secretary's Tribal Advisory Committee. The National Indian Health Board is the technical support for that committee. Tribal leaders uniformly requested support from the agency for these two pieces of legislation.

Next slide, please. Oh, there you go. This is the -- this is the foundational issue I was discussing earlier about culture being necessary to our health.

Some of you may be familiar with the work of Dr. Michael Chandler. He is a clinical research psychologist in Canada.

And he did a seminal work on First Nations in Canada and suicide rates. And he had a hypothesis that if you have strong cultural presence in community, then suicide rates will be lower. And when I heard him speak on this, he said, the first things that you -- you throw out when discussing suicide rates among First Nations' people is depression and poverty, because they are, quote, "As common as the sand."

That makes me very sad as a native person and as an American because we have normalized suffering for American Indian/ Alaskan Native people, and -- and that cannot continue.

But my point is that he did, in fact, prove his hypothesis that where culture, community, traditional values, traditional feelings were present in community, suicide rates declined in direct relation to the strength of cultural presence increasing.

Now, bring us through this, the boarding school issue. Now, the United States of America had a 100-year policy. And, actually, if you look in the law, the

policy was longer than that because boarding schools officially became a funded entity of the federal government around 1866. But in the 18 -- in the 1820s, there was already federal investment being made directly to churches and -- and religious institutions to transform my people from Indians to just scrubbing us of our identity, which by the way, in the Geneva Convention is a crime against humanity.

So when we talk about culture being part of health, we talk about culture being part of native women's health and cultural grounding in prenatal care and perinatal care, postnatal care.

We have to heal from what has occurred. We have to have truth and reconciliation on what happened with the 100-year boarding school policy. So we hope that as a -- looking at the disease and not its symptoms, the symptoms are these horrible rates that we have in maternal deaths and so forth, our health disparities.

But the disease itself is something far more insidious. And legislation like S.2907

and HR.5444 which would establish a truth and healing commission on U.S. boarding schools will be part of healing that underlying cause. So we encourage you to support this as well.

Next slide, please. And I'm almost done. I'm a little talkie today.

So we, of course, recommend increased funding for the Indian Health Service. Building housing for doctors and health care providers on Indian lands is an absolute necessity. We found that this is a block of people being able to have continuity of care with physicians, with doulas, nurse midwives, whatever the case may be.

When you -- I remember being on a conference call and someone from one of the federal agencies said, "Well, if native women don't like the way they're getting their health care, they should go seek another place." Well, if you're living on Pine Ridge, you don't have a car, you're poor, you have Indian Health Service there, which has limited capacity. Where are you supposed to go to get your other health

care? I mean, it's just not rational. It's not rational from our world perspective.

So if we had housing, we could have physicians who would have a place to live. Doulas, midwives, our health care providers would not have to commute four hours each way, which, as you can imagine, isn't going to happen. It's not happening. So that's a place that is a block to our success in our health systems.

Pre- -- prenatal care capacity investments, traditional culturally-linguistic appropriate care, tribal maternal, infant, and early childhood home visiting program, and food and nutrition investment, both pre- and postnatal.

Next slide, please. We are working on a tribally-led maternal mortality review committee creation. One does not yet exist in Indian country. There is one American Indian OB-GYN in the United States who has served on one of these committees and is serving on one now, and NIHB is contracting with him to help develop this policy

presence, this -- this opportunity in Indian country, and we're working directly with tribes as well.

Next slide, please. Support educational awareness campaigns. I'm going to -- that's self-explanatory, I think.

Next slide please. That is the end of my presentation. In closing, I want to say that the National Indian Health Board is very engaged in the health equity discussions, policy recommendations and development. The -- we have an American Indian/Alaskan Native Committee at the Centers for Medicare and Medicaid Services. We have had a -- two national summits on health equity in Indian country, and we will continue to work this out.

In fact, I'm meeting with the Centers for Disease Control and Prevention head of Health Equity at -- in about eleven minutes to talk about how we can help form those policies that are tribally informed.

We do have issues with a lack of investment directly to the National Indian Health Board and tribal entities to be able

to develop health equity policy, to be able to do the kind of community-based key informant interviews and outreach that really needs to be done to get to the heart of this matter and ensure that the tribal voice is accurately reflected and included.

We find that a lot of private foundations will fund non-native entities to do native work. That's not appropriate. And I know that's a little outside your realm, but I felt compelled to mention that.

So we have developed excellent resources in this area, and if you would like to engage with the National Indian Health Board on the tribal side of health equity work, please don't hesitate to contact me. My email is there, along with Elisha's. And I say Chi-miigwech. Thank you for this time.

ED EHLINGER: Thank you very much, Ms. Bohlen. This was, just like the previous presentation, really helpful to the committee.

Did I hear that you will be leaving us in about ten minutes?

STACY BOHLEN: Yes, sir. I have to be on the call with this --

ED EHLINGER: All right. Will -- will -- will Elisha be able to answer some of the questions that I'm sure that the committee will have related to your presentation?

STACY BOHLEN: I think that she is very, very capable. Yeah.

ED EHLINGER: All right.

STACY BOHLEN: I think she can answer the questions.

ED EHLINGER: All right. All right.

STACY BOHLEN: And if you have more, I'll rejoin or I'll do the best that I can to be available as a resource. And also, we can follow up in writing to the committee as well, if that would be helpful.

ED EHLINGER: Yes. Thank you very much. All right. Thank you.

STACY BOHLEN: Thank you so much for the time.

ED EHLINGER: All right.

Now, let's transition to Patrice Kunesh, from the Standing Rock Lakota,

Founder and Director of Penín Haha Consulting and Major Gift Officer at The Native American Rights Fund and NPR Commentator as of this morning.

PATRICE KUNESH: Uh-huh.

ED EHLINGER: Welcome.

PATRICE KUNESH: (Speaking indigenous language.)

I'm Patrice Kunesh. And I was on the radio today.

Chief Liz Malerba of the Mohegan Tribe in Connecticut has been confirmed as the U.S. Treasurer. So we shall see her name on U.S. currency. And it is a wonderful reminder to all of us of the wonderful things that can happen through steadfast dedication and commitment to -- to the people and -- and to the work that we need to do in all of our communities.

And when I say, "Anpétu waštέ," I want to say, "It's a good day." And I mean that in both ways. It's good to be here. It's good to be on this topic. And I hope that with this conversation, we're going to do good -- good work.

"Mitákuye Oyás'in" is Lakota word for "all our relatives." And I do believe we are all related, related together on these issues, on these concerns, and in our commitment to improving outcomes for native people.

I'm really impressed with what I've heard today, and I truly do not know what I can add to this. But I -- I -- I -- I heard you say, let's be -- let's be realistic and -- and let's look for better -- better services and programs for outcomes in the future.

I also want to say that improving indigenous birth outcomes is not my area of specialty, my area of subject matter knowledge, as we've heard from the previous presenters. But what I do have is a personal knowledge and a personal experience in this area. And maybe I can start out sharing with you how that vulnerability from a logic model, personally, contextually, can help illustrate or illuminate some of these recommendations that we've heard.

I was a very young mother, 20 years

old, away from my family. I was receiving a number of social services, public health, public housing, food stamps, WIC. And -- and I was -- I was very vulnerable myself but not knowing that I was vulnerable.

I received absolutely wonderful prenatal care on public health, but my -- my birth and after-birth experiences were -- were -- were very unusual and -- and very scary.

One of the cultural things that -- that we pride ourselves in our family as women, as mothers -- and, by the way, I'm one of 13 children, and at one point, my mother had 9 children -- I'm sorry -- yeah -- 9 children under 8 years of age. So I -- I thought I knew how to be a caregiver. I thought I knew how to take care of babies and -- and little ones.

One of the -- the most important elements of being a mother in our family was breastfeeding, that we would nurse our children. And here I was, a young mother at 20 years old trying to work, trying to go to school, trying to feed my family, and just

not realizing the accumulative stress of trying to do all of that at the same time and navigate these social services.

I -- I was very diligent and committed to nursing my -- my daughter. And one day when my daughter was about four months old and she weighed about nine pounds, five ounces, a visiting nurse came to see me. This is a visiting nurse from the public health service.

And she stepped into my apartment, and she took one look at my little girl and she said, "Failure to thrive." I had no idea what that meant. I never heard that term before. For all I knew, I was doing the absolute more important thing, and that was nursing my baby.

I did not know the consequences of that. And she said in the next breath, "If you don't feed that baby we are going to take her away from you." And that was harsh. That -- it was hurtful. That was judgmental. And there was no questions about what is your life circumstances and how is this going for you. And -- and --

and -- and did you know, you know, thus and such.

And right then and there, she fixed a bottle of formula and, certainly, my baby was hungry, and she needed that -- that nutrition.

That daughter is now a mother herself and had complications with -- with -- with her birth, but Lucy Wintermoon is thriving, for all intents and purposes. She's beloved and -- and she's thriving.

But I share this because we know that poor outcomes in American Indian infants are also related to poor outcomes and poor health care for American Indian women. And if it's hypertension and preeclampsia to anemia, to hyp- -- to diabetes, to poor nutrition, all of this goes together.

So while I don't know much about indigenous birth outcomes as an expert, I do know something about inclusive prosperity and building communities. And that's what I really would like to address today.

Another question that I -- I'd want to ask, and I'm really not going to use my

slides today because I think so much of what we've heard and -- and the discussion from the other presenters really has provided the full, rich context of -- of -- of the issues.

But I'd like to ask the question why? Why are we concerned about this? And American Indians/Alaskan Natives are the fastest-growing population. We've heard about life expectancy, and that is truly frightening. And I think that's a reflection of -- of the -- of the devastation of -- of COVID.

But American Indians and Alaska Natives are the fastest-growing population in the United States. And through the U.S. Census 2020, we know that it's a very young population.

So just in the past decade, American Indian's population have gone from 5.2 million to over 7 million, 7.2, 7.3. This is a -- a vastly diverse population. It's a fast -- it's -- it's a very young population. The median age is 26 years old.

And of course, this is the childbearing

ourselves. But nevertheless, we know how healing our culture is.

Next slide, please. This is a slide, an older slide as well, the impact of the -- the -- oh, what's it called now? I'm forgetting what the program's called. The diabetes -- it's our anyway, it's our diabetes program that was started probably in the '80s, maybe '90s, but anyway, it was started to address the fact that we had high renal failure because of diabetes. And so in our clinics, we started programming where we would all come together -- we already tend to work in team in our clinics anyway. Remind me I got to talk about our clinics to you -- and addressing diabetes all together. So when a patient comes in, if they -- if we found out they had diabetes, we'd be hitting them with all the latest and greatest medications. We'd be addressing their dental care. We'd be addressing their foot care, all of that all together. And as a result of that kind of programming, we would be able to significantly decrease end-stage renal disease.

Next slide, please. Land Back Movement. This is a powerful movement. It's not literally us asking for our land back. It's asking for -- for people to recognize the power, and it's for us to regain the power of our culture, our language, all those things that are happening now. It's a very exciting time actually, this decolonization movement, thank goodness.

Next slide, please. And as we heard already, recognition of the impact of boarding schools on us. If you go to Canada, they're not -- they -- they have done terrible things to their people as well, but sometimes I think that there's such power in that truth and reconciliation movement that they are going through that you wonder about the impact of it here. How -- how much could we do here with it?

Next slide, please. And I don't know if -- have -- have you seen this Ed, the -- this is -- have you seen this one? It's pretty cool. It's from the -- I have to always look -- I wrote this up there because

I could never remember what ASPE, assistant secretary for planning and evaluation. This is a document that just came out this year in April, and it really talks about how -- when you address those social determinants, how you can improve health. And some of these ideas are kind of radical. That's why I loved this when I saw it. For instance -- so you don't need to convince HHS. This document already exists within their department. Shows that if you give people housing -- people with chronic decease housing, hey, they do better. Go figure, right? If you give them food and nutrition, they do better. If you hit these social determinants, they do better.

Next slide. So that's the prelude to recommendations.

Next slide, please. Lots of -- lots of recommendations. I tried not to repeat them but some great ones were said today, and so there might be some repeat of these. Prioritize health of indigenous. Within your number one, prioritize health of indigenous mothers and infants. Prenatal

supports. I think I did hear that you might have all these. I just didn't see them. Not only transportation but daycare, providing meals, and here's the crazy one, how about paying people to go to those because people often can't take time away from jobs. That's why people don't come see us often times for any clinic appointments. They can't take time away from the job that's keeping a house over their head, right?

Improve living conditions and just -- you're -- number two, improve the living conditions of indigenous mothers and improve access to high-quality health care. Treatment of -- when I was working in my home clinic, often times, when I was trying to get a patient into treatment, I -- I can't tell the number of times I heard this: We don't have an option open right now. We don't have a slot open right now. You're going to have to wait a month. Well, they're not going to need me in a month. They need me now. And think about those native -- young native women who could

become pregnant and they want to stop using or their partners. We need those treatment options now anytime they walk in the door, baseline. And not only cultural treatment options. I heard that yesterday. Of course we have to have that, but how about treating our entire community because we know, if you treat someone for six weeks, that's not enough. If you treat them for six months, that's not enough. And if you only treat them and not their family and not the people around them, that's not enough. Mental health services times a hundred, and I'm not joking about this. Pre-COVID we did not have enough.

And it's not just for people who are using substances. I just told you about the impact that the history has had on our community. We have mental health needs, and we don't have counselors. I almost don't like to diagnose or look for depression these days. I -- I -- I said I almost. I do in my patients. But we don't have services for them. So you diagnose them and you give them a medication because that's

all you got and you suggest they exercise and -- I often will refer them for traditional -- to meet with traditional people who also are already over taxed. We need counselors.

Collaborate with the Department of Education, include accurate and current indigenous stories. This is supporting programs like the Shakopee Mdewakanton are doing with that history book. Help us get that information out about who we are.

Trauma-informed care training. We heard from IHS yesterday that they're doing this in some areas. All providers who come across our populations, any of our populations need to know trauma-informed care.

Investing in our communities. We heard this said today, and it can't be overstated. We want to live on our traditional lands because -- not because it's the best land. As you've heard, it's often times some of the worst land, but that's where our community are. That's where we're doing our stuff. That's where families gather.

Support those areas and give us some economy, some ways to do that.

So how about we heard about the numbers of people who are waiting for doula training on doula training list. How about -- what was that 200? Some crazy number. Help us pay for training in our communities. Our people want to live there. Let's invest in those communities by paying for those trainings.

Decrease our reliance on grants, same thing. Help us build capacity. I've heard of research project after research project that comes before me when I'm on the IRB for the Fond du Lac Nation where they just want to do the grant, but they don't think about building in our community. One of the things we asked is, what are you going to do? Who are you going to pay in our community? How are you going to invest in our community? That's what we should all be asking. You come to us. How are you going to help us?

Fund -- oh, this is one that I'm going to talk about in a second. Fund academic

and travel health residency as a collaboration, i.e., the VA system. VA -- VA system is able to work with academic centers throughout the country and have great residency programs and different collaborations that serve to increase the number of people serving their communities. We need the same with the IHS.

And then as -- as we talked about, continue to demand transparency from HHS and IHS, especially regarding PIMC and ACOG.

Next slide, please. This is an article. This refers to those collaborations between IHS and Academic Center. This is an article that I wrote, just an opinion piece that I wrote along with Matt Toby up there and -- and another -- a student about the lack of these collaborations that exist for IHS even though they have tons of them for the VA. There's no reason we can't do the same for the Indian Health Services to improve our workforce.

Next slide, please. And then ICWA. I heard someone say today that one of the

re- -- or yest- -- I think it was today that one of the reasons or one of the fears that our patients have when coming to the hospital or coming to our clinics is being reported or having to deal with the system. If you do nothing else, please help us support ICWA. We have to have ICWA alive. You can see the statistics here. Our children are removed higher from our families than any others. This is a travesty. Without ICWA, we return to the days when our -- we lose our children, and it's -- the repercussions are going to be amazing. And this is coming up before the Supreme Court this -- next year, I believe. So please recognize the critical nature of ICWA for native families and all the long repercussions of it.

Next slide, please. This is a project that -- that I started. It's called IHEART, which is Indigenous Health, Education, and Resource Task Force to Address Workforce Shortages. I ought -- I talked to you already about the fact that our kids are okay once they get to medical school. Most

of them will get in. We have good -- good numbers there. And it's the same with the other health professions. The problem are that K through 12 and even prenatal. We don't have enough of that support. So I --IHEART is an effort -- or the other problem that arise is that, excuse me, schools like mine attract people from all over the country, i.e., Alaska to come, and then what do we do? We go back to Alaska. So we end up with shortages in this Bemidji area of the 46 percent that I showed you. So how do we change that? We create regional pathways programs.

So IHEART is working with Association of American Medical Colleges, the tribal colleges, Association American Indian Physicians, and native American medical students to develop these regional pockets of pathways programs from K -- actually, prenatal up through practice, or as Dr. Warne says, up through post-docs.

Next slide, please. Those are the objectives that we have and the goal.

Next slide, please. And here are those

aims. The regional infrastructure.

Now, I was just talking with someone, Norma Poll, who works at the AAMC about this project and feeling kind of a little flustered because you can imagine how big this task is, right, because people -- you have to connect people who have no time, like all of us. So they have to find time and admin power to support these regional structures where we'll develop curriculum, we will -- we will support students coming through the pathway from kindergarten all the way up through post-doc or -- or into the professions. And we will develop data bases where students can find out about scholarships, training programs, all that. It's huge, this effort.

But here's the thing: 20 years ago, I complained to my mentors, then, that we were all cherry picking off the top. We're all pulling students into medical school from all over the country. We're all competing for the same bunch of students and not addressing the K through 12. And I heard then, and I continue to hear it today.

That's not -- you know, there's -- there's no return on that. It'll take too long. If we had started 20 years ago, we'd be so much further ahead. So even though this is big and hard, I'm convinced this is the way that we need to go.

Next slide, please. Next slide, please. And this is just a gross scheme -- schematic of what those pathways could look like. So within the regional hubs, each of them will have K through 12, health professions, involvement from all of these.

We've had three summits. The last one was in Washington D.C. in July, and we had a -- a great turnout for that. People are really excited about this work because we've been talking about the problem forever, but this is the first time we're actually coming together to try to form some solutions. So if any of you know funding, we're happy to hear about it. That's -- that's going to be the big pieces, funding people to have the time to develop these programs. But we definitely -- I think a recommendation is to support for something like this, a program

like this.

Next slide, please. And we are at the end.

Next slide. Yep, that's it. So thank you.

ED EHLINGER: Thank you, Mary. I really appreciate it. I think we have time for a couple of questions. Any questions that people might have?

MARY OWEN: One thing I wanted to address, I forgot to mention this, and Dr. Warren and I were sitting back there on our hands just dying to answer these questions about the structure of the Indian Health Service. In 1975 and 1976 the Indian Health Care Improvement Act and the Indian Self-Determination Education Act were passed under Nixon of all people. But basically they recognized the importance of autonomous in our communities, and so with that, we were able to start assuming care of our own health care facilities.

So as of today, underneath those two acts, 65 percent of our tribal -- of our government -- our -- our tribes now run

their own health care facilities. 65 percent of them are what we call compacted. And there's a difference between contracted and compacted. And Dr. Warren, I think, is going to get into a little bit more of that detail when he speaks with you. But contracting is when we just start to takeover some of our health care facilities, some of our operations. But compacting is when we fully take over our own health care, the total sum of our health care, as in Alaska. We're the only state that has complete -- completely compacted all of our health care.

And yes, it would be obviously great for the other states, but that is no small feat, as you can imagine. But it's --

ED EHLINGER: Speaking of -- speaking of the Indian Health Service, what's the total budget of the Indian Health Service, and what portion of that budget actually goes to health care?

MARY OWEN: Why are you asking me that? So --

ED EHLINGER: Because you brought it

up.

MARY OWEN: I --

ED EHLINGER: You brought up --

MARY OWEN: I want to say --

ED EHLINGER: I might est --

MARY OWEN: I think it's 12. Is 9 or 12? No, no, no, no, no. It's just been increased. It's at least 9 now. It was increased to 9 last year, I'm pretty sure. We'll have to look it up to be sure. But how much of it goes to -- we need 48 billion to become on par. That was the latest by the National Indian Health Board. I think they're on here, so they can correct me if I'm wrong. 48 to get to where we need to be to adequately care for people. How much of that is used for health care, that's a good question because all of us keep asking to do other things with it, right, all the time. So I guess my only point on that one is that, if we have complaints about it, we have to go above the IHS because that's who funds this. It goes through HHS and then goes through our president, right?

ED EHLINGER: Yeah. ShaRhonda?

SHARHONDA THOMPSON: Hello. ShaRhonda Thompson. A couple questions. One, do you have more data on the cause of the lack of high school graduates?

And, two, when you say you need more counselors, are we speaking of American India/ Alaskan Native counselors or more counselors trained to be sensitive and understand the cultural history of American Indians and Alaskan Natives?

MARY OWEN: That's just like in the health professions, it's both. We'll never have enough native doctors, right, so we need to train non-native doctors how to adequately care for our -- our population. So it's both, but yes, we absolutely.

I have had depression since college, and it got worse with residency and have needed a counselor. Have never been able to find a counselor who has a clue of how to talk with me about needs. So finding that for my patients, yes, it's huge.

Regarding the data on -- oh, why -- what I was trying to point out here, and I didn't do a very good job of it, is that the

social determinants of health are the social determinants of education. They're all related, so that poverty, the fact that half of us are on our knees, kids are going -- going to school without enough food. They're going home to inadequate homes. How many of us are living without housing, multiple family generations, so attending to your homework.

And then -- and then the schools. We don't see ourselves in schools. We don't see ourselves in the teachers, we don't see ourselves on the walls, we don't see ourselves in the history.

And discipline. I have a slide that I use for my students on discipline. We, like African-American students are over disciplined. In Duluth, I don't even have -- I don't have the stats on me, but it's ridiculous. In fact, they've been called to task on it. And of course, they're addressing it under the -- under the carpets, not -- not -- with transparency. So those kind of issues combine -- or they just multiply.

ED EHLINGER: Yeah, where do tribal colleges fit in?

MARY OWEN: Tribal colleges are part of our higher program, and I believe that they are critical to everything we do because our students tend to, and generalization, want to work closer to home. We are tied to our communities again. So those students generally want to be around where they have the support. So -- and they are likely -- those student to me, in my mind, and I don't have the data behind me on this one, are likely to return and work in those same areas. So they are critical.

Not only that, but a lot of our tribal schools know how to do it. They're not -- a lot of them are not operating fully, like Fond du Lac is incredible, not operating fully in a western model. They don't have the silly hierarchy that we seem to like in western world, right? Much more equal between professors and deans and all that stuff, right? So they're -- they're incredible -- incredibly important part of the puzzle.

I saw another question.

ED EHLINGER: Dr. Peck?

MARY OWEN: Yeah.

DR. PECK: Thank you, Dr. Owen.

MARY OWEN: Mm-hmm.

DR. PECK: I want to tap you as a modern elder. Elder to elder at the moment. For those of us who have been doing this a long time --

MARY OWEN: Speak for yourself, jeez.

DR. PECK: It's okay. It's a place of pride. We heard from our previous speakers about the birth of the National Counsel of the urban Indian Health being in '76. We heard the National Indian Health Board from Stacey in 1972 that we're about a 50-year time.

We also heard from you in statistics that nothing has changed in some dimensions around the data that you gave, and I was wondering what makes this moment -- for those of us been doing this a long time, what makes the 50-year moment, what is possible now as opposed to incremental change? What is possible in this

transformational now and how -- how can we focusing on women and children, families and fathers, how can -- how can we be part of that strategic moment of now with urgency?

So I'm just trying to figure out what makes this time different, and I thought for someone who is -- is sage and -- that you might give us some wisdom.

MARY OWEN: Well, let me just say that I have more hope now than I have in a long time because of the -- I have more hope now than I have in a long time because of the decolonization movement that's going on and the movements like Land Back that we're seeing that we've never seen and the fact that we finally have a show on television, Reservation Dogs, that represents us, that looks like us, right, not these silly stereotypes.

So there are things that are happening that give me hope, for one thing. And also the fact that Dr. Ehlinger was able to get you all to finally meet on tribal land. Things like that that are critically important.

It's hard to hear about how many people don't know about who we are over and over and over again. I will give you that, so the testimony this morning was good, but it's also really painful for some of us.

So what can you do today? You can help us. You can help Shakopee. Well, Shakopee doesn't need a lot of help, but you can help movements like Shakopee, help them spread that information about who we are in our textbooks. You can go to your school districts and ask -- you can go to Juneau and say, "Where is our history about native people in the school?" You know, enough of just having our art on the walls or our art -- art up throughout town to attract the tourists. Side note, sorry. But, you know, you can help us in those ways. You can help encourage others to learn more about us all the time.

And we talked about the recommendations. You know, there are concrete recommendations. HHS should be working with the Department of Education to support a program like IHEART.

You can support Indian Health -- you can advocate that the Indian Health Service finally be fully funded so that they can do what they need to do. You can advocate that it have more power so that they're not having to hide and get beat up on -- on Capital Hill every time we turn around and that they're able to say and be transparent of what's going on.

There are lots of different things that you can do, lots of different recommendations. Go ahead.

MAGDA PECK: Thank you for helping us make that happen so words become deeds and we fulfil our responsibilities. Thank you.

MARY OWEN: Yeah. Gunalchéesh.

ED EHLINGER: Marie, did you have a question?

MARIE RAMAS: I think Colleen was first, Dr. Mallor -- Malloy.

COLLEEN MALLOY: Okay. I'll go first. The education piece, I think, is really interesting, and I feel like with the school closures that happened with COVID-19 that children -- there was a lot of negative

ramifications for children with school closures and it's -- in an urban setting in Chicago, I mean, kids were kept home from school for almost two years, and that's time that they'll never get back. And I think it was very, very negative, and we're still seeing so many ramifications from that. So I imagine that the same for your community with, like, school -- schools being closed? Like, where do all those kids go, like, what happened to it?

And I -- in thinking about this issue, if you had more independence in directing your own school and saying what you want for your children of your community, if you want them to go to school versus the school being completely closed -- because at least in Chicago that kept -- you know, what you're saying, meals were left out and kids -- sex abuse and physical abuse sky rocketed in children all across America with school closure.

So I don't know if you had thought about that or, like, when you look at the negative statistics of graduation rates, is

it going to be even worse when that data comes out for the past couple of years do you think?

MARY OWEN: Well, it is worse. That's the 41 percent. Went from 51 to 41 percent for native kids in Duluth. It got worse over the COVID years.

Do I think that they shouldn't be going to school? As a doctor, that's a really tough one, but how do we make it equitable if they're not at school? Like you said, if they're at school, they're getting free lunches, right? So how about giving those families the lunches and the food they need so the kids can be at home. How about getting the broadband so those kids can -- at least in urban areas don't get good broadband coverage. We're starting to get it more in our rural areas, but it's not at the -- we're not in our urban areas.

So there's all those other structural issues that are impacting our kids that are not being addressed if you -- whether you leave them in school or take them out of school. So if you don't have them there,

where you need to support them even more --

Jackie Dionne said this well yesterday. You need to give -- you know, it's about equity. In our community that's been so hit by trauma, we need more resources than ever, right, and that's what you need to think about anytime any of these things happen. They're not affecting us equally. They're affecting our community that much more.

I don't have a question of -- thank God I don't have to sit in Fauci's role or anybody else's role in deciding whether or not kids should be or should be out of school. But if you're going to -- either way, you need to think about the repercussions for communities like ours. Go ahead.

ED EHLINGER: One more question.

MARIE RAMAS: Thank you. Thank you for your -- your passion and your -- your action forward presentation. I very much appreciate it.

Marie Ramas, family medicine. So my question in thinking about practical applications to the intersection between

the -- the 80 percent of life lived outside of the medical home which contributes to our patients' well-being.

And one of the questions that we brought up yesterday was workforce and pipeline. We discussed that a striking number of native families are in homes that are single parent homes. We also recognize and it's been discussed that there are typically multiple generations living in homes that are inadequate, and so I'm behooved to think that on average, because of these external stressors, kids have to grow up quickly and they probably have to think about how can they contribute economically to the livelihood of their family and their home. So that's the background.

So in thinking about pipeline and how do we help to encourage students, and for that matter, family, to prioritize education in the long run, have you seen or do you have any examples for the committee of programs that can help bring both introduction of needed services -- and we're

going to talk about maternal child health here and families -- so needed services that may be able to leverage non-certificate roles, right, for the community members that can pay and also encourage families and -- and children and those of child bearing age to continue along that path.

So multiple kind of layers there, and I -- I offer you to pick whichever layer you want out of the question.

MARY OWEN: Well, first of all, I don't know why it has to be non-certificate. One of the things we need to do is invest in our community, so pay kids -- pay people to get those certificates.

If you are going -- but there are programs that exist, and when I say pathway up there, I'm referring to pipeline. A lot of native people don't like the use of pipeline because of what it's done to our communities, so that's why we -- the pathways means the same thing.

But there are a lot of pathways programs that do just that. We recognize the impact of family and -- and others

around a student that needs to be involved. For instance, we have been awarded for an NARCH grant, which is Native American Research -- I forget what NARCH stands for. But, essentially, we're working with the -- my -- our medical school is working with the tribal college to support students making it through the tribal college and then success -- successfully matriculating into the local UMD science school and then onward to either research or into our medical school.

Now, the components that we put into the grant include supporting funds -- or supporting families joining us at every single meal, every single event. We also have components of teaching the family what it means to have their -- their loved one go through education. It also means providing transport support, providing all the books, providing the computers, supporting all members, but particularly as to your question, supporting all members of the family to help the student succeed.

It also includes monies to pay for a traditionalist to be part of -- to hang out

with the students because that's such an important part of our community. And the traditionalists also oftentimes will work with their families as well. They just know them. They're part of our community. So there are all those different facets, and that's the reason that we need to lead this programming. We know these things. Those are just part of who we are.

I think that starts to answer it. Really, again, critical to find ways to get that money to support the economy for those communities. Thanks.

ED EHLINGER: Dr. Owen, thank you very, very much. This is very, very helpful.

What a morning. Do you think we can have lunch in 45 minutes if we go to different restaurants that we don't all go to the same restaurant. I would like to have us back here in 45 minutes. We have so much and -- and there's -- and I really want to have a lot of time for conversation because it's these conversations, the questions that are raised that are really, really crucial and really helpful.

So let's come back here at 1:15 Central Daylight Time, and if you find some of the presenters who were here and you can join them for lunch and have a little conversation, that would be great. So we'll see you back here in 45 minutes.

(A recess was had from 12:29 p.m. until 1:23 p.m.)

JANELLE PALACIOS: Before we get started, I just wanted to share with you something that happened very serendipitously. As I was coming down stairs, coming into this room, thinking about how we set the tone for the next session that's about to start, I ran into these wonderful, amazing ladies who were coming out of a first medicine conference down the hall put on by the Indigenous People's Task Force, which we should all learn about because of this STA work, they do -- it sounds like they do an amazing job with health care.

And I asked if they would be able to share this honor of being present with us and share a song with us. So I'm going to

pass the mic and let them introduce themselves, but I just want to let you know that we said many times that it was, you know, HRSA, the Health Service and Research Administration, they did -- they moved mountains to be here, but Ed was that big impetus. Ed -- Dr. Ehlinger was the person who really pushed for it, who strong-armed people into it who probably -- I don't know, did you have to, like, I don't know do you have any dirt on someone?

ED EHLINGER: I did whatever I could to get people to come.

JANELLE PALACIOS: Thank you. Because you did that, Ed, we are here today. Thank you, Ed.

SPEAKER: (Speaking indigenous language.

Hello, my name is Beswaway Anadukway (phonetic spelling). I'm from Red Lake Reservation and my clan is Wolf Clan.

NORTHERN THUNDERBIRD WOMAN: (Speaking indigenous language.) Hello, all my relatives. I am a Northern Thunderbird Woman. My clan is the Eagle Clan. I come

from White Earth Nation, and I'm a descendant of those that reside on Madeline Island.

SPEAKER: (Speaking indigenous language.) Hello, my name is Awanishbasin (phonetic spelling), which means the Breath of the Spirits. I come from the White Earth Nation from Snake Clan, and me and these beautiful women here today have just spent the last three days here with the Return to First Medicines Conference just right next door to you.

And we're just -- we're out the door. We were just headed out the door, and we got grabbed. But we also have been working towards -- it sounds like your conference has been about healing. That's my work. I -- I have my own healing practice as well, and so we all, each one of us, tries to bring that out to the -- to the rest of the world as well.

And our conference was about food sovereignty and healing, so it's great to just drop in here for a minute. We'll -- we'll do a song here in a second it sounds

like.

MARIA MCCOY: (Speaking indigenous language.) Hello, my relatives. My name is -- English name is Maria Morin McCoy, and I work at the American Indian Family Center in St. Paul. I worked with Stephanie Graves. In 2006 we were working through the Healthy Start grant, Twin Cities Healthy Start grant. And at the American Indian Family Center in St. Paul we did a really, really beautiful work there and we actually were be able to reduce the mor- -- the infant mortality rate, and unfortunately, because the work was going so well, the grant went away because the three years we had it, the -- the infant mortality rate went down, but that didn't mean that the work wasn't necessary and needed.

And so the work continues. It's been a huge disparity in our community, and the support is always needed to help families thrive. And so I work with, primarily, women and their families and also the children in the community.

So (indigenous language). Humbling

experience to be here. We were on our way out and asked to come in and sing one song. We will sing the spirit bear song. And it's a song about asking that White Bear, that big white bear that's in the north, that will be coming out more as the season changes and will come out and dance with the northern lights, our ancestors, and we're calling the spirit of that bear medicine to come in and help us heal. (Indigenous language.)

(Singing performed.)

ED EHLINGER: I have to admit, I was in tears during that song. It was really touching. Thank you, Janelle for -- for being out there, and this just highlights the fact that where you hold the meeting makes a difference. It really made -- context is everything but context makes a huge difference so being here to allow that to happen is really cool.

But now we have another -- I mean, every session is just, I mean, incredibly powerful. And I'm looking forward to this one that Janelle is going to -- to lead. So

we're going to be looking at learning from our history in a whole variety of ways, and so we've got three presenters who are joining us. Two of them are here -- no, two -- one is here in person and two are -- are virtual. So I will let Janelle introduce them.

JANELLE PALACIOS: So this next afternoon panel will include three speakers from diverse areas of our nation representing different tribal communities, cultures, and languages, each with their own unique, issues, concerns and strengths, but also unified in this shared experience of native American history within this nation rooted in systemic and structural racism.

Rhonda Clairmont Swaney, past managing attorney and formal tribal chairwoman for the Confederated Salish and Kootenai Tribes will share her lived experience as a Salish Kootenai member.

She will be followed by Ms. Nicolle Gonzales, founder and midwife director of Changing Woman Initiative who will speak about special concerns rural and urban

native women have and accessing health well-being services.

Finally, we will hear from Ms. Abra Patkotak from Alaskan Native Birth Workers Association located in Anchorage, Alaska.

As you listen to the next panel, please incorporate all that you have review, learned, and discussed thus far from the past three SACIMM meetings and over the past two days. I invite you to ask yourselves what differences have developed over the past 50 years? What remains the same? And what actions will take us into a future where all native families are healthy?

Welcome. You may take the floor, the virtual floor, Rhonda. And we can see you Rhonda. And you're welcome to introduce yourself.

RHONDA CLAIRMONT SWANEY: Good afternoon everyone. (Speaking indigenous language.) My name is Rhonda Clairmont Swaney. I am Salish and Kootenai from the Flathead Reservation located in Northwest Montana where our ancestral homeland is. Thank you for inviting me. No one's ever

asked me to -- to share my story before. Granted, it is 45 years old, and I didn't think it would have any relevance today but Janelle assures me that it has relevance. I hope we can learn from it.

A little bit of background about my reservation: There are seven reservations in Montana. I live on Flathead Reservation, the home of the Salish and Kootenai and Pend d'Oreilles people. It is -- was created by treaty in 1855. It's a mere fraction of our ancestral homelands. However, we -- we were successful when we negotiated the treaty in the provision that we would have exclusive occupancy.

Our reservation is about 90 miles long and 60 miles wide. It's 1.3 million acres. It bisects Flathead Lake, and it's very -- still very rural. There are three stop lights on the reservation in two different small towns.

The reservation was opened in 1910 because it was so beautiful and people wanted to live here. It's now 75 percent non-native and 25 percent native. My tribe

has about 8,000 members but not all of them live here.

The 1855 Treaty I spoke of has been broken by the federal government over 200 times. I worked for the tribes for many years. The tribes are the largest employer on the reservation and enrolled members automatically qualify for Indian Health Service health care. That can be supplemented by tribal dollars, and we have compacted all of the health services at this point in time, Medicaid, Medicare and Tricare.

Tribal employees are now eligible for federal health care insurance, which they purchase and the employer pays a portion as well. For those people with only IHS-funded health care -- excuse me. Let me turn that off. For those with only IHS-funded health care, there is a committee that approves procedures to be done and paid for by IHS dollars and tribal dollars. The committee uses IHS regulations, that is, to be eligible for a procedure, you have to be very sick, that is, be nearly losing your

life or a limb.

We have very limited capable -- clinic capabilities with the tribes and we have one doctor that's a tribal member and all of the procedures that are waiting to be approved generally begin getting approved the 1st of October and then our money runs out very quickly. So people rush to get -- get -- get in there and get treated. There was one individual that I know of personally who had cataracts and he was left unable to see for about 25 -- 25 years before he was treated.

They have two low-level hospitals. Specialty care is located 60 to 140 miles away depending on where you start from on the reservation. Local hospitals, two hospitals rely heavily on IHS purchased care reimbursements to stay in business. They shift costs and ERs are use primarily -- are useful for primary care as well.

Now on to my story. As I mentioned, it was 45 years ago. I was 25 -- 4 years old at the time of my first pregnancy. I had been to college. I was married, I was working for my tribes, and my husband was a

heavy drinker just like many other men his age. I attended all prenatal appointments with my family doctor through purchased care.

On the six-month appointment, it was a Friday afternoon late in the day, the nurse told the doctor I had protein in my urine. Said I was fine to go, and he didn't give me any warnings about what to look for or problems should occur.

The next night, I developed what they called toxemia then, they now call preeclampsia. And it was my first pregnancy, so I didn't know what was normal but it began to feel that something was very wrong. About 5:00 or 6:00 in the morning, I drove to the local emergency room. Because it's rural and there aren't many providers, the local hospitals put doctors who are providers for their hospital on call, and so they're only there on the weekend if there's an emergency.

I went to the ER, but the nurse told me that they didn't have my blood type on hand so they would be transferring me by

ambulance to a bigger hospital about 60 miles away. The on-call doctor didn't ever look at me, didn't come in.

When I began my trip to the larger hospital, my baby's heart was still beating. When I arrived at my destination, the heartbeat couldn't be detected. I began to hemorrhage heavily. The on-call doctor in the larger hospital induced labor. He told me I couldn't have a C-section because I'd lost too much blood and I wasn't clotting.

I delivered my dead baby, and was hospitalized for several more days, given units of blood and anti-seizure medication and was released without instruction how to care for myself or how long to wait before getting pregnant again.

Being young and thinking it was just a terrible accident that wouldn't happen again -- I -- did learn recently that preeclampsia occurs when there's stress in your life. I want to say that most reservation residents have stress in their life every minute of every day; just going to work, trying to get equal treatment,

knowing that you're a second-class citizen is very stressful and you know you're not -- never going to get ahead, never be as good as everybody else. You try harder, but you're never successful.

As I was young and wanting to move on, I became pregnant again rather quickly. I was given a high-risk designation because of the still birth I had, and I was sent to a specialist about 60 miles away. I chose the same OB-GYN that delivered my first baby because he knew my problems.

I drove a 120 miles each way for each 15-minute appointment. He didn't take any special care or any special tests. And one night right after New Year's, I began spotting and was told by the hospital to drive -- drive in. It was January. It was cold and the roads were icy. I remember we slid through one or two stop lights in Missoula.

When I arrived, I was informed that I was in preterm labor, and I delivered a little tiny baby at midnight. I was told my son probably would not live until the next

morning.

He was put in an isolette in the nursery, and they gave me something to sleep. My son weighed in at 1 pound 12 ounces with the umbilical clamp on. Measured 13 inches. My husband's hand was bigger than the baby.

The next morning, my son was still alive, and the doctor decided to transfer him to the U -- University of Utah Medical Center, neonatal unit 500 miles away. I did get to see my son and touch his hand before he left but couldn't hold him. I was also able to visit him twice while he was in that medical center.

I was told that children born as early as my son did not live and his chances of surviving was 1 in 100. I was asked to sign paperwork promising not to sue the medical center if anything happened to my son because they would be providing him experimental treatment.

I learned that I delivered at about 26 weeks and the cause of the early delivery was attributed to DES syndrome, that is my

uterus couldn't support the weight of anything over two pounds. I still don't know if that's true.

The only thing the doctors told me was keep trying. Eventually, you'll have one that lives. My son did live. Today, he's a 44-year-old man with severe cerebral palsy, profound deafness, and an intellect that can't be accurately measured. I love him more than words can describe. He accepts his disabilities with humor and grace and lives defiantly to this day, that is, if you tell him he can't do something, he'll find a way to do it. Oh, but what he could have been, what they both could have been.

Again these -- these events happened over 45 years ago and, really, nothing has changed. There -- the reservation I live on is still very rural. Providers are not plentiful. They use an on-call system on the weekends. And, frankly, Indian people are considered disposable. That's what I felt, and that's what I feel today.

Although these events happened 45 years ago, I challenge you to think about what's

changed over that time. Native women are still at high risk for complicated pregnancies. Our babies die at the highest rate compared to other populations in our nation. Scarcity of funds for health care is an ongoing issue, particularly if you go to the Indian Health Service for help.

Health literacy among our population remains low. We are deficient in providers in our communities. Many of our people are under housed or considered homeless or live in a -- in a unit that's too small because several other family members live there.

Access to transportation and good roadways are still an issue. And through this, I have not even touched on the mental health needs of our community; suffering from intergenerational trauma, endless daily encounters of racism in our communities, violence, and substance misuse.

So what has changed in 45 years? Not much. I understand your efforts to bring all the problems of native American pregnant women to the forefront and provide them better care, but I just challenge each and

every one of you just to help one person. Thank you.

JANELLE PALACIOS: Thank you Rhonda. Limlmtx. We will now hear from Nicolle Gonzalez, and we will hold questions for the end. Thank you.

NICOLLE GONZALEZ: Good morning or good afternoon everybody. (Speaking indigenous language).

I'm Navajo from the Navajo nation. I'm Nicolle. I am a nurse midwife, I've been a nurse practicing for 17 years, and I've been a nurse midwife for ten years. During those years, I provided midwifery care and nursing care within a hospital setting in a rural area north of Albuquerque. I worked two years as a nurse in a obstetrical and med-surg unit in Santa Fe during the time that their OB unit was closing, and from what I saw there, I felt very propelled and bothered and concerned by the care that native American women were experiencing under the care of midwives and doctors in that facility.

Since 2008, I returned to school, and I

became a nurse midwife to address maternal health issues in my communities because I did not see a lot of native indigenous women choosing midwifery as a career path. I'm actually now one of 20 native American nurse midwives in the United States providing midwifery care in my community.

I do not work for Indian Health Services. Many of us have chosen not to work for Indian Health Services because of the racism and a lot of violence we experienced as health care providers trying to serve our own communities.

I've been propelled to create this nonprofit organization called Changing Women Initiative. We've been a nonprofit since 2015. We are currently located in Albuquerque, New Mexico, providing home birth services to native American indigenous women in the Navajo Nation in Albuquerque/Santa Fe. We cover about three hours' distance from our location to attend births, not only in people's homes but in providing traditional home birth, meaning returning birth to community in a hogan with

traditional medicine, with medicine people, with doulas that we have trained.

Our services cost about $4,000 per client. It doesn't include midwifery care. Right now, Medicaid reimbursement for global return of care for midwifery care or just birth services is a 1,500. So if it -- the funds that we provide services to our families covers food, so we work with local farmers to get food every two weeks to our families up to six weeks postpartum.

We pay for tradition medicine body work with healers. We also provide plant medicines and tinctures and teas to our women during their pregnancy. They get a paid doula to attend their birth, and they get a lactation specialist consultation support through their pregnancy and postpartum.

All of those services cost $4,000. And so because of what's happening in New Mexico in regards to hospitals closing, like Santa Fe Indian Hospital closed their OB unit in 2008, San Juan Medical Regional Centers closing their -- their midwives are having

to go elsewhere to provide care. The Phoenix Indian Medical Center has closed their obstetrical units. Las Vegas, New Mexico does not provide OB care. Los Alamos does not provide OB care. Santa Fe has two hospitals, but, basically, the native women are now required to navigate a very complex health care system because their IHS services are not providing care to them anymore or they're having to transfer at some point during their prenatal care visits.

So a lot of the women that I see, especially during COVID, have not received care up to 20 weeks into their pregnancy because; A, they can't access a care provider; B, they have to travel more than 30 miles to get access to care; or they have to wait more than six weeks to get in with a health care provider to access -- to get care for their pregnancy.

And so when we see the statistics around obesity, diabetes, hypertensions, postpartum, hemorrhage, native women not accessing care in the first trimester

increase maternal mortality rates because of car accidents just trying to get an appointment, it's because these hospitals are closing or labor and delivery unit causing women to have to travel further, but also, IHS is not fulfilling their treaty obligations to the tribes around maternal health care and women's health care in general.

I have an easy-access clinic on Wednesdays where I see women often times who will traveled two hours to come in for care. Regardless if they have health insurance or a proof of insurance, I will see them for care. I'm seeing women who have diabetes that hasn't been managed or controlled for two years because they can't get in for an appointment at their local hospital or their clinic within their tribal facility. I'm seeing 20-year-old -- I'm sorry -- 14-year old pregnant young woman who've gotten no prenatal care up to 20 weeks because they can't get in for an appointment for their prenatal visits and they are unsure of how to navigate the health care system that

ourselves. But nevertheless, we know how healing our culture is.

Next slide, please. This is a slide, an older slide as well, the impact of the -- the -- oh, what's it called now? I'm forgetting what the program's called. The diabetes -- it's our anyway, it's our diabetes program that was started probably in the '80s, maybe '90s, but anyway, it was started to address the fact that we had high renal failure because of diabetes. And so in our clinics, we started programming where we would all come together -- we already tend to work in team in our clinics anyway. Remind me I got to talk about our clinics to you -- and addressing diabetes all together. So when a patient comes in, if they -- if we found out they had diabetes, we'd be hitting them with all the latest and greatest medications. We'd be addressing their dental care. We'd be addressing their foot care, all of that all together. And as a result of that kind of programming, we would be able to significantly decrease end-stage renal disease.

Next slide, please. Land Back Movement. This is a powerful movement. It's not literally us asking for our land back. It's asking for -- for people to recognize the power, and it's for us to regain the power of our culture, our language, all those things that are happening now. It's a very exciting time actually, this decolonization movement, thank goodness.

Next slide, please. And as we heard already, recognition of the impact of boarding schools on us. If you go to Canada, they're not -- they -- they have done terrible things to their people as well, but sometimes I think that there's such power in that truth and reconciliation movement that they are going through that you wonder about the impact of it here. How -- how much could we do here with it?

Next slide, please. And I don't know if -- have -- have you seen this Ed, the -- this is -- have you seen this one? It's pretty cool. It's from the -- I have to always look -- I wrote this up there because

I could never remember what ASPE, assistant secretary for planning and evaluation. This is a document that just came out this year in April, and it really talks about how -- when you address those social determinants, how you can improve health. And some of these ideas are kind of radical. That's why I loved this when I saw it. For instance -- so you don't need to convince HHS. This document already exists within their department. Shows that if you give people housing -- people with chronic decease housing, hey, they do better. Go figure, right? If you give them food and nutrition, they do better. If you hit these social determinants, they do better.

Next slide. So that's the prelude to recommendations.

Next slide, please. Lots of -- lots of recommendations. I tried not to repeat them but some great ones were said today, and so there might be some repeat of these. Prioritize health of indigenous. Within your number one, prioritize health of indigenous mothers and infants. Prenatal

supports. I think I did hear that you might have all these. I just didn't see them. Not only transportation but daycare, providing meals, and here's the crazy one, how about paying people to go to those because people often can't take time away from jobs. That's why people don't come see us often times for any clinic appointments. They can't take time away from the job that's keeping a house over their head, right?

Improve living conditions and just -- you're -- number two, improve the living conditions of indigenous mothers and improve access to high-quality health care. Treatment of -- when I was working in my home clinic, often times, when I was trying to get a patient into treatment, I -- I can't tell the number of times I heard this: We don't have an option open right now. We don't have a slot open right now. You're going to have to wait a month. Well, they're not going to need me in a month. They need me now. And think about those native -- young native women who could

become pregnant and they want to stop using or their partners. We need those treatment options now anytime they walk in the door, baseline. And not only cultural treatment options. I heard that yesterday. Of course we have to have that, but how about treating our entire community because we know, if you treat someone for six weeks, that's not enough. If you treat them for six months, that's not enough. And if you only treat them and not their family and not the people around them, that's not enough. Mental health services times a hundred, and I'm not joking about this. Pre-COVID we did not have enough.

And it's not just for people who are using substances. I just told you about the impact that the history has had on our community. We have mental health needs, and we don't have counselors. I almost don't like to diagnose or look for depression these days. I -- I -- I said I almost. I do in my patients. But we don't have services for them. So you diagnose them and you give them a medication because that's

all you got and you suggest they exercise and -- I often will refer them for traditional -- to meet with traditional people who also are already over taxed. We need counselors.

Collaborate with the Department of Education, include accurate and current indigenous stories. This is supporting programs like the Shakopee Mdewakanton are doing with that history book. Help us get that information out about who we are.

Trauma-informed care training. We heard from IHS yesterday that they're doing this in some areas. All providers who come across our populations, any of our populations need to know trauma-informed care.

Investing in our communities. We heard this said today, and it can't be overstated. We want to live on our traditional lands because -- not because it's the best land. As you've heard, it's often times some of the worst land, but that's where our community are. That's where we're doing our stuff. That's where families gather.

Support those areas and give us some economy, some ways to do that.

So how about we heard about the numbers of people who are waiting for doula training on doula training list. How about -- what was that 200? Some crazy number. Help us pay for training in our communities. Our people want to live there. Let's invest in those communities by paying for those trainings.

Decrease our reliance on grants, same thing. Help us build capacity. I've heard of research project after research project that comes before me when I'm on the IRB for the Fond du Lac Nation where they just want to do the grant, but they don't think about building in our community. One of the things we asked is, what are you going to do? Who are you going to pay in our community? How are you going to invest in our community? That's what we should all be asking. You come to us. How are you going to help us?

Fund -- oh, this is one that I'm going to talk about in a second. Fund academic

and travel health residency as a collaboration, i.e., the VA system. VA -- VA system is able to work with academic centers throughout the country and have great residency programs and different collaborations that serve to increase the number of people serving their communities. We need the same with the IHS.

And then as -- as we talked about, continue to demand transparency from HHS and IHS, especially regarding PIMC and ACOG.

Next slide, please. This is an article. This refers to those collaborations between IHS and Academic Center. This is an article that I wrote, just an opinion piece that I wrote along with Matt Toby up there and -- and another -- a student about the lack of these collaborations that exist for IHS even though they have tons of them for the VA. There's no reason we can't do the same for the Indian Health Services to improve our workforce.

Next slide, please. And then ICWA. I heard someone say today that one of the

re- -- or yest- -- I think it was today that one of the reasons or one of the fears that our patients have when coming to the hospital or coming to our clinics is being reported or having to deal with the system. If you do nothing else, please help us support ICWA. We have to have ICWA alive. You can see the statistics here. Our children are removed higher from our families than any others. This is a travesty. Without ICWA, we return to the days when our -- we lose our children, and it's -- the repercussions are going to be amazing. And this is coming up before the Supreme Court this -- next year, I believe. So please recognize the critical nature of ICWA for native families and all the long repercussions of it.

Next slide, please. This is a project that -- that I started. It's called IHEART, which is Indigenous Health, Education, and Resource Task Force to Address Workforce Shortages. I ought -- I talked to you already about the fact that our kids are okay once they get to medical school. Most

of them will get in. We have good -- good numbers there. And it's the same with the other health professions. The problem are that K through 12 and even prenatal. We don't have enough of that support. So I --IHEART is an effort -- or the other problem that arise is that, excuse me, schools like mine attract people from all over the country, i.e., Alaska to come, and then what do we do? We go back to Alaska. So we end up with shortages in this Bemidji area of the 46 percent that I showed you. So how do we change that? We create regional pathways programs.

So IHEART is working with Association of American Medical Colleges, the tribal colleges, Association American Indian Physicians, and native American medical students to develop these regional pockets of pathways programs from K -- actually, prenatal up through practice, or as Dr. Warne says, up through post-docs.

Next slide, please. Those are the objectives that we have and the goal.

Next slide, please. And here are those

aims. The regional infrastructure.

Now, I was just talking with someone, Norma Poll, who works at the AAMC about this project and feeling kind of a little flustered because you can imagine how big this task is, right, because people -- you have to connect people who have no time, like all of us. So they have to find time and admin power to support these regional structures where we'll develop curriculum, we will -- we will support students coming through the pathway from kindergarten all the way up through post-doc or -- or into the professions. And we will develop data bases where students can find out about scholarships, training programs, all that. It's huge, this effort.

But here's the thing: 20 years ago, I complained to my mentors, then, that we were all cherry picking off the top. We're all pulling students into medical school from all over the country. We're all competing for the same bunch of students and not addressing the K through 12. And I heard then, and I continue to hear it today.

That's not -- you know, there's -- there's no return on that. It'll take too long. If we had started 20 years ago, we'd be so much further ahead. So even though this is big and hard, I'm convinced this is the way that we need to go.

Next slide, please. Next slide, please. And this is just a gross scheme -- schematic of what those pathways could look like. So within the regional hubs, each of them will have K through 12, health professions, involvement from all of these.

We've had three summits. The last one was in Washington D.C. in July, and we had a -- a great turnout for that. People are really excited about this work because we've been talking about the problem forever, but this is the first time we're actually coming together to try to form some solutions. So if any of you know funding, we're happy to hear about it. That's -- that's going to be the big pieces, funding people to have the time to develop these programs. But we definitely -- I think a recommendation is to support for something like this, a program

like this.

Next slide, please. And we are at the end.

Next slide. Yep, that's it. So thank you.

ED EHLINGER: Thank you, Mary. I really appreciate it. I think we have time for a couple of questions. Any questions that people might have?

MARY OWEN: One thing I wanted to address, I forgot to mention this, and Dr. Warren and I were sitting back there on our hands just dying to answer these questions about the structure of the Indian Health Service. In 1975 and 1976 the Indian Health Care Improvement Act and the Indian Self-Determination Education Act were passed under Nixon of all people. But basically they recognized the importance of autonomous in our communities, and so with that, we were able to start assuming care of our own health care facilities.

So as of today, underneath those two acts, 65 percent of our tribal -- of our government -- our -- our tribes now run

their own health care facilities. 65 percent of them are what we call compacted. And there's a difference between contracted and compacted. And Dr. Warren, I think, is going to get into a little bit more of that detail when he speaks with you. But contracting is when we just start to takeover some of our health care facilities, some of our operations. But compacting is when we fully take over our own health care, the total sum of our health care, as in Alaska. We're the only state that has complete -- completely compacted all of our health care.

And yes, it would be obviously great for the other states, but that is no small feat, as you can imagine. But it's --

ED EHLINGER: Speaking of -- speaking of the Indian Health Service, what's the total budget of the Indian Health Service, and what portion of that budget actually goes to health care?

MARY OWEN: Why are you asking me that? So --

ED EHLINGER: Because you brought it

up.

MARY OWEN: I --

ED EHLINGER: You brought up --

MARY OWEN: I want to say --

ED EHLINGER: I might est --

MARY OWEN: I think it's 12. Is 9 or 12? No, no, no, no, no. It's just been increased. It's at least 9 now. It was increased to 9 last year, I'm pretty sure. We'll have to look it up to be sure. But how much of it goes to -- we need 48 billion to become on par. That was the latest by the National Indian Health Board. I think they're on here, so they can correct me if I'm wrong. 48 to get to where we need to be to adequately care for people. How much of that is used for health care, that's a good question because all of us keep asking to do other things with it, right, all the time. So I guess my only point on that one is that, if we have complaints about it, we have to go above the IHS because that's who funds this. It goes through HHS and then goes through our president, right?

ED EHLINGER: Yeah. ShaRhonda?

SHARHONDA THOMPSON: Hello. ShaRhonda Thompson. A couple questions. One, do you have more data on the cause of the lack of high school graduates?

And, two, when you say you need more counselors, are we speaking of American India/ Alaskan Native counselors or more counselors trained to be sensitive and understand the cultural history of American Indians and Alaskan Natives?

MARY OWEN: That's just like in the health professions, it's both. We'll never have enough native doctors, right, so we need to train non-native doctors how to adequately care for our -- our population. So it's both, but yes, we absolutely.

I have had depression since college, and it got worse with residency and have needed a counselor. Have never been able to find a counselor who has a clue of how to talk with me about needs. So finding that for my patients, yes, it's huge.

Regarding the data on -- oh, why -- what I was trying to point out here, and I didn't do a very good job of it, is that the

social determinants of health are the social determinants of education. They're all related, so that poverty, the fact that half of us are on our knees, kids are going -- going to school without enough food. They're going home to inadequate homes. How many of us are living without housing, multiple family generations, so attending to your homework.

And then -- and then the schools. We don't see ourselves in schools. We don't see ourselves in the teachers, we don't see ourselves on the walls, we don't see ourselves in the history.

And discipline. I have a slide that I use for my students on discipline. We, like African-American students are over disciplined. In Duluth, I don't even have -- I don't have the stats on me, but it's ridiculous. In fact, they've been called to task on it. And of course, they're addressing it under the -- under the carpets, not -- not -- with transparency. So those kind of issues combine -- or they just multiply.

ED EHLINGER: Yeah, where do tribal colleges fit in?

MARY OWEN: Tribal colleges are part of our higher program, and I believe that they are critical to everything we do because our students tend to, and generalization, want to work closer to home. We are tied to our communities again. So those students generally want to be around where they have the support. So -- and they are likely -- those student to me, in my mind, and I don't have the data behind me on this one, are likely to return and work in those same areas. So they are critical.

Not only that, but a lot of our tribal schools know how to do it. They're not -- a lot of them are not operating fully, like Fond du Lac is incredible, not operating fully in a western model. They don't have the silly hierarchy that we seem to like in western world, right? Much more equal between professors and deans and all that stuff, right? So they're -- they're incredible -- incredibly important part of the puzzle.

I saw another question.

ED EHLINGER: Dr. Peck?

MARY OWEN: Yeah.

DR. PECK: Thank you, Dr. Owen.

MARY OWEN: Mm-hmm.

DR. PECK: I want to tap you as a modern elder. Elder to elder at the moment. For those of us who have been doing this a long time --

MARY OWEN: Speak for yourself, jeez.

DR. PECK: It's okay. It's a place of pride. We heard from our previous speakers about the birth of the National Counsel of the urban Indian Health being in '76. We heard the National Indian Health Board from Stacey in 1972 that we're about a 50-year time.

We also heard from you in statistics that nothing has changed in some dimensions around the data that you gave, and I was wondering what makes this moment -- for those of us been doing this a long time, what makes the 50-year moment, what is possible now as opposed to incremental change? What is possible in this

transformational now and how -- how can we focusing on women and children, families and fathers, how can -- how can we be part of that strategic moment of now with urgency?

So I'm just trying to figure out what makes this time different, and I thought for someone who is -- is sage and -- that you might give us some wisdom.

MARY OWEN: Well, let me just say that I have more hope now than I have in a long time because of the -- I have more hope now than I have in a long time because of the decolonization movement that's going on and the movements like Land Back that we're seeing that we've never seen and the fact that we finally have a show on television, Reservation Dogs, that represents us, that looks like us, right, not these silly stereotypes.

So there are things that are happening that give me hope, for one thing. And also the fact that Dr. Ehlinger was able to get you all to finally meet on tribal land. Things like that that are critically important.

It's hard to hear about how many people don't know about who we are over and over and over again. I will give you that, so the testimony this morning was good, but it's also really painful for some of us.

So what can you do today? You can help us. You can help Shakopee. Well, Shakopee doesn't need a lot of help, but you can help movements like Shakopee, help them spread that information about who we are in our textbooks. You can go to your school districts and ask -- you can go to Juneau and say, "Where is our history about native people in the school?" You know, enough of just having our art on the walls or our art -- art up throughout town to attract the tourists. Side note, sorry. But, you know, you can help us in those ways. You can help encourage others to learn more about us all the time.

And we talked about the recommendations. You know, there are concrete recommendations. HHS should be working with the Department of Education to support a program like IHEART.

You can support Indian Health -- you can advocate that the Indian Health Service finally be fully funded so that they can do what they need to do. You can advocate that it have more power so that they're not having to hide and get beat up on -- on Capital Hill every time we turn around and that they're able to say and be transparent of what's going on.

There are lots of different things that you can do, lots of different recommendations. Go ahead.

MAGDA PECK: Thank you for helping us make that happen so words become deeds and we fulfil our responsibilities. Thank you.

MARY OWEN: Yeah. Gunalchéesh.

ED EHLINGER: Marie, did you have a question?

MARIE RAMAS: I think Colleen was first, Dr. Mallor -- Malloy.

COLLEEN MALLOY: Okay. I'll go first. The education piece, I think, is really interesting, and I feel like with the school closures that happened with COVID-19 that children -- there was a lot of negative

ramifications for children with school closures and it's -- in an urban setting in Chicago, I mean, kids were kept home from school for almost two years, and that's time that they'll never get back. And I think it was very, very negative, and we're still seeing so many ramifications from that. So I imagine that the same for your community with, like, school -- schools being closed? Like, where do all those kids go, like, what happened to it?

And I -- in thinking about this issue, if you had more independence in directing your own school and saying what you want for your children of your community, if you want them to go to school versus the school being completely closed -- because at least in Chicago that kept -- you know, what you're saying, meals were left out and kids -- sex abuse and physical abuse sky rocketed in children all across America with school closure.

So I don't know if you had thought about that or, like, when you look at the negative statistics of graduation rates, is

it going to be even worse when that data comes out for the past couple of years do you think?

MARY OWEN: Well, it is worse. That's the 41 percent. Went from 51 to 41 percent for native kids in Duluth. It got worse over the COVID years.

Do I think that they shouldn't be going to school? As a doctor, that's a really tough one, but how do we make it equitable if they're not at school? Like you said, if they're at school, they're getting free lunches, right? So how about giving those families the lunches and the food they need so the kids can be at home. How about getting the broadband so those kids can -- at least in urban areas don't get good broadband coverage. We're starting to get it more in our rural areas, but it's not at the -- we're not in our urban areas.

So there's all those other structural issues that are impacting our kids that are not being addressed if you -- whether you leave them in school or take them out of school. So if you don't have them there,

where you need to support them even more --

Jackie Dionne said this well yesterday. You need to give -- you know, it's about equity. In our community that's been so hit by trauma, we need more resources than ever, right, and that's what you need to think about anytime any of these things happen. They're not affecting us equally. They're affecting our community that much more.

I don't have a question of -- thank God I don't have to sit in Fauci's role or anybody else's role in deciding whether or not kids should be or should be out of school. But if you're going to -- either way, you need to think about the repercussions for communities like ours. Go ahead.

ED EHLINGER: One more question.

MARIE RAMAS: Thank you. Thank you for your -- your passion and your -- your action forward presentation. I very much appreciate it.

Marie Ramas, family medicine. So my question in thinking about practical applications to the intersection between

the -- the 80 percent of life lived outside of the medical home which contributes to our patients' well-being.

And one of the questions that we brought up yesterday was workforce and pipeline. We discussed that a striking number of native families are in homes that are single parent homes. We also recognize and it's been discussed that there are typically multiple generations living in homes that are inadequate, and so I'm behooved to think that on average, because of these external stressors, kids have to grow up quickly and they probably have to think about how can they contribute economically to the livelihood of their family and their home. So that's the background.

So in thinking about pipeline and how do we help to encourage students, and for that matter, family, to prioritize education in the long run, have you seen or do you have any examples for the committee of programs that can help bring both introduction of needed services -- and we're

going to talk about maternal child health here and families -- so needed services that may be able to leverage non-certificate roles, right, for the community members that can pay and also encourage families and -- and children and those of child bearing age to continue along that path.

So multiple kind of layers there, and I -- I offer you to pick whichever layer you want out of the question.

MARY OWEN: Well, first of all, I don't know why it has to be non-certificate. One of the things we need to do is invest in our community, so pay kids -- pay people to get those certificates.

If you are going -- but there are programs that exist, and when I say pathway up there, I'm referring to pipeline. A lot of native people don't like the use of pipeline because of what it's done to our communities, so that's why we -- the pathways means the same thing.

But there are a lot of pathways programs that do just that. We recognize the impact of family and -- and others

around a student that needs to be involved. For instance, we have been awarded for an NARCH grant, which is Native American Research -- I forget what NARCH stands for. But, essentially, we're working with the -- my -- our medical school is working with the tribal college to support students making it through the tribal college and then success -- successfully matriculating into the local UMD science school and then onward to either research or into our medical school.

Now, the components that we put into the grant include supporting funds -- or supporting families joining us at every single meal, every single event. We also have components of teaching the family what it means to have their -- their loved one go through education. It also means providing transport support, providing all the books, providing the computers, supporting all members, but particularly as to your question, supporting all members of the family to help the student succeed.

It also includes monies to pay for a traditionalist to be part of -- to hang out

with the students because that's such an important part of our community. And the traditionalists also oftentimes will work with their families as well. They just know them. They're part of our community. So there are all those different facets, and that's the reason that we need to lead this programming. We know these things. Those are just part of who we are.

I think that starts to answer it. Really, again, critical to find ways to get that money to support the economy for those communities. Thanks.

ED EHLINGER: Dr. Owen, thank you very, very much. This is very, very helpful.

What a morning. Do you think we can have lunch in 45 minutes if we go to different restaurants that we don't all go to the same restaurant. I would like to have us back here in 45 minutes. We have so much and -- and there's -- and I really want to have a lot of time for conversation because it's these conversations, the questions that are raised that are really, really crucial and really helpful.

So let's come back here at 1:15 Central Daylight Time, and if you find some of the presenters who were here and you can join them for lunch and have a little conversation, that would be great. So we'll see you back here in 45 minutes.

(A recess was had from 12:29 p.m. until 1:23 p.m.)

JANELLE PALACIOS: Before we get started, I just wanted to share with you something that happened very serendipitously. As I was coming down stairs, coming into this room, thinking about how we set the tone for the next session that's about to start, I ran into these wonderful, amazing ladies who were coming out of a first medicine conference down the hall put on by the Indigenous People's Task Force, which we should all learn about because of this STA work, they do -- it sounds like they do an amazing job with health care.

And I asked if they would be able to share this honor of being present with us and share a song with us. So I'm going to

pass the mic and let them introduce themselves, but I just want to let you know that we said many times that it was, you know, HRSA, the Health Service and Research Administration, they did -- they moved mountains to be here, but Ed was that big impetus. Ed -- Dr. Ehlinger was the person who really pushed for it, who strong-armed people into it who probably -- I don't know, did you have to, like, I don't know do you have any dirt on someone?

ED EHLINGER: I did whatever I could to get people to come.

JANELLE PALACIOS: Thank you. Because you did that, Ed, we are here today. Thank you, Ed.

SPEAKER: (Speaking indigenous language.

Hello, my name is Beswaway Anadukway (phonetic spelling). I'm from Red Lake Reservation and my clan is Wolf Clan.

NORTHERN THUNDERBIRD WOMAN: (Speaking indigenous language.) Hello, all my relatives. I am a Northern Thunderbird Woman. My clan is the Eagle Clan. I come

from White Earth Nation, and I'm a descendant of those that reside on Madeline Island.

SPEAKER: (Speaking indigenous language.) Hello, my name is Awanishbasin (phonetic spelling), which means the Breath of the Spirits. I come from the White Earth Nation from Snake Clan, and me and these beautiful women here today have just spent the last three days here with the Return to First Medicines Conference just right next door to you.

And we're just -- we're out the door. We were just headed out the door, and we got grabbed. But we also have been working towards -- it sounds like your conference has been about healing. That's my work. I -- I have my own healing practice as well, and so we all, each one of us, tries to bring that out to the -- to the rest of the world as well.

And our conference was about food sovereignty and healing, so it's great to just drop in here for a minute. We'll -- we'll do a song here in a second it sounds

like.

MARIA MCCOY: (Speaking indigenous language.) Hello, my relatives. My name is -- English name is Maria Morin McCoy, and I work at the American Indian Family Center in St. Paul. I worked with Stephanie Graves. In 2006 we were working through the Healthy Start grant, Twin Cities Healthy Start grant. And at the American Indian Family Center in St. Paul we did a really, really beautiful work there and we actually were be able to reduce the mor- -- the infant mortality rate, and unfortunately, because the work was going so well, the grant went away because the three years we had it, the -- the infant mortality rate went down, but that didn't mean that the work wasn't necessary and needed.

And so the work continues. It's been a huge disparity in our community, and the support is always needed to help families thrive. And so I work with, primarily, women and their families and also the children in the community.

So (indigenous language). Humbling

experience to be here. We were on our way out and asked to come in and sing one song. We will sing the spirit bear song. And it's a song about asking that White Bear, that big white bear that's in the north, that will be coming out more as the season changes and will come out and dance with the northern lights, our ancestors, and we're calling the spirit of that bear medicine to come in and help us heal. (Indigenous language.)

(Singing performed.)

ED EHLINGER: I have to admit, I was in tears during that song. It was really touching. Thank you, Janelle for -- for being out there, and this just highlights the fact that where you hold the meeting makes a difference. It really made -- context is everything but context makes a huge difference so being here to allow that to happen is really cool.

But now we have another -- I mean, every session is just, I mean, incredibly powerful. And I'm looking forward to this one that Janelle is going to -- to lead. So

we're going to be looking at learning from our history in a whole variety of ways, and so we've got three presenters who are joining us. Two of them are here -- no, two -- one is here in person and two are -- are virtual. So I will let Janelle introduce them.

JANELLE PALACIOS: So this next afternoon panel will include three speakers from diverse areas of our nation representing different tribal communities, cultures, and languages, each with their own unique, issues, concerns and strengths, but also unified in this shared experience of native American history within this nation rooted in systemic and structural racism.

Rhonda Clairmont Swaney, past managing attorney and formal tribal chairwoman for the Confederated Salish and Kootenai Tribes will share her lived experience as a Salish Kootenai member.

She will be followed by Ms. Nicolle Gonzales, founder and midwife director of Changing Woman Initiative who will speak about special concerns rural and urban

native women have and accessing health well-being services.

Finally, we will hear from Ms. Abra Patkotak from Alaskan Native Birth Workers Association located in Anchorage, Alaska.

As you listen to the next panel, please incorporate all that you have review, learned, and discussed thus far from the past three SACIMM meetings and over the past two days. I invite you to ask yourselves what differences have developed over the past 50 years? What remains the same? And what actions will take us into a future where all native families are healthy?

Welcome. You may take the floor, the virtual floor, Rhonda. And we can see you Rhonda. And you're welcome to introduce yourself.

RHONDA CLAIRMONT SWANEY: Good afternoon everyone. (Speaking indigenous language.) My name is Rhonda Clairmont Swaney. I am Salish and Kootenai from the Flathead Reservation located in Northwest Montana where our ancestral homeland is. Thank you for inviting me. No one's ever

asked me to -- to share my story before. Granted, it is 45 years old, and I didn't think it would have any relevance today but Janelle assures me that it has relevance. I hope we can learn from it.

A little bit of background about my reservation: There are seven reservations in Montana. I live on Flathead Reservation, the home of the Salish and Kootenai and Pend d'Oreilles people. It is -- was created by treaty in 1855. It's a mere fraction of our ancestral homelands. However, we -- we were successful when we negotiated the treaty in the provision that we would have exclusive occupancy.

Our reservation is about 90 miles long and 60 miles wide. It's 1.3 million acres. It bisects Flathead Lake, and it's very -- still very rural. There are three stop lights on the reservation in two different small towns.

The reservation was opened in 1910 because it was so beautiful and people wanted to live here. It's now 75 percent non-native and 25 percent native. My tribe

has about 8,000 members but not all of them live here.

The 1855 Treaty I spoke of has been broken by the federal government over 200 times. I worked for the tribes for many years. The tribes are the largest employer on the reservation and enrolled members automatically qualify for Indian Health Service health care. That can be supplemented by tribal dollars, and we have compacted all of the health services at this point in time, Medicaid, Medicare and Tricare.

Tribal employees are now eligible for federal health care insurance, which they purchase and the employer pays a portion as well. For those people with only IHS-funded health care -- excuse me. Let me turn that off. For those with only IHS-funded health care, there is a committee that approves procedures to be done and paid for by IHS dollars and tribal dollars. The committee uses IHS regulations, that is, to be eligible for a procedure, you have to be very sick, that is, be nearly losing your

life or a limb.

We have very limited capable -- clinic capabilities with the tribes and we have one doctor that's a tribal member and all of the procedures that are waiting to be approved generally begin getting approved the 1st of October and then our money runs out very quickly. So people rush to get -- get -- get in there and get treated. There was one individual that I know of personally who had cataracts and he was left unable to see for about 25 -- 25 years before he was treated.

They have two low-level hospitals. Specialty care is located 60 to 140 miles away depending on where you start from on the reservation. Local hospitals, two hospitals rely heavily on IHS purchased care reimbursements to stay in business. They shift costs and ERs are use primarily -- are useful for primary care as well.

Now on to my story. As I mentioned, it was 45 years ago. I was 25 -- 4 years old at the time of my first pregnancy. I had been to college. I was married, I was working for my tribes, and my husband was a

heavy drinker just like many other men his age. I attended all prenatal appointments with my family doctor through purchased care.

On the six-month appointment, it was a Friday afternoon late in the day, the nurse told the doctor I had protein in my urine. Said I was fine to go, and he didn't give me any warnings about what to look for or problems should occur.

The next night, I developed what they called toxemia then, they now call preeclampsia. And it was my first pregnancy, so I didn't know what was normal but it began to feel that something was very wrong. About 5:00 or 6:00 in the morning, I drove to the local emergency room. Because it's rural and there aren't many providers, the local hospitals put doctors who are providers for their hospital on call, and so they're only there on the weekend if there's an emergency.

I went to the ER, but the nurse told me that they didn't have my blood type on hand so they would be transferring me by

ambulance to a bigger hospital about 60 miles away. The on-call doctor didn't ever look at me, didn't come in.

When I began my trip to the larger hospital, my baby's heart was still beating. When I arrived at my destination, the heartbeat couldn't be detected. I began to hemorrhage heavily. The on-call doctor in the larger hospital induced labor. He told me I couldn't have a C-section because I'd lost too much blood and I wasn't clotting.

I delivered my dead baby, and was hospitalized for several more days, given units of blood and anti-seizure medication and was released without instruction how to care for myself or how long to wait before getting pregnant again.

Being young and thinking it was just a terrible accident that wouldn't happen again -- I -- did learn recently that preeclampsia occurs when there's stress in your life. I want to say that most reservation residents have stress in their life every minute of every day; just going to work, trying to get equal treatment,

knowing that you're a second-class citizen is very stressful and you know you're not -- never going to get ahead, never be as good as everybody else. You try harder, but you're never successful.

As I was young and wanting to move on, I became pregnant again rather quickly. I was given a high-risk designation because of the still birth I had, and I was sent to a specialist about 60 miles away. I chose the same OB-GYN that delivered my first baby because he knew my problems.

I drove a 120 miles each way for each 15-minute appointment. He didn't take any special care or any special tests. And one night right after New Year's, I began spotting and was told by the hospital to drive -- drive in. It was January. It was cold and the roads were icy. I remember we slid through one or two stop lights in Missoula.

When I arrived, I was informed that I was in preterm labor, and I delivered a little tiny baby at midnight. I was told my son probably would not live until the next

morning.

He was put in an isolette in the nursery, and they gave me something to sleep. My son weighed in at 1 pound 12 ounces with the umbilical clamp on. Measured 13 inches. My husband's hand was bigger than the baby.

The next morning, my son was still alive, and the doctor decided to transfer him to the U -- University of Utah Medical Center, neonatal unit 500 miles away. I did get to see my son and touch his hand before he left but couldn't hold him. I was also able to visit him twice while he was in that medical center.

I was told that children born as early as my son did not live and his chances of surviving was 1 in 100. I was asked to sign paperwork promising not to sue the medical center if anything happened to my son because they would be providing him experimental treatment.

I learned that I delivered at about 26 weeks and the cause of the early delivery was attributed to DES syndrome, that is my

uterus couldn't support the weight of anything over two pounds. I still don't know if that's true.

The only thing the doctors told me was keep trying. Eventually, you'll have one that lives. My son did live. Today, he's a 44-year-old man with severe cerebral palsy, profound deafness, and an intellect that can't be accurately measured. I love him more than words can describe. He accepts his disabilities with humor and grace and lives defiantly to this day, that is, if you tell him he can't do something, he'll find a way to do it. Oh, but what he could have been, what they both could have been.

Again these -- these events happened over 45 years ago and, really, nothing has changed. There -- the reservation I live on is still very rural. Providers are not plentiful. They use an on-call system on the weekends. And, frankly, Indian people are considered disposable. That's what I felt, and that's what I feel today.

Although these events happened 45 years ago, I challenge you to think about what's

changed over that time. Native women are still at high risk for complicated pregnancies. Our babies die at the highest rate compared to other populations in our nation. Scarcity of funds for health care is an ongoing issue, particularly if you go to the Indian Health Service for help.

Health literacy among our population remains low. We are deficient in providers in our communities. Many of our people are under housed or considered homeless or live in a -- in a unit that's too small because several other family members live there.

Access to transportation and good roadways are still an issue. And through this, I have not even touched on the mental health needs of our community; suffering from intergenerational trauma, endless daily encounters of racism in our communities, violence, and substance misuse.

So what has changed in 45 years? Not much. I understand your efforts to bring all the problems of native American pregnant women to the forefront and provide them better care, but I just challenge each and

every one of you just to help one person. Thank you.

JANELLE PALACIOS: Thank you Rhonda. Limlmtx. We will now hear from Nicolle Gonzalez, and we will hold questions for the end. Thank you.

NICOLLE GONZALEZ: Good morning or good afternoon everybody. (Speaking indigenous language).

I'm Navajo from the Navajo nation. I'm Nicolle. I am a nurse midwife, I've been a nurse practicing for 17 years, and I've been a nurse midwife for ten years. During those years, I provided midwifery care and nursing care within a hospital setting in a rural area north of Albuquerque. I worked two years as a nurse in a obstetrical and med-surg unit in Santa Fe during the time that their OB unit was closing, and from what I saw there, I felt very propelled and bothered and concerned by the care that native American women were experiencing under the care of midwives and doctors in that facility.

Since 2008, I returned to school, and I

became a nurse midwife to address maternal health issues in my communities because I did not see a lot of native indigenous women choosing midwifery as a career path. I'm actually now one of 20 native American nurse midwives in the United States providing midwifery care in my community.

I do not work for Indian Health Services. Many of us have chosen not to work for Indian Health Services because of the racism and a lot of violence we experienced as health care providers trying to serve our own communities.

I've been propelled to create this nonprofit organization called Changing Women Initiative. We've been a nonprofit since 2015. We are currently located in Albuquerque, New Mexico, providing home birth services to native American indigenous women in the Navajo Nation in Albuquerque/Santa Fe. We cover about three hours' distance from our location to attend births, not only in people's homes but in providing traditional home birth, meaning returning birth to community in a hogan with

traditional medicine, with medicine people, with doulas that we have trained.

Our services cost about $4,000 per client. It doesn't include midwifery care. Right now, Medicaid reimbursement for global return of care for midwifery care or just birth services is a 1,500. So if it -- the funds that we provide services to our families covers food, so we work with local farmers to get food every two weeks to our families up to six weeks postpartum.

We pay for tradition medicine body work with healers. We also provide plant medicines and tinctures and teas to our women during their pregnancy. They get a paid doula to attend their birth, and they get a lactation specialist consultation support through their pregnancy and postpartum.

All of those services cost $4,000. And so because of what's happening in New Mexico in regards to hospitals closing, like Santa Fe Indian Hospital closed their OB unit in 2008, San Juan Medical Regional Centers closing their -- their midwives are having

to go elsewhere to provide care. The Phoenix Indian Medical Center has closed their obstetrical units. Las Vegas, New Mexico does not provide OB care. Los Alamos does not provide OB care. Santa Fe has two hospitals, but, basically, the native women are now required to navigate a very complex health care system because their IHS services are not providing care to them anymore or they're having to transfer at some point during their prenatal care visits.

So a lot of the women that I see, especially during COVID, have not received care up to 20 weeks into their pregnancy because; A, they can't access a care provider; B, they have to travel more than 30 miles to get access to care; or they have to wait more than six weeks to get in with a health care provider to access -- to get care for their pregnancy.

And so when we see the statistics around obesity, diabetes, hypertensions, postpartum, hemorrhage, native women not accessing care in the first trimester

increase maternal mortality rates because of car accidents just trying to get an appointment, it's because these hospitals are closing or labor and delivery unit causing women to have to travel further, but also, IHS is not fulfilling their treaty obligations to the tribes around maternal health care and women's health care in general.

I have an easy-access clinic on Wednesdays where I see women often times who will traveled two hours to come in for care. Regardless if they have health insurance or a proof of insurance, I will see them for care. I'm seeing women who have diabetes that hasn't been managed or controlled for two years because they can't get in for an appointment at their local hospital or their clinic within their tribal facility. I'm seeing 20-year-old -- I'm sorry -- 14-year old pregnant young woman who've gotten no prenatal care up to 20 weeks because they can't get in for an appointment for their prenatal visits and they are unsure of how to navigate the health care system that

they're kind of pushed into navigating because IHS isn't providing those services in their community.

I've just recently returned from Sweden, Geneva and represented and talked about these issues to the committee on elimination of racial discrimination because, clearly, this is a problem. When I look at the data and it's 20 years since 1980 to current, like the maternal mortality rate for native women has tripled despite all the health care advances that we like to talk about.

I'm seeing structural racism impede access to quality care because funding isn't in getting where it needs to go. I know that Biden gave nine billion more to IHS facilities to take care of our health, but that funding isn't getting to grass roots organizations or even nonprofits who are trying to fill the gaps where they are not filling the gaps.

And so I work on the front lines. I take care of all of these women who can't get care or have issues with how they're

being treated in the hospital's setting. I hear stories over and over around their rights as indigenous people, native women not being honored in their birthing experience, people still getting episiotomies that they don't need and did not ask for.

Un-consented procedures is still an issue. I don't see an apology from Indian Health Services for their forced sterilizations that our people have gone under in the 1970s, which is interesting because it's in other research that I read, but there's no formal apology about that act ever happening to our people.

My concern is, like, at what point when we continue to tell -- tell our stories of hardship, like, who is going to listen? Where is the funding going to come from? You know, I'm hearing -- I'm seeing like Joe Biden, president, talk about protecting our reproductive rights and I'm seeing these things happen at a high level, but they're not trickling down to the state. And so what's -- where is that break happening?

And so I just wrote down some recommendations in regards to what I'm seeing. I would like to see a federal mandate within IHS to work with grass roots midwifery, doula, birth assistance to improve maternal health care.

A majority of nurse -- nurse midwives and doctors work in the city, they do not work in rural settings, I think it's great, we want to improve and get more doctors out there, but we need the people who are going to work in rural communities to do the work, and we need the funding to help support their education and their training.

I think the funding that follows -- that needs to follow native American women, no matter where we live. As I heard earlier that native women are just native of people. We don't just stay on a reservation. We live in all different parts of the world and different parts of the state.

We're putting a lot of pressure for Medicaid to cover the cost of care for those women who are not able to get care under Indian Health Services. And it's not

working like, they're still -- I have a story of a woman who has health insurance. Actually, she didn't have health insurance, she had IHS health care here in Albuquerque. She had a miscarriage and needed a D&C and she had to go back to her tribal nation up in North Dakota to get that D&C, and so because of how funding is placed in some of these locations, like, you're not capturing the needed services that native women need to have healthy lives.

I would like to see antiracism training and oversight within IHS for all providers and nurses; funding to go towards non-profits and grass roots organizations who are addressing health care gaps and maternal health care.

As I mentioned. It's $4,000, about, to take care of the families that natives -- that CWI is taking care of. To take care of 30 families with that budget it's about a 100,000. Our budget is a million. It's not enough to take care of all of the families and areas that we're trying to fill in the gaps.

Funding is focused on health impacts studies in these areas where OB services are going away. I know we play a -- pay a lot of attention to research, and you've just been presented with a lot of research from -- from very well educated native indigenous people, but a lot of what I read around maternal health, especially the experiences that native women have in childbirth is that it's more of a focusing on our culture and our traditions, and from a wide lens, it's nothing about whether we felt respected or honored or that we had things done to us that we did not ask for or understand. I think that information needs to be captured.

We need to have tax incentives for midwives, especially for licensed, certified midwives, and these are not nurse midwives, these are licensed midwives by the State or by the government to attend births in people's homes. They are the ones who are trained specifically to go into rural communities with special skills around maternal health. I don't see any of that type of legislation supporting those birth

workers in the community.

I would like to see a statement of support for indigenous midwifery in a collaboration with grass roots organizations serving their communities. Right now, we've been trying to get a meeting with Fort Defiance Hospital in a Navajo Nation just to talk about the services we're providing in the community, and they won't meet with us. They have to have a meeting around safety and whether they feel, like, safe to meet with us, which I find it's interesting because we've had a lot of women die within Indian Health Services over the years, and so the fact that they have to do a meeting to -- around the safety about meeting with a community organization serving them in their community is -- is concerning to me.

As I talked about, Medicaid only covers 1,500 of prenatal care as a global fee. As I mentioned, our services are $4,000. If someone wants to birth in a hospital, it probably be around 20,000 for them to birth in a hospital, and so there's no -- that isn't enough to cover the cost of birth.

And definitely, I heard this earlier around funding for indigenous health care workforce. I believe that we -- because we have blinders on and who can do this work, we're leaving out the ability for our own communities to be trained as doulas, to be trained as birth assistants, to be trained as licensed midwives. Not everybody has the capacity to go to school to be a doctor. I'm a nurse midwife, I've been in a school for eight -- my nurse midwifery education from post-graduate is four -- two years and then there's been five years for my bachelor's. That's seven years of education. And considering the communities that we come from where the families are fractured, transportation, electricity, not having a computer, single-family members, having to work at Walmart for their job, like how do we expect those individuals to go to school, to be doctors and then come back to their communities to serve them? I think we need to think outside the box and be innovative in our options, in our choices around serving our communities.

I know my organization has focused on that work. We do bring in training for doulas and lactation specialists to the community so they can be trained. They're committed. They're experts. They're not going anywhere, and it creates seeds of skills that our -- our communities are hungry for.

I know there's just a resurgence of returning traditional birth back to our community, and that's exactly what my organization does. That's what I do. Sometimes I travel three hours to a hogan out on the Navajo reservation with a fireplace and the medicines are all there and this -- these women are supported by their healers and by doulas that look like them and by their midwife that looks like them. Their babies are granted and presented into this world with song and prayer and the smell of cedar. And that's so different from the hospital setting, and I think we need to create opportunities for places like that where birth can happen.

I see hogans all over the Navajo

reservation. They're -- they're right next to hospitals but they don't use them to birth in. They don't use them to do care in. And so I believe there's this understanding that care has to happen in a clinic and it has to happen in facility, but it doesn't. You can do a prenatal visit in a hogan. You can do a prenatal visit in a teepee. If someone can't come to appointments, you can go to their house and do their prenatal visit. But I think we are all very -- like, have this idea in our head that it needs to look a certain way, but it doesn't.

And I'm happy to chat with anyone individually on innovative ways to address these issues because I know that's what we're focused on. That's what I'm focused on. I know what the story is. I know the history. I've read the reports. I've got three reports in front of me now about maternal mortality for native women in New Mexico and Joe Biden's recommendations for reproductive health care.

But, like, how do we get to the

communities? You know, that's what I'm interested. Where's -- what's the holdup? And so that's my message, and that's what I have to offer. Thank you.

JANELLE PALACIOS: Thank you Nicolle. Thank you. We will next hear from Abra.

SPEAKER: Let's see, is this already on?

JANELLE PALACIOS: Yeah.

ABRA PATKOTAK: Okay. Good. Okay. And James, I emailed you an image. I don't know if you could pull that up. Okay -- just of Alaska.

So it's really good to be here today with you all, and I did come down from Anchorage Alaska. This is not a presentation but a map of Alaska. And I'll start by introducing myself so.

(Speaking indigenous language.) So I am Abra, and my Inupiaq name is Nungasuk (phonetic) and I'm from Utqiagvik which is way up north, the furthest north dot on that map where it says Inupiaq. And I am a Inupiaq.

I also grew up in Idaho, Nez Perce

Reservation. I'm not Nez Perce, but I've been in Alaska for ten years, and that's where my -- my roots are. And I was able to live in Utqiagvik for six years where I ran the pre-maternal home for Arctic Slope native Association.

And I also was a 9-1-1 dispatcher for the North Sapporo Police Department dispatching for police, fire, and EMS. I had two jobs. And they -- that work greatly informed my current role on the Alaska Maternal and Child Death Review Committee, which has been wonderful. And I want to say thanks to the manager of that program, Ness Verigin, for making sure that there's native people at the table.

Like people have said when we were making these decisions about native people and thinking about these things, native people need to be included. Our voices need to be there.

So I'm really grateful also to Janelle and Ed for making this possible and having this voice of Alaska. I was giving a little grief early about one of the maps earlier

didn't have Alaska on it. So it's okay wherever you are. I forgive you. But we are a part of the Unites States. We're -- I have some Alaskan statics, actually, which you might have heard, but we have 586,412 square miles or about 365 million acres. We are the largest state. We're one-fifth the size of the lower 48 states. And there are not that many people in Alaska. We're very sparsely populated. There's 700,000 people, around there, in the whole state.

So I guess the other thing about -- I'm not just on the MCDR committee. I forgot. I'm also here as the cofounder of the Alaskan Native Birth Workers Community, and within that organization, I'm an indigenous birth worker. I -- I am a doula, but one thing I do want to talk about is language and how important language is, and our people don't know what the word "doula" means. We all know because we work in this realm. We're working with pregnancy. We're working with doulas, and we want to extend that.

But in Alaska, when I talk to people

from Utqiagvik or Point Hope or Bethel or somewhere -- like -- and they don't know. When I say, oh, yeah, we mention -- the nurses refer people to our care and they say, "what's a doula?" So when we're thinking about that care we provide, we have to really think about how important language is and whether or not it's accessible to people.

The other thing about language -- so most of the births that I attend are at Alaskan Native Medical Center, and Dr. Owen had a wonderful presentation earlier talking about -- in Alaska, we -- it's -- the health care is a little bit different. So we are owners of our health care system. As Alaskan Native people, we -- I actually didn't know we're the only state that has all that -- the -- in our -- the health care is in our hands. And I really love going to births at the Alaskan Native Medical Center in Anchorage. It's -- it's special, and the -- most of the time, the team there affirms people's choices and the care they receive, and it's a positive thing.

I -- I do -- I -- I don't see, I've been to births in the lower 48 and it's a lot more difficult. So those are -- that's maybe one of the benefits of Alaska. There's some things that are -- that are going right up there that I really appreciate. But one thing that's come up over and over is the way -- if -- culturally matched care.

So if a health care provider is non-Native, Alaskan Native people speak with their eyebrows and nose, and health care providers don't know that. We -- I've seen, so many times, people with their backs turned to someone charting and the computer asking questions and the person is answering, and they will, you know -- they'll answer like five times without saying a word, and it's really frustrating that they are not being listened to because they're not using words.

But that is our language and when I'm there, I hear that. I hear those words that are not words. I hear that body language. So it's so important. It -- and then is

frustrating. It's like, okay. I -- I answered you and then finally on, like, the fifth time, the -- the person in labor, "Yes, I said, yes" like, you know, very frustrating.

And we heard about how stress can lead to, we know, negative health care outcomes. So when you're not being listened to, when people don't even understand how to read your body language or speak to you, that's really going to lead to difficulties during birth.

Some of the other numbers that I'll share about here is the pregnancy-associated mortality rate for 2011 to 2020 is 8.5 per 10,000 live births. And we use pregnancy-associated because our numbers are small in Alaska. For Alaskan Native people, that is 17.9 per 10,000. For white people for 4.1 per 10,000.

So those are all the numbers. But what we're looking at lately -- let me -- what's really concerning is that 58 maternal deaths ending in the 5 years before 2021, 19 percent were from homicide and 14 percent

were suicide. 74 percent of those deaths were by POC people, majority of those were indigenous. 60 percent of those deaths were native people.

So I found it interesting. I'm learning a lot this week and in the past few months of this -- the way this committee works. From what I understand, there's no law enforcement or public safety individuals that serve on this committee, which was really interesting to me when we're seeing these really high rates of violence in -- within a year of childbirth against indigenous women. So that is really, really concerning that just being pregnant increases those rates of violence so much.

And I -- I -- I bet that some of you committee members do have a background in mental health, but we talk about mental health and how important that is, and that is a huge issue that we're facing and that really, really needs to be addressed in a way.

And men, Lee mentioned men earlier. So when we are seeing these rates of homicide,

who is causing -- who's -- who's killing people who recently gave birth? It's usually a male partner. It's intimate partner violence that we're seeing happening in our communities.

And going back to this map. So these are languages. I think -- pretty sure this is a language map, actually. This is not necessarily all the different people but different dialects of our language. But it shows you, too, you could see how we like, kind of move into Canada, and -- and Alaska often gets left out, we're way up there. We're, like, just it -- this imaginary line that was drawn between Alaska and Canada. We could have easily just been a part of Canada or whoever Russia decided to sell Alaska to when that happened. But the way it worked out, we are a part of the United States. But this imaginary line here that's crossing us, I mean, our people, we move freely between those places.

And we are so diverse and we are also living in very, very rural places. So there's hardly any -- the road system in

Alaska, I'm sure you all know at least to a certain extent that it's not that extensive. So most of the communities you have to fly to give birth, and most people are flying to Anchorage.

The thing that we are seeing that I just -- other people don't have to go through, I -- I appreciated hearing about -- from lots of people how far you have to travel usually by car. Well, in this case, you're flying. And do medical providers want women flying at 40 weeks? No. So you -- you're flying at 35 weeks, and you're leaving behind your family. You're leaving behind your children, your support person, your aunties, your mother, your cousins, your sisters, all of those people who traditionally were there to support you.

Every indigenous group of people the world over had a support system in place, people who were knowledgeable and who knew how to provide that care in their communities. And this forced evacuation from your home community at 35 weeks, maybe 34 weeks if something's going wrong or

earlier where you're sent to a city hundreds of miles away, Anchorage usually, also there's hub communities. There's Juneau, Kotzebue. There's -- there's different hospitals; Bethel, Barrow has a hospital or Utqiagvik. So you're sent away though from your village and removed from your support system leaving your family behind. Can you imagine how stressful that is for someone who is pregnant, all alone, possibly doesn't have anyone else to care for their other children? They have to bring those children with them who are then not allowed to be at the birth and then they have to struggle to find health care.

And if people do choose to stay in the hub communities, because births don't normally happen in villages anymore though. And the North Slope of Alaska, which is where I'm from, there were still children being born by midwives at home in the 1990s. But that hasn't happened very often since then. Sometimes also babies will just be born because they come when they want and they come early. And oftentimes that

results in a medevac, so the medevac flight has to then remove that family, that mom and that baby to Anchorage.

I have also seen at my time in the North Slope Borough with the pre-maternal home that was run by Arctic Slope native Association, there was one mom who was overdue, and the doctor -- she -- I think she might have been, like, 40 weeks and 1 day and the doctor was, like, "Well, you know, just go ahead. We're going to put you on Alaska Airlines." She was sent on a commercial flight by herself from Utqiagvik to Anchorage, and she -- within two hours after the plane landed, she delivered that baby. So she almost had the baby on the airplane. These choices that are being made by these providers for our people are not always in our best interest and can be really difficult.

And then she had to deal with all of the stress and expenses of being in that in -- far away from her home, and she could have just as easily have stayed in Barrow.

So the other thing that I wanted to

touch on is a personal story of -- the really difficult -- I had a real -- unexpectedly very difficult time postpartum with one mom recently. She got discharged and it took a while for her baby to get discharged. They get discharged at separate times. And our -- we do have within our health care system, we have got patient housing, and we have the hospital, Alaskan Native Medical Center in Anchorage.

People from patient housing can usually just go over to the hospital and give birth, and they go back to patient housing. At this time patient housing was full. Alaska -- airline issues have been a huge thing across the whole world, but it was -- it also affected Alaska, and there were no flights for a while because of weather, construction, et cetera.

The hotels in Anchorage were -- were also full, and this mom had a baby two days before. She was dealing with stressful postpartum bleeding, terrible backaches, all alone, no support people. She didn't have anywhere to go. She didn't have anywhere to

stay. She --

So we -- we -- we went to the travel office. We had to find a Medicaid voucher for her to get a stay at a hotel. The hotels were full. There was one left and even though it was a Medicaid-approved hotel, this hotel required a hundred-dollar deposit from a credit card to stay there. She was this close to not having anywhere to stay in Anchorage, Alaska, and she's from a village of 3 or 400 people. And I had no idea how difficult it was, I have a bed, I have a home in Anchorage so I don't have to deal with that.

But can you imagine just trying to get home with a two-day-old infant, having to fly multiple airlines, but before you do that, you have to find a place to stay? You're on Medicaid, but you're required to have a credit card. I mean, it's -- it made no sense to me at all.

So I -- I did end up just using my credit card, because what was I going to do? Let her -- I mean, it was very -- it was horrifying how difficult it was, and it took

12 hours between discharge and getting her to a hotel late, late, late at night.

Yeah, that was just one story of how difficult it can be getting home from giving birth to your baby. And I can't think of anyone who would willingly choose to get on an airplane with a two or three-day-old baby and that's what people have to do just to get home. And we wonder why these babies are getting sick, why they're having ear infections.

I also don't know -- I'm not sure if this -- if a study exists, but I don't know what the studies are like of bringing a brand-new tiny baby on these flights. Like it's not -- I had a terrible earache on the way here. It was so painful. I'm an adult, and I -- I -- you know, could work with it. I could chew gum and take an ibuprofen, but these babies that it's -- it's unnatural. We all know that when babies are born and it's ideal if we're just at home with them in our arms immediately and we don't have to go anywhere.

Okay. The other thing I wanted to

touch on here is the importance -- and I've heard this already multiple times, but an indigenous worker, which I like to say I'm an indigenous birth worker, indigenous birth keeper. I'm not a health care provider. I'm a community member that cares about people. And I do have birth work in my history too on my -- both grandparents' side -- or side of my family there were birth workers.

So thinking of history, it's important that we have these people to speak up. Going to the appointments, we mentioned that. Or this morning we heard it in opening. When you're at a doctor's appointment and you've just had a baby or you're pregnant and you hear stressful news, you're not going to be able to carry all that information and -- and -- and adopt it and absorb it. So having someone there.

And I had a conversation with another doula, like, traditional doulas who have businesses. At our organization, we provide our services at no cost to native birthing families. We -- we are paid through grant

-- grant money. This is my job, but we don't charge those families money because that is not how we traditionally operated. You -- in community, you didn't pay the -- the midwives. You maybe traded with them. I get plenty of dried fish and salmon and traditional foods. I love that. That's -- -- that that's great. That's what I appreciate from families.

But being there with them through this process as they navigate the health care system, which in Al-- in Anchorage, I really appreciate. They see midwives. There's certified nurse midwives who are there who provide people care. But being there to help them navigate that system, that is so, so important.

And I do have some -- I guess I did ask that question -- the other about, you know, public safety, law enforcement. Also how many of the committee members have a background in suicide prevention? That's really, really important when we're thinking about Alaska, when we're making these recommendations. How many committee members

have a background in rural emergency services?

So being -- yeah, rural Alaska, being a 9-1-1 dispatcher, a lot of the calls I got were about small babies or pregnant people in distress that needed to end up getting medevaced.

So my main recommendations are that there are indigenous birth workers at all births. I know the family. I know these families. I know their community members. I -- I ask about who their parents are. I ask about their traditional names. I know the relationship between the two parents and whether or not there's something dangerous going on there.

Speaking of OCS or Child Protective Services earlier, I've also been at a birth where the doctor and nurses were very threatened by the male partner in the room because birth is a stressful and scary event sometimes. It's not always. Sometimes it is. And there was an OCS report that was opened up. I knew enough about this family that it was -- it's just completely -- it

made no sense to me. When we're thinking about families, and native men and native women -- sometimes there is violent -- often, oftentimes there's violence there. Sometimes it's false accusations. If you have an indigenous birth worker there, then it's great.

And also, remove this certification of a doula, like, a certified doula. Indigenous people can certify themselves in becoming a birth worker. It's having that person there. Thank you, yes. We have this knowledge and having that person there who can -- who looks like them, like that's going to provide better health outcomes.

We also need, again, to look at language. Listen to people. I even worked with someone who was native from the lower 48, and I forgot to tell her about how Inupiaq and Yup'ik people are going to talk with their eyebrows and nose. So I know that. So when I'm working with those families, we can really -- we can talk to each other without saying a lot of words. We need culturally-matched care. We need

people that look like us in the room.

And the home visiting program, that is huge. And that's come up over and over in our Alaska MCDR programs. We need that in every native community, but we need American Indian and Alaskan Native people doing that work, visiting those homes, and watching out for those things. And when we're looking at violence, suicide, overdoses -- those people are going to help identify those issues, and they're going to be trusted and welcomed in those homes.

The other thing that I would -- am really curious about and want to learn more about is this American Indian/Alaskan Native led maternal and child death review committees. We need to make that funding accessible and the process of getting those funds accessible. I'm not -- I have more to learn. I don't know very much about that -- I've heard a little bit about that funding.

But the one thing I want to close with is native people. We love our people. We value our people. With every maternal child death review that we go to, I'm a core

committee member, so I help compile groups for the panelists. I also serve on reviews for maternal deaths, sudden infant deaths, and youth deaths up to the age of 18. When we open, we talk about honoring those lives. And that is what we need to do. And I don't know if it's going to look like individual tribal-led reviews or maybe state or like Janelle and I talked about briefly, maybe regional. But when indigenous people, when American Indian and Alaskan Native people are reviewing these deaths, they will honor those lives, and that will greatly help in reducing our maternal and child mortality rates. So thank you so much.

JANELLE PALACIOS: Thank you. Thank you Abra. Thank you Abra. So thank you Abra for bringing to our attention the notion that the border crossed us.

And that's something that we don't often talk about is that we have native people along the borders. We have you know, people that have our -- like, I have family that live in Canada. They're still part of my community, part of my nation, and there

are people in the south have their families in Mexico.

And then also this -- another point that stuck out to me -- all of it stuck out -- but another point was that we are a policed people. Depending on what -- some reservations and communities you have multiple layers of police task force. You have the tribal police. You have the non-tribal police or the local community police or the county sheriff. You have the state troopers. And then you have the FBI. So we are a policed population as well.

So thank you for sharing, Nicolle, Abra and Rhonda. I will open up the floor to any questions. We can probably take about three. Yeah, Colleen?

COLLEEN MALLOY: Thank you for your stories. I was blown away by the travel aspect both with -- with Ms. Clairmont Swaney and driving 120 miles and then the idea of the plane. That's -- I've never heard that before. That's shocking. So, clearly, we need to get more providers, more local, so that doesn't need to happen.

Mrs. Clairmont Swaney did say that you feel like nothing's changed in 45 years, and I -- I heard that loud and clear. I kind of wanted to say that from a medical standpoint, I think we've made a lot of improvements and a baby at 26 weeks today should have a different outcome than your son did. And I love that you celebrate your son's life, and that's fantastic how you have so much love for him.

I think the piece that -- so I can say it's better from a medical standpoint, but, clearly, it's not better from the receiving end of it. So it's not translating to your community is what you're saying. So we can make all the medical advances in the world, but if it's not getting to you where you live so that a baby who's 26 weeks is born today, close to you, should have the same outcome as a baby that's born in a city with access to university hospitals.

So I do think the positive is that there have been a lot of improvements in premature birth, but these issues of getting that to you didn't happen, and a 26-week-old

shouldn't have been left in the room with a mom overnight and then reassessing the next morning. That doesn't sound like a good plan at all. So that's the part that we have to work on, obviously.

And I just really wanted to tell you I appreciate your story as a neonatologist because it shows me how far that we've gone over 45 years, but how much more we need to do to kind of get that to the people so the improvement is uniform across the country and not just in pockets where there's academic medicine.

JANELLE PALACIOS: Thank you. Are there any other questions?

JOY NEYHART: I don't have a question, but I do -- this is Joy Neyhart from Alaska. I wanted to mention to Abra that I've been on the State of Alaska Maternal Child Death Review Committee since 2014 or 2015. And my first few meetings, there were no -- there was no native representation at the table. And I brought it up slowly and forcefully, and then I actually yelled at somebody and said, "We can't keep doing it this way."

So yes. Thank you to Ness and her predecessor Katie and Jared Parrish and all the people that work on -- on the committee and support it. And thank you for being part of our committee.

And you are so correct that when we review deaths that happened in the villages, I -- I can review it, I can come up with an -- an educated understanding and help with some information, but I can't change it. You -- but you can change it. You can change the outcome, then you make it fewer. So thank you.

ABRA PATKOTAK: Thank you so much Dr. Neyhart, right? (Speaking indigenous language.)

JANELLE PALACIOS: Yeah, please, Dr. Ramas.

MARIE RAMAS: Thank you all for your presentation. Once again, I'm just struck by the dichotomy that we live in here in the United States, how we can have third-world conditions in one of the richest countries in the world. It continues to baffle me. So I want to thank you, once again, for

sharing your stories, and I apologize that you have to continue to share your story and re-traumatize yourself for the benefit of others.

With that being said, something that has struck me and I -- I'm curious to hear the panelists' suggestions. One of the things that -- as a family physician that has provided maternity care for over a dozen years -- I recognize is this notion of having comprehensive, whole person care in one setting. And there's this notion in -- particularly in -- in western and United States that people have to come to get their care, and that's how we think about access. And that's a bias. But what I'm hearing continually is that we have to bring the care and help people make the right decisions for themselves and reduce those barriers.

So it's increasingly come -- becoming evident to me that, one, we know, based on statistics, that family physicians, nurse midwives, multidisciplinary teams are part of the way to create a solution and creating

a comprehensive home base, safe place for our -- our birthing families.

My -- my question is, if you had an ideal world, I hear "funding." If you had an ideal world where, one, the system and the people within the system of indigenous or not indigenous actually saw you and listened, what would that ideal setting look like for you and the communities that you each serve?

So paint us a picture on this committee on what would that look like for the birthing parents and the communities that you serve if people dared to listen and act.

ABRA PATKOTAK: Okay. I can speak to that to an extent. So thank you. Thank you for your question. Like Dr. Owen said earlier, and I think it's really true, we have a pretty incredible health care system in Alaska in many ways. And I do have the privilege -- well, and it's also a burden in some ways because I'm not home in my community of Utqiagvik, but I do live in Anchorage where we have pretty amazing health care. And we actually -- so I

receive my primary care at South Central Foundation, and they do something called the Nuka model of care, and I really appreciate it. I am -- I go to one place where I can see, if I were pregnant, a midwife, my primary care physician or whoever my provider is, possibly a PA and behavioral health all in the same room. And I do like that. They come to me. They come to me and it's wonderful.

It does not exist in our rural villages or, I guess, anywhere outside of Anchorage, I'm assuming. It's -- it's wonderful. It -- it -- we do have a lot of Alaskan Native, native American, American Indian people if we're using, like -- we were told earlier by Stacy the federal terms -- in -- in Anchorage.

I believe South Central Foundation cares for 60,000 native people in that area who can then go and get their primary care. There's also a clinic in Wasilla. They come to us. It's amazing. I really, really appreciate our health care system. If anyone in Alaska complains about it, I do

say you have not received care through an IHS facility in the lower 48, which I did, because I did grow up in Idaho and had pretty terrifying health care experiences in New Mexico that informed what I do now because I don't want people to get treated the way I do where I almost died. I -- I can share more about that later.

But I want that for everyone in Alaska, for all of our native people. When they go to get their care, those providers are coming to them. Yes, they do have to go to one appointment, but then they come to them. And you sit -- you can -- you're in that clinic. You don't have to hop around to a million different places. It's hard to imagine thinking of that and bringing birth back to our communities. I would love that, and I don't actually know exactly what that would look like, but I would love to see that.

JANELLE PALACIOS: Nicolle or Rhonda, if you have any response. And Nicolle, I know you're -- you're trying to show this, living this, doing this.

NICOLLE GONZALES: Yeah, I would say part of the colonization model has made us dependent on a system that is not serving us and hasn't served us and even wasn't created to serve us intentionally. And so decolonization from that model, for me, is more about creating systems and health care that reflect the communities that they're serving, which means redistributing funding, to food and access and to things that maybe we might not think are part of our health care.

I know we are experiencing high rates of suicide and depression in our maternal communities and not having access to a mental health care provider. But also understanding that native women, just native people, that trauma we've experienced and continuing to experience is partially because of having to navigate a complex system, one; two, is not being able it practice our traditional ways of life because we are separated from that in one way or another; three, our families are fragmented and so our support systems are

not there and I think that's where the poverty is -- what I see -- is not having a support system.

But also thinking that as a native woman, that I want to go talk to somebody about my problems, that's not traditionally what we did. Like, we would go to sweat lodge. We'd go to ceremony. We would go see a medicine person. And so when I say decolonizing our way of thinking about what we think mental health care looks like is incorporating those practices and centering them in our care as well as thinking a little bit outside of the box about going to people and providing care for them in their home and not putting all of that burden on a family to access care and then reading statistics that make us look bad as native women that we don't care about ourselves, right, we don't care that we're not getting care early like we're supposed to.

And everybody uses a lot of different terms to describe that. So for me, you know, yes, funding. Two, is policy and legislation that allows and especially

specifically the language around certification. Indigenous midwifery, doula, you know, like, unfortunately, when we start to make policies it begins to criminalize those who don't adhere to that policy. And like, we need to think that when we are creating policies that support our communities for better access that it doesn't criminalize our traditional medicine healers and women and people choosing not to license or to be regulated but who are choosing to still serve their community as a healer, as a medicine person outside of that policy and that model.

And often, I see that off -- in circles specifically creating policy to support communities is like we just -- we're seeing that right now with the -- the access to abortion services. Like, that -- is that even a topic of discussion? Like, is there a support for native women to get an abortion if they need it because a lot of the funding comes through the government? And like that's not something that native women can access right now.

So as native women, I feel like we're -- our body is highly-regulated and, decisions around what we can have access to or can't have access to is tied to funding and to government decisions that we can't even be a part of, and that's a problem. And so how do we -- ideally, I would love to see a think tank of doctors, midwives, doulas, medicine people sitting down and talking about what the problems are and think about inno- -- innovative ways to address them and coming to you all with recommendations.

Oftentimes, I get invited on the back end for recommendations, and then I'm not invited to the spaces where those recommendations are being read out or even continued through their policy, changing phases, and so, like, that needs to change.

I would love to say access to food and clean water, but, like, some of that is out of our hands. I just went to the U.N. committee hearing recently and hearing from a Shoshone tribe that their land is being desecrated for gold. And, like the majority

of their sacred lands is being torn up and their water quality is not good. And they're fighting this battle that they're not winning right now.

And so a lot of our tribes are in that place with -- with not only the government, but, like, companies coming in to steal our resources, our water, our minerals, our coal mining and that's affecting our health. And, like, what is our obligation to -- to our community and to the land if we can't even fight those battles? Like, we can make a recommendation, but is that going to change anything?

And so I think -- I -- I think this is an opportunity to change and to have innovation. That's how I'm seeing it.

I -- I hope I answered your question.

JANELLE PALACIOS: Thank you Nicolle. You've all given us a lot to think about. I know we're supposed to go to the next session, but Abra?

ABRA PATKOTAK: I just want to say something really quick in response to Dr. Malloy. Sorry, I keep trying to read. I

might need a new prescription here. But like, we -- you mentioned that things have changed, and I wanted to first -- you know, Rhonda, her baby was removed from her hundreds of miles away. That happens in Alaska all the time. I do have so many more stories. If any of you want to come and talk to me afterwards, I'm going to be here until tomorrow, and I'm very grateful to share these stories.

I had from the pre-maternal home a mom who had a C-section and her and dad and baby went back to Utqiagvik, and baby needed to get medevaced to Anchorage, and they only had room for one parent, and she was recovering from major surgery and couldn't carry a bag or car seat. You know the -- you know rules after a C-section. And she was separated from her child. She was trying to breastfeed and there was no way or resources for her to get back to her baby.

So yeah, it's still happening, sadly, today very, very often. Thank you.

JANELLE PALACIOS: And thank you. It's all these stories that need to be heard so

that changes can be made and that hearts can be -- to be changed as well.

I know that we're running behind but I just want say thank you all for being here. And you are in the room where it happens Nicolle, Abra and Rhonda. And we're going to have to keep you in the room where it happens.

ED EHLINGER: Just one comment. 45 -- 45 years ago, I was a pediatric resident at the University of Utah flying throughout the intermountain west picking up babies who needed newborn intensive care unit. Rhonda, I may -- I don't know. I may have picked up your baby.

But that experience was one of the things that drove me into public health and focusing on health disparities because of all of the in- -- inequities that I saw throughout the intermountain west when I was a pediatric resident. So things don't change a lot, but some things change. And whatever we do influences things as they move forward in some myst- -- mysterious way. So just learn from your presentation.

We're going to take one minute to stand and stretch while we get our next panel to come forward. Just to let you know, we're going to cut short on breaks and we are going to cut short on the discussion time for the committee just because all of these sessions are running a bit longer than usual. We also have Tina Pattara-Lau from the CD -- or from IHS. We're going to give her some time. She's on the screen, and I'm going to give her time near the end of our meeting so that we can have some discussion with her. So one minute and we'll get started.

All right. The minute is up. Get back in your chairs. Crack the whip.

MAGDA PECK: Thank you. Well, welcome back, everyone.

I wanted to know, Dr. Ehlinger, is there anything you wanted to do about why you wanted this session to be able to tee us up? And -- and then I'll take it and introduce.

While we're doing that, Emma, could we get our two colleagues, Terrance and Debra,

on split screen so we have the full family up here while we're getting ready?

Ed, would you set us up?

ED EHLINGER: Yes. So many -- many of us have worked in the field of maternal and child health. So we know the organizations that really focus on MCH issues, AMCHP, CityMatCH, Healthy Start. But a lot of new members of this committee may not have had the same kind of public health experience. So it was really good.

I wanted the members of this committee to learn about some of these organizations that are outside of government but work a lot with government on maternal and child health issues, to learn about some of what they are doing, but also particularly what they're doing around American Indian and Alaskan Native birth outcomes and also, to have them learn a little bit about what the issue is so that their organizations can focus on it, on some of those issues, and I want to form a relationship so that these organizations can leverage what we do here and amplify what we do here by taking

whatever the recommendations come forward and putting them into their work plans as they move forward.

MAGDA PECK: Thank you, Dr. Ehlinger.

By introduction, my name is Magda Peck, I'm a member of ACIMM/ACIMM/SACIMM, but it is the Secretary's Advisory on Infant and Maternal Mortality. And I come to you today with a chance to hang out with family. Folks that I have known for the -- we've been talking about 40 years. It's been -- it's been a 40-year-in-the-desert-journey. And here we are to come home to some core maternal and child health impact organizations who have come together over years, most recently, with an explicit statement to embrace an antiracist strategy together in the pursuit of health and racial equity.

And we've had some new faces here. So, Terrance, we're so glad to have new family members join us over time.

So here's what I'd like to do: This is the lightning round. We are not doing a series of presentations that you've heard.

This is a conversation among the family so that folks who work with organizations whose public health missions are explicitly dedicated to changing systems, policies, and programs can have a chance to give their reflections on what they heard over the last two days, family goes last, and what their positions can be to help amplify our work.

So the lightning round goes like this: And, Terrance, I'm going to start with you and then go to Debra and do a once-around. If -- and you don't have to both give the full explanation. But if we were in the elevator and I were to say "What's AMCHP?" because there may be folks here who don't know. So what's the elevator, two or three sentences, you now use to describe your organization?

TERRENCE MOORE: First and foremost, I want to thank the committee for assembling on this important topic over the last day or so. The session that I've just participated in or listened in on is deeply rich. And so I'm excited to be a be a part of this discussion this afternoon with my friends.

I like the discussion on family because I do believe in most families, we know that in order to sort of advance progress, part of it is getting to know one another, getting to better understand the needs and desires of our families. And so I want to thank you all this afternoon for this.

About AMCHP, the elevator -- elevator speech I would say is, AMCHP is a membership organization that represents governmental public health, particularly state governmental leaders as well as leaders and community, families, people with lived experience. Our folks are sort of deep in the health department across areas of foci including children with -- children, youths with special health care needs directors, MCH epidemiologists, adolescent health coordinators, et cetera.

And we really come today sharing, what you've already mentioned, a deep commitment to antiracism and recognizing that in order to sort of move the needle on our work in MCH and beyond, we must acknowledge past harm. We must interrogate the ways in which

we interact with each other and community, and also, looking at the policy landscape and the tools that we have at our disposal and what we know already works among communities. And so we're excited to participate in this discussion, to add, but also to learn and listen.

MAGDA PECK: Thank you, that is a very tall building. And we love that you're in the elevator with us.

Deborah Frazier, give us your elevator. What do people need to know about the National Healthy Start Association?

DEBRA FRAZIER: Thank you, Magda. Thank you all for allowing us to join you this afternoon. And -- I -- I am not here. Terrance is not here, obviously, and -- and -- and our condolences to Terrance for his reasons for not being here. And I am not there with all of you because I'm here with our pilot sites that are working on addressing maternal health and disparities in maternal health. And so I was not able to tune into all of the proceedings today.

We are in New Orleans, and I want to

acknowledge that we are here on the banks of the Mississippi River and -- and what was, for centuries, home to the Chitimacha tribes, the Choctaw, Houma, and Tunica tribes, and the Biloxi tribes and -- and what the Choctaw tribe called the Bulbancha, The Place of Other Tongues. And so we acknowledge that -- and acknowledge the injustices that led to those tribes during all of those centuries and continues to happen during colonization, then and now. So -- and we did that in our meeting today.

We as an association, we inculcate all of our work with equity, but the Healthy Start Program is a community-driven -- which is important -- community-driven and community-based program, which was founded and continues to work to address disparities and equities in birth outcomes for moms, dads, and families, and we put an emphasis on the work that we do with fathers, and that's really, really important.

And that is our quick elevator speech. And we can expand on that, but we -- I mentioned fathers. I mentioned at the

beginning of this, we have a portfolio of programs that we do with our NCCI, and we have a racial equity learning series with seven modules that address equity across a course. And -- and it is inculcated in our policy for the National Healthy Start Association. It is a required part of our personnel policy, and we also lean on that for our contractors and our partners as well.

MAGDA PECK: Thank you, Deborah.

I'm going to turn to our family members at CityMatCH. Denise Pecha, who is the deputy executive director, and our current board chair, Stephanie Graves, who you've heard of many times mentioned over the last two days locally who is the lead for Maternal and Child Health at -- one more time, one more M. It's been a long three M's -- the Minneapolis Health Department.

May I pass it to you, Stephanie, first?

STEPHANIE GRAVES: All right. My elevator's just a couple floors. So CityMatCH is a national maternal child health organization that the membership

consists of local, urban public health members, and then community members that also work on and believe in trying to improve the lives of woman and children, and especially to enhance birth outcomes. That's who we are.

We also believe in equity, and we believe in -- you know, we did our antiracist statement, and Denise can talk a little more about that.

DENISE PECHA: I would also say that we focus on MCH, and on the elevator, I always say that's a very big umbrella. It's hard to find anything that doesn't fit under MCH, including men.

And I think there's -- we talked about this at a previous meeting, and you have it. It's in the folder, that all of us are committed to being antiracist organizations. I think all of us had starred that journey before we had the joint statement. So you'll hear that, I think, as we talk more about our work.

MAGDA PECK: Scott, if I could bring it, I'll take that back, that one.

If I could go to our last organization, which is NICHQ, which is The National Institute for Children's Health Quality. We have folks here to be able to tell us what that is and what that means. And maybe as a way sure you are self-introduced.

SCOTT BERNS: Okay. I'll go and then you'll go, right?

All right. Hi, everybody. Scott Burns. I'm CEO at The National Institute for Children's Health Quality or NICHQ. We're a 501(C)(3) nonprofit that's based in Boston, Massachusetts. And I do want to acknowledge that is the land of the Massachusett, Nantucket, and Naumkeag -- hope I pronounce that correctly -- peoples who stewarded that land for generations and generations.

And NICHQ, what we do is -- our mission is to improve children's health. Our vision is that every child achieves his, her, their optimal health. And we boldly lead improvements in children's health by addressing inequities and other complex issues facing families. That's my elevator

speech.

LaToshia?

LATOSHIA ROUSE: So I'm LaToshia Rouse. I'm a birth doula. Mother of 9-year-old, 26-weekers. They -- the triplets are nine. I can't believe it. And a 12-year-old. And I am a board member on the board at NICHQ, and I am excited about the work that we're going to get to do.

MAGDA PECK: Well, the opportunity we have today -- and -- and -- and we want to first of all acknowledge that time has been expansive today. And sometimes when you have something that's quite extraordinary, it takes the time that it takes to tell the stories that must be told. So we're going to use our time in having the organizations tell their stories. In response to a couple of questions that I shared with them to be reflective about background, about these organizations are in your briefing book. Ways to follow up about the long list of many accomplishments that they have can be done at another time.

This is a conversation, and in the

first conversation I want to ask -- and I'm going to start with CityMatCH, and I'm going to start with you if I could, Stephanie. What have we learned? And what are the strengths that you've seen over to the years you've been with CityMatCH that lend itself to this moment of an explicit and intentional focus on American Indian and Alaskan Native policy change and broader indigenous health and equity?

So what -- what have we learned from an organizational lens of CityMatCH? And -- and what are the strengths that you wanted to make sure that folks can count on?

STEPHANIE GRAVES: Thank you, Magda. I think what I -- what I -- I've learned over the years -- Magda and Ed both being founders of CityMatCH and how -- how many years it's been around -- I've been around doing this work close for -- close to Noya as well, about 30 years. Long time, Belinda, I know.

And what -- what I've seen through the years is the shift and the change of what is important, that it's not just one group of

people that matters in this country, that it's all of us that matter. And I think I've seen that, and I've watched it because I have been going to CityMatCH for a long time and now actually a board member.

But I've seen the faces change. I've seen the dynamics change of who sits at the table. And this is part of what you heard earlier. Who sits at the table and who's impacted by the health disparities that we talk about matters. So I've seen more BIPOC community or black and brown folks sitting at the table. I've seen CityMatCH shift and incorporate American Indian people into the program.

When I first went, we weren't -- we weren't even there. There was maybe a couple of us that -- that showed up at the big conference in this whole group of hundreds of people. And we know that across -- you know, across the country how many tribes there are. So that -- that to me was devastating to find out, where -- where's all the people?

And so I've seen CityMatCH take an

interest and do what they say. They listen. They listen to what we're saying, and then they take it and do action. And that is something that's different. And that's even with the antiracism work that we've done. We had to look at ourselves internally first because we can't go out and change the world if we don't change internally first. And so that's something else that CityMatCH has done, and I have been proud to be part of that -- that transition.

DENISE PECHA: It's hard to top that. Thank you, Stephanie.

I would just say that -- that that's true. We have funding from HRSA, MCHB, and CDC, DRH. I'm looking at Charlan because back in the day, she was our project officer. And we started doing work with the tribal epicenters, which we talked about earlier, as part of our conference. And the very first year we were like, yay, for us, right? We've got the tribal epicenters here, and we've -- we've -- we've got some stuff. And the feedback was, like, not enough. We don't see ourselves beyond this

conference. So we took that very seriously.

We have -- our conference next week, we have a session on data sovereignty on the main stage. Abigail Echo-Hawk was our keynote last year. We incorporated main stage and workshops throughout. We're working with the tribal epicenters throughout the year. So we're just really looking at the opportunities that we can build on that and be intentional.

MAGDA PECK: Terrance, can you?

DENISE PECHA: Terrance, you're next.

TERRENCE MOORE: Thanks so much. I want to acknowledge Belinda Pettiford, AMCHP's president and committee member that's in the room. We've had lots of conversations about the importance of health equity. And one of the sort of main lessons that we continue to discuss internally as team members and also with members is really the importance -- and this came up in the last session -- around Rhonda Swaney mentioning -- the -- the sort of the 200 times that the treaty had been breached and how often we don't acknowledge the harms

that have occurred.

And so we believe Step 1 is, as part of our phased approach to -- or journey to racial equity is we believe the important process is reconciliation, to improve ourselves -- as was just mentioned, the examination of self, the admission of ignorance or error, acknowledging past actions that have not destined -- that we are not destined to repeat, and in that spirit, acknowledging that some of what we have done, we are deeply regretful for.

And some examples are: You know, as an organization, recognizing that we have, at times, used language that characterizes racial groups as, you know, "at risk," or, "vulnerable," as if the race of a person is a predetermined factor as opposed to racism itself.

We've contributed to the invisibility of indigenous populations of women, their children, youth, their tribes, their birth caregivers, and their histories by existing as an organization for decades having few long-standing historical relationships that

we know are so critical and important in this effort.

We've talked about -- with our members and also internally about our membership structure, our events, our annual conference, how they're not always easily accessible for community-based organizations, and they have not always appropriately prioritized the engagement of their wisdom, which we know is profound and potent in the work that we do.

And so we're willing to share our truths, and we believe that that's Step 1 to provide clarity about our failures, to illuminate how we intend to approve -- improve and challenge ourselves and those around us to do the same.

MAGDA PECK: Thank you so much, Terrance.

Deborah, given you're right across the way from him on this lovely screen, tell us about your lessons learned and -- and -- and how we can appreciate the work Health -- of Healthy Start.

DEBORAH FRAZIER: Thank -- thank you,

Magda.

And so Terrance and I couldn't be better partners. We're sharing the screen and a board member.

So -- so Belinda Pettiford is -- is a founding board member of National Healthy Start Association. And so for those in the room who don't know this, Healthy Start is a -- the -- the membership organization of the Healthy Start grantees. And Healthy Start grantees can be city, county, state health departments, community health centers, 501(c)(3)s, universities, hospital systems. So it's -- it's - it -- it's a mix of organizational grantees. And so we represent those grantees that are funded who respond to the notice of funding opportunities. So I want to lay that landscape there for you. So what's who we represent.

So in -- in that context, what we've learned, we were funded as a demonstration project in 1991 with 15 grantees. And -- and I want to invite Belinda, with your permission, Magda, as a backup in this

conversation because we were funded with 15 demonstration projects, and of those 15, one was the -- the Great Plains Tribal Nation. And -- and so we -- we went along with those 15 tribal nations. So bear with me on what we've learned.

When we began to expand this program about 1999 or so, I -- I think -- because it was under Belinda Pettiford as a founding board member and -- and the board president at that time working with the division -- the division director who had actually spent time in service as -- as the -- you know, nursing leadership position on tribal nations, we expanded the Healthy Start Program and carved out -- Healthy Start Program was going to expand addressing disparities and equity.

And so at the end of that funding period, we had maybe 104, 105 Healthy Start, something like that, and we had an indigenous population in Alaska, 1 in Hawaii. We had three -- three or four tribal nations, and then we were serving tribal population in North Carolina under

Belinda's Healthy Start in -- in North Carolina.

The next funding opportunity written differently. I think it was Healthy Start 3.0. We lost Alaska. We lost Hawaii. But the next -- and I think one of our tribal nations. The next funding opportunity, we lost another. Right now, we are representing two tribal nations. We, as an association, represent those tribal nations. Anything I say is a direct comment from those tribal nations.

When we had all of those indigenous and tribal nations, they compiled a report that Belinda has. And we -- we asked -- and that -- that report was developed, again, with Mary Beth Medura at that time with Belinda, under her leadership.

And we've asked some of our tribal advisors to help us to update that report from that time, and they -- they said two things: One, we cannot speak for indigenous populations that are no longer with us, but looking at it now, there is really no update because very few recommendations have been

implemented. They gave us a series of other recommendations, many of which you already have. And all of that is to say what we've learned is that much of what we were asked to do some time ago has -- have not been heeded. But we represent in the Healthy Start Program, community-driven, community-based programs. But we represent those tribal nations that meet the eligibility criteria.

And -- and so what we've learned is that those eligibility criteria are not being written for tribal nations to qualify. And so what they ask me to deliver today is that message that they'd like to be in the Healthy Start family. Because when they're funded -- and I think we heard that from one of the -- I -- I think the presentation you had immediately following lunch, we heard from a representative who said, we were formally a Healthy Start grantee. That's one of the grantees we've lost. We formally had the Great Lakes. We form- -- had several Healthy Start grantees from tribal nations.

And what they also say is that this is a very hard project to manage. We have a list of recommendations, and we can give those to you. But that's -- that's what we've learned.

MAGDA PECK: Right.

DEBORAH FRAZIER: That it's -- it's hard for them to qualify because of the way -- the geography of the reservations, the way they're counted in census of the CDC, and the way that they -- the tribal leaders know best what works for them, and -- and they make good decisions. But they're not -- what works for researchers, what works for the general population does not work for tribal nations. Once you write a Notice of Funding Opportunity for the general population that says you much -- you must reach this infant mortality rate, or you must reach this number of women, that doesn't work for tribal nations, and it automatically eliminates them.

So there are a number of things I think we can do. Because, as they say, when we received money from Healthy Start, we move

the needle on the addressing infant and maternal mortality and morbidity. We can implement our spirit curriculum for moms and daddies, and we can improve breastfeeding rates and other rates and look at other programs that have made strides in how they can carve out, Head Start, maybe, in other programs that provide the support to tribal nations.

So that's a long answer. But that answer is -- it doesn't come from me because I've been a lot of things in my career, I've trained native Amer- -- I'm sorry, Alaskan Native providers in how to do FEMA many, many years ago. But I've never worked a tribal nation. So I only speak for those tribal nations that we serve and represent.

And -- and I would ask Belinda to add what happened to the tribal nation that she served in terms of lessons learned in North Carolina.

MAGDA PECK: Belinda?

BELINDA PETTIFORD: Thank you, Deborah. You know, I think Deborah-- I think you've already shared the basic information,

Deborah, and I'll share the report with the full committee.

We did work with the tribal sites -- the Healthy Start sites that were tribal sites and worked with Bureau and came up with a report. The recommendations are so in line with the recommendations coming from SACIMM.

I did spend time last night trying to look -- do a comparison and see where things were missing, and the conversation is the same. I mean, we were -- the -- the recommendations were made in 2005, the report that we worked with through the National Healthy Start Association, and we're still not seeing the movement because the recommendations are the same.

In North Carolina, we actually ended up -- we have two sites in North Carolina -- two federally-funded Healthy Start sites in North Carolina; one that serves primarily native American/American Indian families. And they have continued to receive funding. Some of the challenges that they've shared with me has been around -- you know, with

the Healthy Start Program -- is around the screening tool and all of the data that has to be collected. It seems -- you know, a bit much to ask families to respond to all of the questions on the screening tool. And so those are, you know, some of the challenges that they see. And we see those same things that came out in the report that came out in 2005. You know, if there are areas of improvement, what could you improve? And I will say that was one of those areas.

But it -- you know, in that same report, it talked about the importance of program implementation, having -- working on the systems, making sure that the screening tools could, you know, be changed, the level client, level data was a bit much and that, really, it needs to be a family approach. It has to be a holistic approach. It does not happen in isolation.

Our second program in North Carolina, we actually have a second site that once our -- out of my office, we actually, at one point, had three federally-funded sites.

The last NOFO that came out allowed us to only apply for one. So at that time, we did work with the American Indian tribe, the -- Haliwa-Saponi Indian tribe in our area, but we couldn't get the numbers in the -- we could not get the numbers lined up for them to actually apply for the program on their own. So we work with them in some level. More recently, they are a partner with us on our doula grant and will be helping us with that implementation, but Deborah is correct. I mean, the way the data -- and I understand the data. I've been in this field for 30-plus years. I understand the data -- but there's got to be a way the data can be released and the -- and the way that you qualify to apply does not eliminate a whole population of individuals, and we see that in our state.

MAGDA PECK: Thank you for those insights, Belinda.

Let us round out that with best experiences and lessons learned, from NICHQ.

Want to start us off, LaToshia.

LATOSHIA ROUSE: The internal work of

an organization is the first step in how important it is to make sure that it's not just staff. It's also the board. And everyone is learning this information together.

So I appreciate being here as a board member and -- and not just a lead. I think that's important because what happens is, a board member comes to something like this, and they start to recognize if I close my eyes, as a black woman, there are several things that I heard that I could have been at a black maternal mortality meeting. It's the same stories. It's the same recommendations. We're trying to get the same things done. There are differences, and those are significant. But when you close your eyes and you hear that, you realize that not much is changing.

And so the impatience of having someone like me on the board means that you start to think about the experience of the person and not just the data and the big, tall orders. What things can we do that will change the experience of people on the ground locally

and not just live in the cloud of it all?

And so my lesson is to make sure that I keep pushing those kind of discussions in board meetings and anywhere that I sit.

SCOTT BERNS: So I need to give a shout out to the representation here from NICHQ. I should add that Charlene Collier is on the NICHQ board as well, a member of ACIMM, and we have Ken Harris here, who is our engagement lead and executive project director who's leading our support and HRSA funded supporting Healthy Start Performance Project. We provide technical assistance and capacity building assistance to the 101 Healthy Start sites -- funded sites around the country.

I think in terms of lessons learned and what NICHQ does, I'll just first say that, well, we're completely grant funded, by the way. I didn't say that earlier. We've about 12 current projects right now. Most of our funding is public funding, some private foundation funding.

In listening here and hearing in the last two days, we clearly need to do more.

There's no doubt about it. That's my takeaway. We've got -- we've done some work. And I -- I'm proud of our work. We've done work in Oklahoma, in Chickasaw Nation Medical Center, around safe sleep and breastfeeding. We've done work in Alaska at the Matanuska-Susitna Borough, or Mat-Su, on our early childhood efforts. We also did some work with some tribal communities in Oklahoma in our early childhood efforts and, of course, in -- in our -- in our Healthy Start efforts.

And then just to circle back to LaToshia's point is that we need to be really, very purposefully talking about the antiracism commitment of the organizations that are here together today. We maintain communication monthly. We do hold each other accountable. We share our lessons learned. You know, we try to fail fast, as we say in quality improvement, and -- and try to share those lessons learned.

And internally, I would add that we've been very purposeful about diversifying our staff, about diversifying our consultants,

about analyzing our vendors but -- and our consultants. It's -- there's clearly more work to be done.

MAGDA PECK: So we have these organizations that are essential partners to elevating the work. So our last round as we are here together -- and this conversation will continue. It's not about this moment alone, but it's about pivoting from this moment.

So the question to you is, you -- you've had a chance to listen in over the last two days. Many of you have been to the -- many of SACIMM/SACUMM/ACIMM meetings over the last 30 years, and in particular, the last couple of years that we've had the opportunity to serve.

Now that we have this very strategic focus on indigenous women, children, families, and fathers, the first time and the first time here as your guest, what do you see is strategy or advice that you have as we shape these recommendations so that they will move from word to deed that they become more than a list of 10, 20, 30, 40?

How to we make them actionable? How do we make them strategic? And how will you leverage them in the work while we're waiting for the secretary, as he has said, to listen and act?

So recommendations to us as this committee for being able to seize this moment, make these strong, and how you can use them for change? And I open that in no order. As the spirit moves you, I give you back the mic.

LATOSHIA ROUSE: So I would say a lot of times when I see recommendations like this, there's no way of knowing how those will be implemented. So asking people and -- and taking suggestions that they already gave as to how these could be implemented I think is always helpful because it could be interpreted a whole other way than what the feeling was in the room just by saying, "doula program" or "community-based doula program." Those mean different things to different people.

So making sure that some details follow those amends and we are clear about how

those -- how those play out and how organizations like ours can help support that work.

SCOTT BERNS: Thanks, LaToshia. I'll just add to that a couple things.

And really it all comes down to community, you know, in -- in every sense of the word. And that's who we are here today together. But what I mean community in the sense of action, it's connecting with communities. In every, you know, interaction I have, listening session, whatever, it all comes down to meeting the needs of the community and truly listening and engaging the communities you're trying to serve, you know, the American Indian/Alaskan Native communities. In this context, we have to engage the community.

I think for me, for NICHQ, this has been an eye-opening two days for me, and I am -- I am -- I'm ready to go back. I've already been communicating with my communications lead about what we could potentially do in terms of raising awareness on our part. I mean, I think that's

something that's important and working with our partners to do that as well.

And we also talk about -- in quality improvement, we talk about the will to change, and I think that that's something that while we're waiting for the recommendations to hopefully come to fruition or whenever that will be, I think -- you know, I would like to say that, at least from a NICHQ standpoint and I imagine our colleagues that are here, that we will have the collective will to -- to think through and to take action.

And, for example, I mentioned private foundation funding, we have a planning grant we're actually finishing up from the Kellogg Foundation around something called an Equity Systems Continuum that Dr. Stacy Scott, who's our equity lead, had been working on at the Global Infant Safe Sleep Center, and then brought -- we've been involving it at NICHQ. And we're creating something called an Equity Systems Auditing Tool, and what that's going to enable an organization, wherever they may be, including in tribal

communities or a local hospital or an MCH organization, to see where you are on an Equity Systems Continuum. Are you a savior design system where you're coming in as a savior? Are you an allied design system where you think you're sharing power, but you're just having, let's say, a family member on a committee to check a box, or a member of the community? Or are you an equity empowered system where you are actually giving up some power, you're -- you're actually, truly having a partnership and truly listening?

So we're excited. We're actually starting to pilot this. We're validating this. And I think that could be something that we bring in a very powerful way to this conversation. Thanks.

DEBORAH FRAZIER: So, Magda, this is Deborah. And since I can't see the room, I hope I'm not speaking over someone else.

I just spent the morning listening to the feedback from our NCCI contractors who've been doing focus groups around the country with birthing mothers and fathers.

And the stories left me in tears, and then I listened to part of this today. And so -- and I'm beyond a sense of urgency about this.

This is actually com- -- and let me first also commend Ed and this committee for taking this on with a sense of urgency because we are honestly beyond urgency. This -- this -- this is a moral issue. It is so unacceptable.

And -- and I -- I've -- I've said to my staff and all of the folks who work with us, I want you to look at every piece of data, every number, and I want you to see your momma, your sister, your auntie, because that's exactly -- you are who we serve. And we have to stop telling people -- we have to stop expecting the people we serve to be resilient, and we -- we, the structures and the funding, have to become resilient to serve -- to serve the populations we are in charge to serve.

DENISE PECHA: Thanks. I -- it is about -- when I think about everything everybody has said, but it's -- we talk a

lot about doing our own work, right? And I've been on this journey, if you're doing antiracist work you're doing your own work. And I've continued to learn a lot, you know, I know a lot, and I learned a lot more. And I've already -- like, I was texting our leadership team and talking to Stephanie, our board chair, about additional training that we can do with our board because our board represents health departments around the country. And we're talking about urban Indians, right, and where our urbans live in the cities and the counties that our members serve. So how can we really help accelerate the work and thinking?

But I have the same sense of, like, these -- these conversations aren't new. A lot of the stuff, you could close your eyes and say "but." The simple answer is, let's just honor the treaties, right? Let's do what's in the law, and let's do what we're supposed to do. But -- so I also say run for office, look at who you vote for -- I mean, those are all, like, we need to -- at the system level.

And there's just other things I wanted to highlight that people have said over the last two days, but I can send those in an email, just things I think were said once, and I checked them off my list, and I go, okay, that was said. But I think that's it.

STEPHANIE GRAVES: Well, I think that one of the things -- my recommendation would be to -- you have an opportunity to do something as a committee, right? This committee has been around for what, 30 years or something, and what changes have been made? We know not very many, especially for our people. And so change your narrative. We're always asked to look at our narrative and do something different. Why don't you all change your narrative and do some actionable items? You know, you heard a lot of information, you got a lot information, what is it you can do to propel some actual change for the lives -- you know, this is an -- as someone said earlier -- and might have been Deb -- this is an emergent situation. You know, we're constantly in a state of emergency. American Indian people,

we live this way every single day, and as Lisa said, we don't want to be a unicorn. We just don't want to be, you know, some mythical creature that comes around once in a while that you have to think about. What is you can do?

So undo some of the biases that you have and say what is it we can do different to move and make that dial better for our people.

MAGDA PECK: Thank you.

Terrance, AMCHP, what are you going to do? What are your advice to us?

TERRANCE MOORE: First, I -- I think the laser focus today is an amazing sort of first step. And at AMCHP, we firmly believe that there is no solution to the crisis that we are talking about, particularly the racial inequities in maternal mortality that indigenous women do not already have. As published and practiced indigenous women scholars who have spoken, health care workers who have spoken, and many of the individuals around the table.

And so as it relates to AMCHP, AMCHP's

role as a membership organization can be to continue to support our members and listening to these solutions, actualizing these solutions.

And then I point to the flexibility of the Title V maternal and child health block grant and that hope to uplift and invest in those solutions, the solutions that I mentioned of indigenous and other women of color who are implementing them.

And so we can support our members in striving to remove these fundamental health barriers, such as losing health care coverage 60 days postpartum, and losing access to abortion care.

MAGDA PECK: I want to thank you.

And before so, a final comment, absolutely. There's always room for one more.

DEBORAH FRAZIER: Thanks. So one more thing. We talk about "something." Ideas on what something could be that we could do as organizations would be to offer our platforms that we have because, as we know, we don't have the diversity that we need in

the medical staff in -- in any community. So being able to offer the platforms where we know that we have access to those clinicians and being able to help train them on just what is smudging? We heard that here. Did anyone look it up? Look it up.

Right. So what is smudging? How can we accommodate that? You know, what is a cradle board? How is it used? Getting information so that we don't have CPS called for something that they don't understand. Those are some things that we can actually say that we can do. We can bring those stories to the forefront. It's out there, but if you're not looking for it, you don't know.

So being able to use the platforms that these organizations have to put it on the forefront and so that we can make the connections between all the people of color having the similar experience and not look at them in isolation as anomalies that just happened.

MAGDA PECK: We heard this morning, started the day with our tribal organization

leaders, the tribal health board, the urban Indian Health Centers, those that are on the front lines from a tribal perspective. This afternoon we begin to close up with the organizations that are on the front line from a MCH perspective.

From this day forward, may they not be in separate places, but partnered, integrated where we wake, where we work, and where we do the work. And may this conversation not be a one-off. Shame on us. May it be the beginning of a fresh conversation with collective action that build on the racial equity and antiracism work you've already begun.

Please join me in thanking my colleagues and family members for coming to this time.

Concede my time to Dr. Ehlinger

ED EHLINGER: My -- my -- my thanks to Magda. The fact that you here today, that took you the time. I know all of your schedules are busy. That makes a statement, your being here. And I think, as Magda said, it's just the beginning, that you as

organizations can amplify whatever recommendations come out of this committee. And moving forward, you can be a resource to this committee moving forward on other issues.

So all of the SACIMM members, these are the people that should hold you accountable for what you're doing, and they should be resources for you to get information and -- and ideas. So it is a partnership. SACIMM has a particular role. It has the ear of the Health and Human Services Secretary. That's what our job is to make recommendations to him or her or they. But we get information, and it can be leveraged in other ways. So this partnership needs to move forward in -- in a really robust way.

And moving forward, we're going to take five-minute break, and then we're going to come back. So move quickly, and then we will have Dr. Warne, and then we will get some public comment, and then we will have Dr. Tina Pattara-Lau.

(A recess was had from 3:36 p.m. until 3:45 p.m.)

ED EHLINGER: All right. Let's start to settle in. All right. Dr. Peck -- some people just like to chat. They love to visit. And -- and -- and I -- I never want to be a meeting planner, but I had to be a meeting planner. And you need to build just a lot more, just interaction time, communication time, non-scheduled time, and I'll learn. But that's going to be in my next life when I'm a meeting planner, which I think that will be hell. So I hope I don't have that.

But I've asked Dr. Don Warne to -- to take on a very important task, and I'm not sure if it's mission impossible, but I -- when I asked him to speak, I said, you've got a lot of experience and you're looked up as --as a leader in American Indian and Alaskan Native health and had been a -- you know offered a lot of wisdom over the years on how to approach this. I wanted him to kind of end up our formal presentations sort of reflecting on what we've learned, what we've heard. We started by putting it in context with that first panel. That was the

context.

Now I want to kind of think about what did we learn and what's the new context moving forward? How do we take this sort of to the next step? How do put this into the bigger picture of -- of where we're -- we're moving and what our opportunities might be.

Dr. Warne, I think, is going to be the -- the perfect person to do that. Particularly, I'm really excited about his new position at the Center for Indigenous Health at the -- in health -- at indigenous health policy at Johns Hopkins University. It'll take me a long time to figure out all of those things. There's got to be an acronym somewhere. But good luck on that job. But welcome to -- to SACIMM. Really appreciate you being here.

DONALD WARNE: (Speaking indigenous language.)

Hello. Thank you, and welcome to all my relations here today. I'm very honored to be a part of these important discussions. And I know we've had a lot of material that we've gone over over the last couple of days

and a lot of things that are very emotionally and spiritually heavy and mentally taxing just to think of some of the -- the suffering and the challenges that are going on right now. So I really applaud all of you for doing work in this space.

Again, my name is Dr. Donald Warne. I'm Oglala Lakota. Originally from a small town called Kyle, South Dakota on the Pine Ridge Indian Reservation. And I always like to ask, whose's been to Kyle, South Dakota?

Wow. That's four -- that's four more than usual. That's actually really impressive. Very small community on the Pine Ridge Reservation.

And I've worked in a number of different areas in medicine and public health the over years. I'm a family physician, also have training in public health, particularly in health policy. And I've served on a number federal advisory committees and other national boards. I was a member of the national board of trustees for March of Dimes for a number of years working in this space as well as serving on

the national advisory committee on Rural Health and Human Services through HRSA. And then on several CDC committees as well.

So I know this work is challenging and difficult and -- and really trying to make a difference at the policy level. So I've been on faculty at University of North Dakota for a number of years, and just as of last -- let's see what -- what is today? 13 days ago, I took a new position at Johns Hopkins. I'm now the co-director of the Center for Indigenous Health and also the Provost Fellow in Indigenous Health Policy. And they're expanding their work to include international indigenous health.

Next slide, please. So what I'll cover -- and it'll be an interesting task because there's been so much important information already covered, but I wanted to share additional thoughts just even on our definitions, and what -- how we describe ourselves and Stacy Bohlen, I think, did a very good job in kind of delineating the different types of terminology, but I have a diagram that helps to explain it a little

bit more clearly.

And we'll look at historical con- -- context as well as positionality, you know, where are we in physical space, but also where are we historically. And, then, just we'll look at some very brief discussions on the disparities, data issues, and then the recommendations report.

Next slide, please. So when we're defining ourselves, we know the term is American Indian and Alaskan Native. And that's actually the legal term of -- set forth by the federal government. It's actually Office of Management and Budget that determines the race and ethnicities. I've never understood why it's OMB that determines the races and ethnicities in the US. But there's the -- the five races. So American Indian, Alaskan Native, White or Caucasian, Black or African American, Asian American, and Pacific Islander, and they're just one ethnicity, right, Hispanic. So you're either Hispanic or Non-Hispanic. So the legal term, at least in the census is American Indian and Alaskan Native. And I

really appreciate the discussion on Alaska and the map because not all Alaskan Natives are American Indian.

So the Inuit populations, for example, are more of a circumpolar population. So there's Inuit people in Siberia, Alaska, Canada, and Greenland. So if you call them American Indians, they get very angry with you, right? Okay. Yes.

But there are some people in Alaska, the Athabaskan groups, who are also connected to American Indian populations. Athabaskans are all across North America. Same with the Navajo and Apache tribal groups are Athabaskan culturally. So that's why it's American Indian and Alaskan Native. So 9.7 million of us self-identified in the U.S. Census.

Next slide, please. So there's also within that enrolled tribal members. And to be eligible for Indian Health Service, you have to be enrolled in your tribe. So anybody in the census can claim American Indian or Alaskan Native heritage. There's no checks and balances. But to be eligible

for services like IHS, you have to be enrolled in your tribe or a descendant and closely connected to your community.

So next slide, please. So we've talked a lot about Indian Health Service. What's important to remember is that the IHS user population, so an active charge in the IHS is about 2.6 million people. So 2.6 million out of 9.7 million. So it's important to remember that the IHS database does not include all American Indians and Alaskan Natives. There are people like me who have health insurance and live in a city in which there are no IHS facilities. So I am not in the IHS database. I am an enrolled tribal member, and I'm American Indian on the census, but I'm not in the IHS database. So it's something important to keep in mind. We tend to look at IHS data as being representative of all American Indians, and it is not. It's actually the -- a minority of American Indians in the Indian Health Service database.

Next slide, please.

So we also look at the term native

American, and we use it interchangeably with American Indian. And I think it's even in the -- the recommendations. We might want to be really consistent and intentional about what terminology we're using. Native American is also legally defined. In 1978, there was the native American Programs Act and it defines Native Americans as American Indian and Alaskan Native but also native Hawaiians and indigenous people of the Pacific Islands, like Guam and America Samoa. So if you're saying, "native American" and you're not including them, you're actually using the wrong term. So if we're talking about American Indian and Alaskan Native, we need to be very specific about that.

Next slide, please. So one of the other terms that's much more commonly used now is "indigenous." And the indigenous peoples are the first inhabitants of various parts of the globe. So we kind of use some of those terms interchangeably, but if we're talking about American Indian and Alaskan Native or tribal groups, we have to be very

specific about that terminology that we're using. So we might want to be cognizant of that. Stacy Bohlen from NIHB mentioned that earlier today as well.

Next slide. So where we are now is in the land of the Dakota people. And I'm Lakota or my tribal group is a little bit further west. So historically, we called ourselves the Oyate, and it's Lakota, Dakota, and Nakota. And the reason it -- it became the Dakota territory is that the Dakotas were further east and colonization came from the east. So that's why it became North Dakota and South Dakota. I always like to point out if colonization had come from the west, it would have been the Lakota territory and would be and North Lakota and South Lakota and I would've worked at UNL instead of UND, right, but it was from this direction.

So the Dakotas are in what is now western Minnesota, Lakotas further west, and Nakota also were renamed Assiniboine if you've heard of that tribal group, and they're further north. So you can see where

we are in Minneapolis.

Next slide, please. So if we look at this region and where I have been working in Grand Forks, North Dakota where University of North Dakota is located, and that's actually a sacred gathering point for Dakota and Lakota peoples. The reason it was called Grand Forks is that it was a confluence of the Red Lake River heading west and the Red River heading north. And people would gather there throughout the summer months. And, again, the reason it was the Dakotas is because the Dakota people were further east. And then, of course, there's Minnesota. And out of curiosity, how many people know what the word "Minnesota" means?

One, two, three, four, wow. That's actually more than usual as well.

Most people have no idea what the word Minnesota means. But it comes from two Dakota words. "Mni" is water, and "Sota" means cloudy or smokey.

Next slide, please. So this time of year when the weather starts to change and

it appears that the clouds are rising off of the water, that's a Mnisota. So the Dakota called this region the Mnisota Makoce, the land where the clouds rise off of the water. Isn't that beautiful? This is the land where the clouds rise off of the water. And now we just call it Minnesota, right? Don't know what it means.

So you probably flew into Minneapolis. Every time you say the word "Minneapolis," pat yourself on the back. You're being bilingual. You're actually saying "water city" in Dakota Greek, right? Again, "mni" is "water" in Dakota, "polis" is "city" in Greek. This is "water city." People don't realize that that's part of where we are.

Next slide, please. So and, again, we talked about the tribal communities in the very beginning when we had our opening blessing from our cultural leader and knowledge bearer. He talked about the fact that there was a Dakota war in the 1860's, and most of the Dakota people were pushed west of the Red River into what is now North Dakota and South Dakota. So along what is

now eastern Dakotas, the Spirit Lake Nation, Sisseton Wahpeton Oyate, Flandreau Santee Crow Creek tribes are Dakota communities. And the ones further west are still the Lakota communities.

And in what is now Minnesota, there's only four Dakota communities, and we're at one of them right now, Shakopee Mdewakanton Sioux Community.

Next slide, please. So I think it's important just to know where we are in some of the history, but I know most of you are from other parts of the country. And it's also important to understand the history and why we actually have things like historical trauma and intergenerational challenges and intergenerational poverty and marginalization and distrust. There's -- all these factors have an impact on maternal and child health and wellness.

So next slide. So we know that the 13 colonies were not good for the indigenous peoples of what is now the northeast.

So and next slide, please. Thank you. So the 13 colonies were devastating to the

northeastern tribes. I know many of you are from the northeast, and, you know, there's very few American Indian people left in that part of the country.

And I'm sure many of you have heard of Amherst, Massachusetts, right? Named after Lord Jeffery Amherst. And Jeffery Amherst is very famous in Indian country because he is the colonial governor who ordered the distribution of blankets from a smallpox hospital to the regional tribes with the purpose of killing them.

So next slide, please. So this is well-documented that the intention was to spread smallpox intentionally to the north eastern tribes with the purpose of killing them. And you can actually Google this, Amherst smallpox.

Next slide, please. And you can actually find the letter written from Amherst, this is in his hand. I know it's in cursive and hard to read, but this is what he said: "You will do well to try to inoculate the Indians by means of blankets as well as to try every other method that

can serve to extirpate or get rid of this exorable or horrible race." "Extirpate this exorable race. I should be very glad your scheme for hunting them down by dogs could take effect.

This is part of our history. It's not pleasant to think about. It's not pleasant to talk about, but it is the truth. And if we're ever going to get to equity, we have to walk through truth even when it's unpleasant. Even when it makes us uncomfortable. This is a part of our US history.

And what do we do now? We honor him, right, with Amherst College, UMASS Amherst. We have a city named after him. We have statues of him. He was our first documented bioterrorist and killed many, many thousands of indigenous peoples in what is now the northeast of the United States. It's a true part of our history even though it's not taught, effectively, in our history books.

Next slide, please. So that explains why there's relatively few American Indians in the northeast. But in the southeast,

there was a law passed in 1830 called the Indian Removal Act. And Indian Removal Act removed tribes from their homelands in the southeast to what is now Oklahoma.

So next slide, please. And this map shows the -- the pattern of tribal migration -- forced migrations from their homelands into what is now Oklahoma. So as a result, some of the tribal members refused to leave. They stayed in their homelands. And some did get removed to Oklahoma. So that's why we have this interesting dynamic where we have Seminoles in Florida and Seminoles in Oklahoma; Cherokees in North Carolina, Cherokees in Oklahoma; Choctaws in Mississippi, Choctaws in Oklahoma. So you get the idea.

Of the 38 federally-recognized tribes in Oklahoma, only 4 are actually from Oklahoma. The rest were removed from other parts of the country. So that -- that's why we have that interesting dynamic now and why we have tribal nations in the State of Oklahoma. This was also called the "Trail of Tears." I'm sure you've heard that

terminology as well.

Next slide, please. So the discovery of gold was devastating to the California tribes. And there was a time when there was a bounty. It was actually legal to kill American Indians to make way for the gold rush. It was actually legal. There was a bounty. You can -- there's many articles written on this. It's just not in our history books, unfortunately, so...

Next slide, please.

What we're left with, this is from the 2020 census, you can see the states that have the highest concentrations of indigenous people. So Alaska has the highest concentration of its Alaskan Natives. And then you can see other states, like Oklahoma, New Mexico, South Dakota, Montana have at least six percent American Indian. Other states like Washington, Oregon, Arizona, Colorado, and -- I'm sorry, Wyoming, and North Dakota have at least four percent. So our numbers actually grew significantly from 2010 to 2020. And it's -- I don't think it was actually true.

Growth in the population, it was better response to the census is really what happened. There was a lot of outreach that was conducted, even in the midst of the pandemic.

So you can think about where you're from, and you might be from a state that has relatively few American Indians, but there's a reason for that. There's policy-based reasons put forth by the federal government that removed people or killed them. That's why we have such a small population now.

So next slide, please. So I've done a lot of work in this space really trying to understand the impact of historical trauma and how that directly links to current day health disparity. And we just have to be honest. There was genocide in the United States. That's what created opportunities for this country to grow. And, again, it's not comfortable to think about or talk about. And I talk about these things not to make anyone feel bad, that's not the intention. I talk about these things because it's the truth. We have to

understand the truth if we're going to get to real solutions.

Next slide, please. So there was also the boarding school era, and I'm sure many people are familiar with that. There was actually a report put forth by the Department of Interior just this past May looking at the history of boarding schools in the United States. And this was forced removal -- and I know a couple other speakers have talked about this. But the way that the families were compelled to give up their children is that when the populations were put onto reservations, they lost their food sovereignty, and they lost their food systems. So our populations became dependent on the federal government for food. So the families were told, either give up your children to go to boarding school, or we will withhold your rations. So give up your children or starve. That's the message from the federal government. This is well-documented as well. Again, not documented in our history books because it doesn't paint us in a very good light, but

it's the truth. So that's how our children were compelled to go to boarding school.

Next slide, please. So in the boarding schools, if you visit them now, most of them have a huge graveyard right next to them. And the reason is, we had huge mortality rate of children while they were at boarding school. We don't know why so many children were dying, the basis for all that excess death. We know there were outbreaks of things like influenza and tuberculosis, but it doesn't answer the question as to why so many children were dying at boarding school. And this is a picture of the Carlisle Indian School in Carlisle, Pennsylvania where many of our children perished, unfortunately.

Next slide, please. This other picture is a famous picture. It's a school picture at Carlisle. And I have four children, and I've seen lots of school pictures over the years. And I always see smiling. I see laughter. And I see joy. I don't see any of that here. I see a lot of fear. I see a lot of anger. I see sadness. And -- and we're talking about thousands and thousands

of American Indian and Alaskan Native children sent to boarding school, including my mother. So my mother is a survivor of boarding schools. This is not ancient history.

And I would strongly encourage you to read the report that was put forth by the Department of Interior just in May. And the reason we finally did this is that for the first time in history, there's an American Indian in -- in the cabinet. The secretary of Interior is Deb Haaland who happens to be American Indian. Isn't it remarkable it took until 2021 until there's an indigenous person in the cabinet of the Administration? So that's why we actually had this report.

Next slide, please. One of the purposes of the boarding school system was to get rid of the culture. The motto was "Kill the Indian. Save the man." And this is another famous picture of a Navajo young man upon entering Carlisle and then three years later. And this was shown as a success story, that this was the purpose of the boarding schools is to get rid of

culture.

Next slide, please. So what is the long-term impact? And one of the research projects that I'm a part of is actually looking at epigenetic and potentially intergenerational epigenetic changes to DNA as well as intergenerational measures of inflammation and allostatic load. So we're looking at boarding school survivors and their adult children and looking at patterns of changes in DNA. And we haven't finalized all the research yet, but there's some compelling evidence in populations, including holocaust survivors from Germany and that Jewish holocaust survivors' descendents tend to have worse health status than matched controls who were not direct descendents of the holocaust. So there's some evidence that there's some sort of epigenetic basis for historical trauma. Still has yet to be fully elucidated, but I think this will be the scientific platform to better understand it.

Next slide, please. So once we get through the boarding school era, we also

have to recognize there's a lot of gestational stressors and a lot of unplanned pregnancies. And in my own experience as a family doctor, you know, we've tried so many different methods. And I remember there was a public health nurse on one of the reservations where I worked, and they tried everything they could think of to try to prevent pregnancy in the teenage girls. And, you know, the -- all the educational programs and, you know, free condoms, whatever they could do. And nothing seemed to work until the public health nurse decided to pay the girls $5 a week to not get pregnant. And that was the most successful intervention, believe it or not. It was never evaluated or studied, but even the boyfriends were saying, let's not get pregnant. We could use that $5 every week. You know, when you're impoverished, that's a lot of money. This is back in the 1990's, so just as a FYI, maybe we can be more creative. I think some have even talked about paying people to go to prenatal care, right?

So once we get through that, then we have other types of stressors. And the USDA -sponsored food programs have improved tremendously. There's actually going to be a -- a White House summit on food and nutrition coming up at the end of this month. So if you're interested, they're going to be looking at some of the policies related to food, and that certainly has an impact on maternal and child health as well. So the WIC program -- women, infants, and children, has done a lot of work in recent years to promote breastfeeding. When I was a full-time clinician in the 1990's, the WIC program was basically a baby formula distribution center. And as a result, we wound up seeing more use of baby formula among American Indians and among the White population because it was free baby formula, basically just distributing it.

So think about the word "formula." Does that sound appealing to anybody? You know, come on over. We'll have in glass of formula. It's formulated in a laboratory, and it's not natural, it's not healthy.

Then there's the food distribution program on Indian reservations, or the Commodity Food Program.

So next slide, please. So when we think of traditional American Indian food, a lot of people think of frybread, right? You've heard of Indian frybread. Well, it's actually not traditional American Indian food. It's people doing the best they can with their commodities. The elder on the right there is using commodity shortening and commodity flour to make frybread. So if we want to call this traditional food, it's traditional USDA food. It's not traditional American Indian food. But now it's been acculturated. And I wonder about the nutritional epigenetics. What's happening to our children when they're taking in this type of food at such a high rate?

Next slide. These -- these are some pictures of commodity foods. And I know it's in fine print, but on the right, this is pure corn syrup. So it's a -- an engineered food. It's not natural. It's incredibly unhealthy, from the USDA. And

look what it says right here: "Use in baby formula." "Use in baby formula." What is the -- the nutritional epigenetic impact of generations of this type of policy on our children? And we know that as a population, formula-fed babies grow up to have higher rates of diabetes, heart disease, and obesity than breastfed babies. And then all kinds of food -- I don't know exactly what all of the ingredients were.

I grew with up eating a lot of these foods. That's where government cheese comes from, right, the commodity cheese. I really like commodity cheese. I wish I didn't, but I actually do like it. That's really kind of valuable if you can get a brick of cheese. But the other foods were just really unhealthy. They had grape juice, which I think was just sugar, water, with purple food coloring, basically. But this is what we were feeding people for many, many generations, and now we wonder why we have such high rates of diabetes. It's because of these types of programs.

Next slide, please. So we also know

that we have higher rates of adverse childhood experiences. And I'm sure everyone here is familiar with the ACE studies that have occurred.

Next slide, please. One thing I'm very happy about and proud of my friends at CDC, particularly in the National Center for Injury Prevention, is that the ACE pyramid used to have ACE's at the base, right, that that was the bottom, and then all of the outcomes flowing from adverse childhood experiences. But the new ACE pyramid recognizes that there is generational embodiment and historical trauma that can create the local conditions in the community to put families at higher risk for adverse childhood experiences. So let's not blame the families and the patients. Let's look at the actual basis for these types of risk factors. So, CDC, thank you for actually recognizing this and putting this in -- in print.

Next slide. We know the -- the outcomes for adverse childhood experiences, and I was co-principal investigator on the

South Dakota Health Survey a number of years ago, and we found just terrible disparities and adverse childhood experiences among children, and all of the associated health conditions and risk factors with that.

So next slide, please. So the adversity does not end at age 18, right? We have adverse adulthood experience as well. We have a lot of toxic stress in our communities. Living in poverty is stressful. Living under marginalized conditions is stressful. Dealing directly with racism is stressful. And when I think about the measures of inflammation, the amount of cortisol and epinephrine that's, you know, coursing through our people's bodies at all times is really tremendous and puts us at greater risk for poor health outcomes. And not surprisingly, our average age of death is much worse for American Indians.

They just ran the data in North Dakota for the decade of 2009 to 2019, so the 10 years prior to the pandemic. Average age of death for White population in North Dakota

was 79. Average age of death for the American Indian population was 58. 21 years difference in average age of death. That's statewide. Even worse in some of our reservation communities.

Next slide, please. So what are we doing about this? We -- and what are the -- the factors that we need to address here? And again, I appreciate being a part of these important discussions and won't go into too much detail regarding the disparities. We've already talked about that, but we know we have worse maternal morbidity and mortality, and we have worse infant morbidity and mortality for American Indians. And we did hear just a compelling story about preeclampsia and that direct experience and what can happen, especially in a remote and rural environment.

Next slide, please.

Again, with my work with the March of Dimes, we were tracking the data for infant mortality as well. And in South Dakota, the infant mortality rate for American Indian population was 8.9 per 1,000 live births

compared to state-wide of 6.2, so much worse for American Indians.

Next slide, please. In North Dakota the disparity is even worse. 9.4 compared to 5.5 for the overall population. But we already know these numbers, these are well-known disparities.

Next slide. So I -- I -- I've read through the draft recommendations, and I really appreciate all the work that's already gone into those draft recommendations. And I also really appreciate the fact that you're using the Broken Promises report from the U.S. Commission on Civil Rights. It was published in 2018. That's a really good document to look at underfunding of federal programs for American Indians and Alaskan Natives.

So next slide, please. And I'll just go through some general thoughts and what might be added to it or thought about or just some considerations. So in the introduction and framing, we should also make reference to the strengths, resilience,

and wisdom that exists in our communities and that we have a lot of culturally-based solutions as well. We tend to focus so much on the disparities and the negativity because that's a compelling story, but in truth, we have a lot of answers within our communities and a lot of strengths that should be a part of that.

And there's mention to include indigenous individuals as active participants. I even take it a step further. Indigenous people should actually be key leaders and decision-makers in moving forward with recommendations and implementation of those recommendations.

Next slide, please.

So in -- in the framing in historical context, there's really no mention of the boarding school era. I would refer to this document because it's very compelling. And so many of us, as indigenous people, have family members who went through that experience very directly and has an impact on intergenerational parenting. So I think it's worth mentioning specifically the

boarding school era. The federal government has acknowledged it. We need to include that as part of the background.

Next slide, please. Also, then, include root causes including racism as part of the social determinants and really make recommendations to have a -- a deep dive to uncover and understand those deep roots of structural racism that persist and how those have an impact on our families, on our -- our pregnant women, infants, and children. And there's structural racism across the board. You know, even when we look at our ability to access recourses. And a little later, we'll talk more specifically about things like the Title V Block Grant, but we're really depending on the friendliness and kindliness of the states as to whether or not American Indians get access to those resources. And if you think that all of the states are friendly to Indians, you're not paying attention. All right? We've got to look at this in a very serious way. There's structural racism that's even a part of whether or not those resources get to the

people who need it the most. That needs to be a part of that discussion.

And then commit to ongoing exploration and learning about what allyship and full partnership actually really looks like. We have a lot of wonderful allies and champions and partners, but we really need to, I think, frame in a way that's genuine collaboration and not just looking at capacity building as someone from the outside building our capacity but genuine partnership.

Next slide, please.

So also looking at expanding the programs and caregivers. We had a lot of really good discussion about doulas. We have a lot of good data to support the -- the use of doulas and other paraprofessionals, but we don't have access to all of those services in each of our communities. And there does need to be recommendations even for Medicaid as payers and for certification programs to make sure that we're having more locally-certified midwives and -- and doulas and

culturally-relevant interventions.

Next slide, please. In addition, we have inherently protective teachings within our cultures. And, you know, long before we had formula, everyone was breastfed. But there was even a system because not every woman can easily breastfeed. We know that there are challenges. Some people just have challenges with successful breastfeeding, and we don't want to marginalize them or traumatize them, you know, by delivering the message that we have to -- to breastfeed. What if they can't? What if there's a challenge in doing that?

Historically, we had wet nurses. It was part of our culture, right? We -- we had a communitarian approach to this.

And then we've talked about other things like the -- the cradle boards and back to sleep. You know, there's a lot of things that we have done throughout history that are consistent with what we're calling evidence-based practices. And I think it might even be worth pointing out that modern science is finally catching up to indigenous

knowledge, right? That's the way it should be framed because it's true. All right?

So next slide, please. Telemedicine was talked about, and I think that's a great idea, but it's not for everyone. Some of our populations respond well to telemedicine, so we need to make it available. But for some people, they don't respond well to it. So it's not going to be a one-size-fits-all solution for each population. And I have all these written out that I'll email to you as well, and you can have the slides, obviously.

So next slide, please.

Medicaid expansion, that's been mentioned before. Of course, that's a state-by-state decision. One of the things that National Indian Health Board has looked at is the whole idea of a 51st state being American Indians. Why is it that state legislators are the gatekeepers between federal dollars and American Indians? Think about that. When an American Indian is seen at an IHS or tribal facility, that Medicaid payment is 100 percent federal dollars. The

FMAP, the Federal Medical Assistance Percentages is 100 percent. So we have 100 percent federal dollars. You have American Indian patients. And then you have a state legislature standing in the way saying no, you can't have access to those federal dollars. That's the circumstance that we're deal with right now in places like South Dakota where I am from. That is unacceptable. That needs to be part of advocacy is get the state legislatures out of the way of access of American dollars for American Indians. I really think that should be a part of what we're advocating for.

In addition, for doulas, looking at the accreditation process, if we just -- going with the existing national accreditation processes, for many people it's cost prohibitive. We should have recognition of tribal sovereignty and tribal certification of doulas. I think that was mentioned before. Yeah. Very good. Excellent.

Next slide, please.

And we -- so happy that we heard from

Debra and Healthy Start. So in one of my previous roles, this is now going 15 years or so back, I was the executive director of, at the time, the Aborigine Area Tribal Chairman's Health Board. It's now the Great Plains Tribal Leaders' Health Board, but we did have a Healthy Start program there.

And the challenge, as was mentioned, is that our reporting requirements, our data collection was kind of the one-size-fits-all approach, right? We were working with 4 states, 17 tribes, and trying to do that in a remote way as the -- we can't have the same practices that would occur in Chicago where you have a relatively small geographic area. We're talking about four states. We're talking about huge regions. We're talking about rural and frontier communities. So the-one-size-fits-all approach doesn't work for us, and it's evident in the data, right?

There's two tribal programs now for Healthy Start. Think about that. The primary program for HRSA is funding two tribal programs, and the competitive nature

of the getting those dollars, the communities that need it the most are the under-resourced communities.

Guess what? They don't have a team of grant writers, right? Do we need to convert all of our local people to grant writers in order to access resources? That's just wrong. And I -- I'm really looking forward to reading the recommendations coming from Healthy Start because the way the system is set up now, the populations who need the resources the most do not have access to those resources. That's something that can to be fixed.

For MIECHV, that's -- it's been wonderful. I think we've seen a lot of good evidence with MIECHV. When I was on faculty at North Dakota State University -- this is now 10 years ago -- 8 to 10 years ago, we were doing the evaluation of the MIECHV programs, the tribal MIECHV programs in North Dakota, and some really good outcomes.

And there's the three percent carve-out for tribes. So the states get it on a formula basis, and then the tribes compete

for it, right? That's just the -- the nature of it. Maybe we need to look at how that's funded as well.

Title V, the state block grants. If you have a friendly state, those resources get to American Indians. If you are from a place like South Dakota, it's not a friendly state to American Indians. It is adversarial. And I think there needs to be more language in the requirements that if you have American Indians in your state, you need to demonstrate exactly how you're using those resources to improve infant mortality rates in those populations. It's -- it's, you know, basically up to the states in terms of what degree they report that data. That's not good enough in states like South Dakota. We need to enforce adequate reporting from the states because the way the legislation is written in Title V of the Social Security Act is that it's with the states. It's not with the tribes. So to change that would be an act of Congress, or we could just make the reporting requirements meet the needs of tribal

people.

And we've had a lot of talk about IHS funding, and I think for Indian Health Service, I've seen a real change over the last couple decades. And I think IHS has been beaten up a lot, and we're seeing a change of behavior, too, that they're less engaging now. I think we see that even here. So we have to recognize that IHS is not a failed system. It's a starved system. It's never been adequately resourced. We don't know how good IHS could be if it was actually funded.

So next slide, please.

So there have some mention of data sovereignty, so I won't go into too much detail there. And this has been a wonderful two days of discussions. But another consideration would be to expand the tribal PRAMS programs and having more specific data collection about pregnancy and the data in the tribal communities.

Next slide, please. And then just -- last couple slides talk about some of the programs that I'm affiliated now through

John Hopkins. Family Spirit -- hopefully you're familiar with this, but it's a -- a wonderful program, and it's the only evidence-based Home Visiting program designed for, by, and with American Indian families. It's now used in over 100 tribal communities across 16 states. But it's largely dependent on grant funding, right? If these programs were evidence based, they should be reimbursable, right? That is not -- shouldn't just be dependent on whether or not the grant is going to continue. I strongly recommend looking at a website for Family Spirit.

Next slide, please. Just a few of the components of that. It really -- it's kind of like a MIECHV model, but it leverages local, cultural assets and indigenous way of knowing about health. It encourages the use of paraprofessionals and addresses behavioral health disparities.

And next slide. There's been some very good publications on this as well. So just recently there's been three randomized control trials using this curriculum. And

the most recent study shows that Family Spirit significantly improves parenting efficacy, reduces mother's drug use and depressive symptoms, and improves social, emotional, and behavioral development for children through three years postpartum. This is evidence-based. It's working. It needs to be scaled up and implemented in other communities.

Next slide, please. So I'm sure many of you have seen this slide or similar images looking at the differences between equality and equity. And I just really like this image because on the left it's the one-size-fits-all approach to equality, right? Everyone gets the same curriculum. Everyone gets the same health care. Everyone has to follow the same reporting requirements for a grant. Everyone has to compete for the same type of grant at the same level as though everyone was the same. We need to be smarter than that.

And an equity lens is not looking at the process or the box on which people are standing, but the outcome, right? And we

might need to do unique programming for some populations, and that just means we have to be flexible. And that's -- and that's easier said than done. I recognize that. But that's part -- got to be part of our solution.

And I've shown this image for years, and a few years ago someone sent me a slide that I think is just brilliant.

So next slide. And the question is, what is that fence doing there in the first place? Is it just the package of services to overcome the barrier, or do we need to get rid of systemic barrier? And I would put forth that so many things we've talked about, like poverty, lack of American Indian providers, all of these things are systemic barriers. So it's much bigger than what can be done in one agency, but we have to be a part of that broader solution.

So next slide. And then just in closing, I did 40 minutes instead of 45. And I'm sorry we're running late.

But we learn a lot from the natural world, in my tribal traditions and lessons.

And one of the things that we observe in this part of the country is the -- the bison herds. And the strongest bison, when there's a storm, stand and protect the ones behind them, the ones who are more vulnerable, the elder, the weak, the children. And the strongest bisons stand and face the storm directly. It's a beautiful image when they're doing this.

And I would put forth that each of us has the opportunity to behave in that manner and to be that strong force facing the challenges directly because there's so many vulnerable people behind us who are depending on us doing exactly that.

Next slide, please. And I'll go ahead and end it there. Thank you all very much.

ED EHLINGER: Dr. Warne, thank you very much. Will you be able to stick around for a little while? Because we have two things that we -- I really need to get in before five o'clock. We have public comment, which we state we have to do, and Dr. Tina Pattara-Lau, from CD -- or from IHS, want to give her a little bit of time. She's been

on the -- the video, so -- and she has to leave by 5:00. So I -- I want to build that in, and then I want to come back. Because there's lots of things that Dr. Warne talked about. And I appreciable the -- the time he took to go through our recommendations and come up with some really important and -- and perfect -- perfect recommendations, from my standpoint. So thank you.

Lee?

MR. WILSON: Yeah, good afternoon, folks. Again, this is Lee Wilson acting as designated federal official for this meeting. As I said yesterday, we are a public meeting under the Federal Advisory Committee Act regulations. And this is our opportunity to provide public comment to those individuals who have contacted us about that public comment.

We have received a number of requests for public comment and I'm going to take them in a particular order just because we are short on time. First, all of the public commenters appear to be -- appear to be with us virtually. So I'm going to start with

Candy Hadsall. If Candy is still available on the line with us, please go ahead, Candy.

Okay. Thank you. We will -- I have been communicating back and forth with Candy. Because of the delay, she was probably not going to be able to make it, but I did want to provide her an opportunity. We may try -- I've sent her a note -- provide her an opportunity to share her public comment with you tomorrow if we can find the space for that. If not, we'll have something in writing.

Let's move to April Phillips who is with Frontier Nursing University. Go ahead, April.

APRIL PHILLIPS: Hello everyone, my name is April Phillips and I'm the clinical director of the Psychiatric Mental Health Nurse Practitioner Program at Frontier. And my question is such:

According to the MMRC most recent report, it was found that 11 percent of maternal death were due to some mental health condition directly. A recent study found that American Indian women have a 62

percent increased risk of developing a mental health diagnosis in pregnancy. In a recent California Health Foundation report found that as many as 30 percent of African-American mothers reported anxiety and depression in pregnancy and postpartum.

Given that 72 percent of women with perinatal mental health conditions never receive treatment, what strategies can we implement to provide mental health services to pregnant and postpartum women, and also, how will the needs of these vulnerable populations be addressed?

LEE WILSON: So April, again, this is Lee Wilson. Just wanted to say that this is not a question and answer period so much that it is an opportunity for you to provide comment to the committee or suggestions. So I -- I realize that as part of the questioning, you may likely have some suggestions or recommendations or areas of deficiency that you would like to call out. So are there any of those points that you would like to make to the committee?

APRIL PHILLIPS: Yes, absolutely. So I

think there is a dire need to increase access to care of certainly during prenatal period and postpartum.

LEE WILSON: Thank you. Are there any questions or comments that the committee would like to make back to April?

Seeing none, thank you. We appreciate your feedback, April. And if you have further information that you would like to provide to us, please do in writing. We will be accepting them, and we will share that information with the committee.

I'd next like to recognize a Lori Roth, who is from Region 9 HHS and I'm wondering whether Lori is on the phone and is able to speak with us.

EMMA ALLEN: Lori, if you're present please use the raise hand function in Zoom so we can identify you.

LEE WILSON: Hearing nothing from Lori, the final individual or organization that had requested an opportunity to make public comment was the Association of Black Cardiologists. We did receive the specific name indicating who would be the speaker,

but I'm wondering whether or not there's a representative from the Association For Black Cardiologists with us.

All right. Then, thank you. This concludes our public comment period.

ED EHLINGER: Thank you, Lee. And I do apologize for -- I -- I usually do like to run a -- a tighter agenda than -- than we've had with this one. So to make -- I didn't make enough time for the public comment. We could if -- if there's other -- are other public commenters, we could make some time tomorrow for -- for that to occur because that's -- that's really important. But now, I would like to open the floor for Dr. Pattara-Lau from IHS. I know Dr. Lau-- Pattara-Lau, you've been monitoring what's going on here, and -- and I think you heard yesterday we had some discussions about IHS. So I'm glad you are here. Thank you. And appreciate your presence here today.

TINA PATTARA: Oh, absolutely. Thank you Dr. Ehlinger and members of the committee for, again, inviting me to participate virtually, to the administration

for putting together the meeting, to panelists just demonstrating amazing honesty, strength that, really, I've -- I've only heard behind closed doors and had the honor and privileges sharing with you.

I do want to apologize that I am not physically in the room with you. I just wanted to let you all know that I have been listening since day one on behalf of IHS and our patients as I'm on -- as Dr. C mentioned, a preplanned trauma for site visit later today.

I am -- for the committee members, as you remember, and I introduced myself in June. I'm an OB-GYN. Spent the last seven years in Phoenix PIMC, flew to Peach Parker, now doing deliveries at Valleywise and started in MCH role back in May at that the committee and presented in June.

My role is basically to serve as subject matter expert, something that hasn't existed in the IHS for the last two years. So as you mentioned the attention in the spotlight is on MCH, and that is my goal, my job.

For example, the CDC has been in talks with me about looking at their AIA and data to make sure that we are accounting for every single -- in this case we're looking at several cancer screening and cancer cases.

I was just on a meeting this morning with HRSA. They reached out because they wanted to look at their cervical cancer screening practices and then looking at how we can be more attuned to the culturally-sensitive needs of our patient population and looking at my work again in last several years.

And also looking at community partners. I know Dr. Warne mentioned family spirit. I've actually been in talks with Christine Speakerman because Family Spirit has been part of IHS for several years and we'd love for that partnership to continue, again, being such a benefit to our patients.

The two things I just wanted to share with the committee and for the panel is, one is -- the first is that I hear the pain. I hear the loss, the healing, and the call

that there is, you know, more work to be done. And I hear it loud and clear.

And that is my passion. As you know, my heart is with our patients and our staff, and I will continue to do my best in ways to move the needle again in the short time that I've been in this role.

The second, I wanted you to know that, again, IHS has -- may not physically be there, but I have been actively listening on behalf of our patients. As I've learned from my care, you know, it's our role to listen, learn, ask questions, and we can always do better. So, again, thank you for allowing me to speak.

Again, we've been reaching out to some of your panelists. Lynne, Heidi in Phoenix, if you would like to, you know, talk about practices in Phoenix and how we can work together, Nicolle Gonzales, we're working with the 12th native midwife to help look at mentoring practices for Dine' or Navajo midwifery students because we want to, again, mentor them and bring them through the training programs and then Rhonda, Abra,

Lynne, and Dr. Lane -- Love-Thurman -- I apologize. I completely agree with you. You have to be creative. You have to think outside the box.

Things that we've done so far. You know, the home visits, Dr. C getting blood pressure cuffs out to the field so our patients don't have to make that long trip and that long travel and perhaps can do some of their care, you know, for the -- over telehealth.

And we know there are mixed -- few things about telehealth, but there was one thing in the pandemic and that is that we had to shift to incorporating telehealth in our prenatal care models and behavioral health. And we noticed that while there are still challenges, broadband access, you know, patient familiarity, it helped us to expand services. It helped us provide care to those patients who are at home that needed child care or transportation, you know, and those were barriers to access. And so we hope to continue that looking at patient navigator and patient advocate roles

in the IHS.

So, again, I am here to listen. I am here to learn, and I am here to work with you. Thank you.

ED EHLINGER: Thank you Dr. Pattara-Lau. Just two things: One I know -- and I appreciate the fact that after our last meeting, you did go over our draft recommendation and submitted some suggestions, which I've incorporated into our draft.

I would appreciate it if you could take another look at that more recent draft, which we'll get to you, and if you have any other additional comments, particularly those related to IHS, we would really appreciate hearing about that.

The other is, I know that we will be having some recommendations related to the Indian Health Service, and I think those -- those recommendations will encourage continued dialogue between this committee and IHS in terms of finding out what's going on, what kinds of information is out there.

So I anticipate for the committee

moving forward, we're going to be seeking additional information on an ongoing basis. So I -- I hope that the relationship is one where we have this partnership of asking questions, getting information, having dialogue and moving forward.

And I'm wondering if there are any other questions that we'd would like to pose to Dr. Pattara-Lau at this point from the committee?

TINA PATTARA-LAU: I would be happy to review, sir and yes, would like to continue the conversation on behalf of both myself and Dr. C.

ED EHLINGER: Okay. Thank you very much.

LEE WILSON: Just for the record, I'd like to say to the committee in response to the discussion that we had yesterday regarding the relationship with IHS, Dr. Pattara-Lau has been in this role for a very short time, a number of months, and in that time we have had a tremendous amount of engagement with her and with the office out of Rockville as a result of her involvement

with us.

So it is -- it has been a tremendous opportunity for us to bridge that gap, and we look forward to a -- continued conversations, information sharing. And hopefully resource sharing in both directions. So I am hopeful that given your commitment to working with us as demonstrated over the last few -- few months that we can continue to make progress from here. So thank you, we appreciate it.

TINA PATTARA-LAU: Thank you.

ED EHLINGER: Thank you, Dr. Pattara-Lau.

TINA PATTARA-LAU: Thank you.

ED EHLINGER: And Dr. Warne, would be able to come back up and take questions from the -- the committee? And, again, thank you for the great presentation that you made. You can -- where -- yeah, up there would be where you have a microphone. So questions for Dr. Warne?

And -- and you said that you did have those recommendations written down so we can -- and get copies, so I think a lot of --

excuse me.

DON WARNE: Yeah. So you know, the slides would also, but I do have the written recommendations on the Word document too.

ED EHLINGER: Dr. Peck?

MAGDA PECK: First, I want to thank you Dr. Warne for being one of my great teachers. I've learned with you and from you since my time in Nebraska and before that. And to see how you are now continuing the make a difference from different vantage points and help us make a greater difference, I just want to personally extend my gratitude for you for being one of my mentors.

I'd like some help with language because how we tell the story was your feedback on framing and going from mild not being acceptable in the words of our -- of our current HHS secretary. So can you go a little deeper on positionality? I'm just going to give you a couple at a time. So when you talk about positionality, that struck me. Can you help me understand that better?

DON WARNE: Yeah, so it has a few meanings, one is just receiving the physical space and where we are but then also other types of the space that we occupy and even our -- our framework of where we are in history. And so the cultural, historical and even the physical space in which we're currently existing because the -- you know, this work would be very different if was ten -- if it was ten years ago, it would be very different if it's ten years from now. And even looking at the discussions of the local communities and who's -- who's here.

So I think just recognizing that there's relative nature to time and space and -- and we formally recognized as many indigenous cultures as part of our framework for even having discussions, you know, about where we are in history, where we are physically, where we are culturally.

MAGDA PECK: Two more, if you would: The notion of adult ACEs, that addition to the -- you know, we've been talking life course for a long time with Michael Liu and Halfon and others that -- and

institutionalize as that. The movement from -- along the life course from, you know, childhood trauma to adult trauma and then the -- I'm curious about listing parenting in -- in the slide around adult trauma and we certainly heard -- and I'm curious, not surprised. We've heard stories of parenting and birth trauma.

And so I was wondering in -- in your work and in recommending to us, how can we build on this adult trauma and, you know, adult experiences that then build on the cumulative toxic effect of acute childhood events?

DON WARNE: Yeah. It's -- it's basically looking at toxic stress that is across the lifetime, and, unfortunately, for a lot of our populations, those stresses are there at all times in across various age groups. So, obviously, you know, childhood trauma is very well studied and has a huge negative impact. And there have been some good studies looking at toxic stress in communities as well and its association with -- with poor outcomes.

But also, you know, for a lot of our people what they're doing is self-medicating their childhood trauma with various substances and, you know, anything that could make them forget their trauma for a little while. And in that setting, we also wind up seeing unplanned pregnancies. We also wind up seeing in some our communities where the solution is to try to incarcerate our way out of the problem, which is never going to work. It's just going to make more trauma for the next generation.

So we see this intergenerational challenge, and I think it's important to remember that the children who've gone through abuse and neglect eventually become parents. And what have they learned about parenting? So it's why we're part of that cycle is historical and intergenerational, but sometimes it's just even within one generation, we can see those cycles continuing. So the -- that cumulative effect of toxic stress is across the entire lifespan and in truth even prenatally, you know, what's happening with toxic stress

during pregnancy and its outcomes.

MAGDA PECK: My last, and I do things in threes, so thank you, Dr. Ehlinger.

Thank you for language, "To get through equity, we walk through truth and painful truth." And one of the ways that you told that story of truth is to talk about weaponization of seemingly harmless things: The weaponization of blankets in the form of disease earliest by our terrorism with the goal of eradication; the weaponization of removal of children as the threat; and starvation in exchange for supposed education; the weaponization of food commodities with explicit instructions on how to do harm for generation by the addition of an unnatural substance in lieu of the most natural, and -- and the consequence being the chronic disease, diabetes and more.

And so I was -- this language about -- about blankets and disease, this way of telling the story, and I just want to thank you for that and -- because I think how we frame this, which is what your advice to us

as how we frame this, needs to be in line with how you're framing it and how indigenous communities want their story told. We can't tell this about you without you.

So I just want to acknowledge the framing of weaponization of things that are in some context additive and other deadly and to wonder if you might be willing to help us further after today in this framing piece as a partner so that the story and stories sing a better future.

DON WARNE: I -- I would be honored to do that. And thank you for picking up on that because things that should be innocuous like blankets, education, and food have been very harmful based on the way they've been implemented.

MAGDA PECK: And strategically so --

DON WARNE: Yeah.

MAGDA PECK: -- with a very clear, insidious, deadly intent.

JANELLE PALACIOS: Thank you. Thank you Dr. Warne. I -- this is a -- a few comments in -- in general because I believe

that your presentation helped -- just informed more about our concerns Indian country, Indian country in particular but, you know, the -- the adverse childhood experiences across the lifetime from even before birth until death, whenever that takes you and that definitely the substance used as a way to self-medicate and not just through adulthood but for childhood as well. I started drinking when I was nine years of age and huffing gas at that time as well to deal with my traumas. And a close friend who lived in the -- our HUD housing project died huffing gas, and that was when I stopped. And that was at age ten.

So it is very much alive and continues today. So these are not things that are delayed that happen but also while you're children, this is what we are doing to help us self-medicate and heal but not really heal.

And the -- the issue that you talked about that states -- when you have a friendly state, when you have a state that's going to be kind to you is reflective of

racism and the structural systems that we have in play and this push and pull that even to have a casino, even though we are sovereign nations and we have rights to our own economics, to even have a casino on our lands, you have to go through a state process. You have to get state -- a governor on board. There is a whole process that's lengthy about that. So our economic -- our economics are controlled even by those who are in power in the state.

And I remember not too long ago Dr. Warne when maternal mortality rates were blinded by state. We did not know which states had the highest maternal mortality rates. That was not too far long ago. And when you shared the slide of all 50 states, we could not pick out whose state had the highest, and it was only recently unblinded.

So there is power in the -- the states controlling, the states having power in terms of whose bodies have access, whose babies are being taken, whose bodies are harmed. So it is -- I would push us to consider what kind of action we can take

that are going -- that it would be pressing the government to press the states to do this work.

And finally, the last comment is Indian Health Service, I shared with Dr. Warne -- or I'm sorry -- Dr. Owens that -- and Dr. Tina Pattara-Lau knows this and Dr. Christensen knows this that, IHS is like the messenger, the starving messenger almost who has that -- who has been given the task to provide a number of tasks, you know, that are almost insurmountable but it is largely the -- the -- the problem lies with our government, with the federal government because that is where this stems from. It is -- it not necessarily, it is not Indian Health Service they're starving, as Dr. Warne has stated. That is the larger government.

So my question to you Dr. Warne is, is a universal health care a possible solution?

DON WARNE: Absolutely. That's where, you know, across multiple populations and -- isn't it remarkable that we are having those discussions and there's other nations that

are already doing it, you know, much more effectively than we are? We're spending a lot more money and having worse outcomes than so many other nations. So absolutely there's better models than what we are doing. Feel this very odd public/private health care system that's, obviously, you know, incredibly complex to understand but even more complex to try to change.

So, you know, we -- we don't want socialized medicine in some sectors politically, but we don't want anyone to touch our Medicare, you know, right? So -- so we have a lot of government spending in health care, but we also have a private sector that makes incredible profits, you know, just looking at the insurance sector. So we have a very odd system, and I don't think anyone would have ever sat down at a -- at a conference room table and design the system that we have. You know what I mean? This is not intelligent design. It's just evolution of multiple stakeholders and their priorities.

So yeah. I think long term for the

entire nation, there would be a less expensive better outcomes approach. But it's been tried before and politically, it's very difficult and I think getting more and more difficult all the time.

And I say specifically for IHS, you know, IHS doesn't determine its own funding levels. That's Congress. And I'm always -- I'm always -- I don't even know what the right word is. I'm stunned. I'm surprised. Every time I hear Congress criticizing IHS. Well, who is funding it?

They should be criticizing themselves for starving a system that's responsible taking care of my relatives and your relatives. That's the fault of Congress, you know. And the -- the analogy that I use, if you need a full tank of gas to get from point A to point B, and every day you only put a half a tank of gas, you can blame the car. You can blame the driver. You can blame -- blame the road, whatever you want to do. But ultimately, it's the fools don't fool -- fill the tank are the ones who are really responsible. And that's Congress --

ED EHLINGER: Now, you -- and Dr. Warne, you've had lots of experience and lots of -- with different federal agencies, and different activities. When you're looking at what SACIMM can do and we have -- we put -- you have 58 or so draft recommendations. Are there things that we should be prioritizing that we, as a committee, might be able to move more effectively than anybody else. And -- and we try to reference, you know, like the American Academy of Pediatrics had some recommendations related to SIDS, and so we didn't repeat those. We support all those things and they're moving that forward, but are there things that this committee should prioritize in -- in our recommendations that -- that might have the biggest impact.

DON WARNE: Absolutely. And there are things that could be done with rulemaking authority within the department for -- for HHS. And so not all of the recommendations are going to require an act of Congress. So, obviously, we can make recommendations that Congress should do X, Y, and Z. But

there are things that could be internal with rulemaking authority, even looking at how the grants are awarded, you know, and how we require reporting requirements for Healthy Start. You know, we had a good discussion on that and, you know, making the -- the tribal nations who are most impoverished and most need compete for resources when they don't have the infrastructure to compete for them. You don't need an act of Congress to fix those types of things, you know.

So I would just outline what are the things that could be done through the secretary and this advisory committee's recommendations within the Department of Health and Human Services, but then there's other departments. There might be recommendations that would have an impact on them and make those recommendations. And then there are things that are going to require congressional approval. And then there's other things that are just going to require advocacy like Medicaid expansion. That's up to the states.

So I would just, you know, characterize

that, you know, what can be done within the department. What can be done within the administration and the cabinet with other departments. What needs congress and what needs to be just advocacy.

ED EHLINGER: All right. Well, thank you very much and best wishes on your new opportunity. Is there -- Joy, did you have a comment?

JOY NEYHART: I think I -- I channel both Magda and Janelle. I'm Joy Neyhart. I'm am a pediatrician. I've worked in Alaska, southeast Alaska for 20-something years and just recently gave up an independent practice to join tribal health in southeast Alaska, and I also work with Abra on the Maternal Child Death Review Committee for the state of Alaska.

Two things stood out: You -- the other lack of bitterness that -- that you -- that you didn't show while relating these grueling and horrible facts that all Americans should know.

And then the second thing is that I -- you know, I -- your comment that IHS is not

the enemy. The crippling underfunding is, so we need to bring these things with us in our recommendations. Thank you.

DON WARNE: Yeah, thank you for those comments. Appreciate that.

JOY NEYHART: I feel very educated.

DON WARNE: Thank you. Thanks.

ED EHLINGER: Go ahead.

JOY NEYHART: This is by no means a final comment in anyway but a question really, for Dr. Warne. I was struck by what you said about should the American Indian/Native American -- native Alaskan, should it be the 51st state and -- and what could that look like and -- and, you know, is there an opportunity to take the state legislature out of the equation. It's there an opportunity to take variable levels of racism and -- and -- and discrimination kind of state to state out of -- out of the equation or what could that look like? And, you know, there's possibilities probab --

I mean, DHS is health care, right? We could do a layer of it without the state, right? We could do it for health care. We

could do it for health care resource distribute -- can you kind of paint picture for me of what that would look like with, what, 600 tribes, right? What would that look like?

DR. WARNE: Yeah. So American Indians are very unique in United States because our tribes have a government-to-government relationship with the federal government. So it's not like other underserved minority populations because we have the separate political entities. We're nations within the nation. So that nation-to-nation relationship could be part of an amendment to Title 19 as the Social Security Act, you know that we will now fund Medicaid-eligible and rolled tribal members directly as opposed to going through the states. That could be done absolutely, so the -- that could be done by amendment to the Social Security Act. It could be done, you know, with a new title potentially within Social Security Act. There would be a whole host of options to do it.

And I think one of the things that

could be done is just the framework of constitutionality. It's very clear in the U.S. Constitution, Article I, Section 8 is the Commerce Clause, and the Commerce Clause states that, "Congress shall regulate commerce with the foreign nations and the Indian tribes." So we are put on par with foreign nations so that's, you know, recognition of tribal sovereignty. But at the same time when we're paying for health care, that's commerce. And right now, who's regulating it? State legislatures. So that's actually unconstitutional but within the federalism system where the states get a lot more authority, it's -- it's legally -- it's actually legal but it's not within the intent of the original writing of the constitution.

So I would frame it, this is unconstitutional the way it's being done. Let's respect to constitution and its framers, and let's amend the Social Security Act and Title 19 and get the state legislatures out of the way of federal dollars to American Indians.

JOY NEYHART: Thank you. One more comment then, may I?

ED EHLINGER: Go ahead.

JOY NEYHART: So yesterday, we have a new congresswoman, Mary Peltola, I'm going to -- I'm going to -- may I introduce you to her, or have you already met her?

DON WARNE: I'd be deeply honored to meet her. I've never met her, no.

JOY NEYHART: I'd be deeply honored to make that connection, so I will.

DON WARNE: Thank you. Yeah, I'll be -- and National Indian Health board annual conference is coming up in a couple of weeks.

JOY NEYHART: I'm -- I'm dreaming of the collaboration you guys can do.

DON WARNE: That would be great.

UNIDENTIFIED SPEAKER: Dr. Warne, really appreciate your presentation, and you gave a very concrete suggestion around Title V and not only the option to change the legislation which is not within our power but you did talk about something that is within the power and that's change in the

guidance.

And so wanted to make sure that the committee knew, we redo that guidance every three years when the process of redoing it now. So it's certainly something you can talk about in the recommendations and there will be an RFI that will be put out, and we'll make sure the committee knows about that because that would be a good opportunity.

Similarly, you heard about Healthy Start earlier. A Healthy Start will reconvene in '24. We've been doing a series of listening sessions with community partners broadly around how we get to equity and then from mortality. We're going to be doing two of those sessions in October or November with Healthy Start guarantees, and there will also be a public RFI. So a number of opportunities to get broad input on things like data collection and the ways the program is structured in addition to the recommendations you all might make.

ED EHLINGER: Dr. Warne, thank you very, very much. This was very helpful and

I -- I hope you stick around for just another five minutes to hear my charge to this committee for tomorrow's work. Could you hand this out to the committee members?

DON WARNE: I would be happy to.

ED EHLINGER: So we didn't have a chance to kind of talk through what we're going to do tomorrow, but I -- this is just going to the committee members because this is home work.

You know, we have, you know, think 58 recommendations and so I'm -- I -- I'm suggesting that you take a look at certain segment of those recommendations just to review them based on what you've heard over the last two days. And I just -- I literally did -- divided them up to every people take a look at it and to make sure that we're not missing something, you know, and how can they be strengthened, you know, what kind of timeline can we put on some of these things, what kinds of partnerships need to be developed, what kind of evaluation report ability and accountability should be there.

So I just want to have you review them one more time, and we're not going to go through each one tomorrow. I just gotta -- want to make sure we are not going to miss anything. But I want you also to think about this, and this is where I'd be interested in Dr. Warne's response after we are adjourned.

I would like to -- given what we've heard, I would like to reframe our report as not recommendations but either -- and -- and this is where we can use the term. Are these demands or are these -- I'm thinking -- or is it to meet the obligations that the United States has, HHS must? You know, frame in terms of not, "We recommend this." These should be givens, so what are the givens that we need to see you step up to accept responsibility for?

So I want to -- as we look over all of those recommendations, think about them in terms of how do they fit with the legal obligation that the federal government has with American Indians/Alaskan Natives and how can they be reframed? I think they --

they -- they're still pretty much accurate. You're asking to do the same thing, you know, in order to meet the obligations, you need to fund IHS. You need to look at different ways of looking at small number analysis. You need to -- I mean, you know, this is the things that you need to do to meet your obligation. So I want you to be thinking about that.

And my -- my goal tomorrow is just to make sure we're not missing anything in terms of the recommendation, are there things we should prioritize? Are there things that are missing? And then how to reframe those. So that I am hoping by the end of tomorrow, we can actually say, we're signing off on this and -- and moving it forward. Because I really do want to, you know, get this out to the Secretary before the election because I think once that happens, you know, the -- the world is going to change a little bit.

LEE WILSON: Can I ask a question?

ED EHLINGER: Sure.

LEE WILSON: As the DFO and sort of

charged to as overseeing your sort of responsibility and role, one of the questions that was raised during an earlier presentation today was whether these are demands or whether these are recommendations that are being made. And I would just like to put out there that as an advisory committee to the Secretary, you represent voices from a variety of areas of expertise, positions and views, regions of the country, professions. Not all of you are Native Americans. And so I -- I would just ask each of you to think about when you're crafting that language to determine how it best presents itself as an advisory committee to the Secretary on certain points and how it presents itself in referring back to native Americans.

So it's easy for a native American to say, "You made a guarantee to my family, therefore." It's a different thing for the advisory committee to use that language or other language to reflect like that. So just been mindful of that in the way you couch your -- your recommendations.

ED EHLINGER: Yeah. Thank you, Lee. And, you know, and we will -- we walk a fine line, and I -- that's why I initially started -- though about demands but as opposed to the other -- not -- to meet the obligations that it appears to us and with input from American Indian Alaskan Native community, you know, this is what we see needs to happen in order for this thing to go.

MARIE RAMAS: To that -- excuse me. To that point, may -- I believe it was Dr. Owens that had a slide that referenced the -- the actual law that obligated the -- that obligated the -- the U.S. government to provide optimal care for -- would it be possible if we could have that sent to the committee so we can look at that and reference. I can't remember who, exactly, it was that -- that put that up there.

ED EHLINGER: Yes, I think it was Dr. Owen, and that -- we should be able to get that to you, to all of the committee members. The slides that were given today. A lot of good recommendations were in those,

and it would be good to review those. Magda?

MAGDA PECK: Towards that end, that is one of the heftiest briefing books that we've received, and I know that the briefing book is not a public document; is that correct? I would like some clarification about that because for the task for tomorrow, in the Broken Promises Report, this history is cited and the law is there, so we can get it from Dr. Owen, but it is already in the briefing book. And so I don't know who read every 1,727 pages. I know I did, Janelle did, and couple of us because we have put it together. But I do think that it would be helpful to look at the Broken -- I'd like to ask Janelle for consult here but their Broken Promises Report is essential reading before you look at our recommendations. Again, it's there.

And the second: To Lee's point, look at our charter. Just as we consider the strategy of language, we have to be to able to fulfill our obligations. And I just think -- I've had fantastic conversations

with our newer members who are still, like, you know -- like they're not drowning but there's a lot of snorkeling going on, right?

So and -- so I just think -- and -- and fabulous members and everyone's at -- but the notions that this is relatively new, a fresh look at the charter and Broken Promises and maybe a third thing -- my rules are three -- that Janelle might recommend. But I just think that this briefing book is -- knocks my socks off in terms of how it is -- allows me to go back and learn in addition to the slides whether it's Dr. Owen or Dr. Warne or others that represented. So I just think it's more homework, but bring it back up and look again.

Any thoughts on that, Janelle.

JANELLE PALACIOS: No, I would agree. You know, in terms of the language, the Broken Promises Treaty, you know, read the letter or the -- the executive summary, right, skim -- read that really well and then skim, the introduction, and because they grind -- they ground it in the -- the law, they ground it in that these were

treaties that were made, you know, all the wording, we can just replicate in this.

And it's this -- I was trying to be very concise in what I recommended, so you can also look in June's briefing book, which you might have an email to and access to, but that has even more resources with other GAO, reports Government Accountability Office and -- but all those reports, a lot of them have that same language that we are not fulfilling the obligations to the first people of this nation.

MAGDA PECK: And hardy thanks for a fabulous job in getting the briefing book. May it be used.

JANELLE PALACIOS: Sorry. One more thing. And it -- so I am sending an email in just a few moments where I will have hopefully Dr. Warne's presentation attached, so that we can review the slides. It will also have NIHB's slides, and let's see, Socia Love-Thurman's recommendations that she gave yesterday. So it will have a few recommendations that people have sent that they presented to us that they're sending so

we can look at them again. And then also Socia sent a link in case anyone wanted to experience the drama again of her dear friend who passed away who was, you know, in -- during -- after childbirth so -- from that NBC report, so that was also -- that will also be in the email. Lots of heavy stuff tonight.

ED EHLINGER: And before I forget, Steve Kelvin isn't here, so, Kate, would you be able to just look -- take a look at the work force once instead of the data -- you know, the data -- I -- I need somebody to just to take a brief look to make sure that we're not missing something.

All right. Any other questions or comments before you collapse -- collapse in your chair?

My hope is that -- that we bring back -- we -- we start with the draft that we have of the recommendations that have been looked at and commented on for nearly four months, see what changes need to be made, see if they can be reframed and -- and -- and -- and then actually vote on the

recommendations that -- that -- that we agree or would like to move them forward.

There will be some need to do some text around that in terms of explanations and -- and that kind of stuff so that won't be finalized tomorrow so won't able to see that. But the recommendations, I would like to see a final vote on those recommendations tomorrow. So that's why we're here, you know, and that's why we had three days to hear the voice and that's -- I mean we didn't -- I didn't want to vote on any of these things that we really had at least two full days of hear -- the hearing them, the stories and -- and the perspectives and lots of -- of American Indian/Alaskan Natives and we did that in an incredibly powerful way over these last two days so it really helped that inform your -- your thinking overnight and our discussion tomorrow.

So with that, we are adjourned for today.

(Recess for the day at 5:11 p.m.)