Historic Day in the US House

Historic day

Growing Our Own: An Indigenous Health Workforce

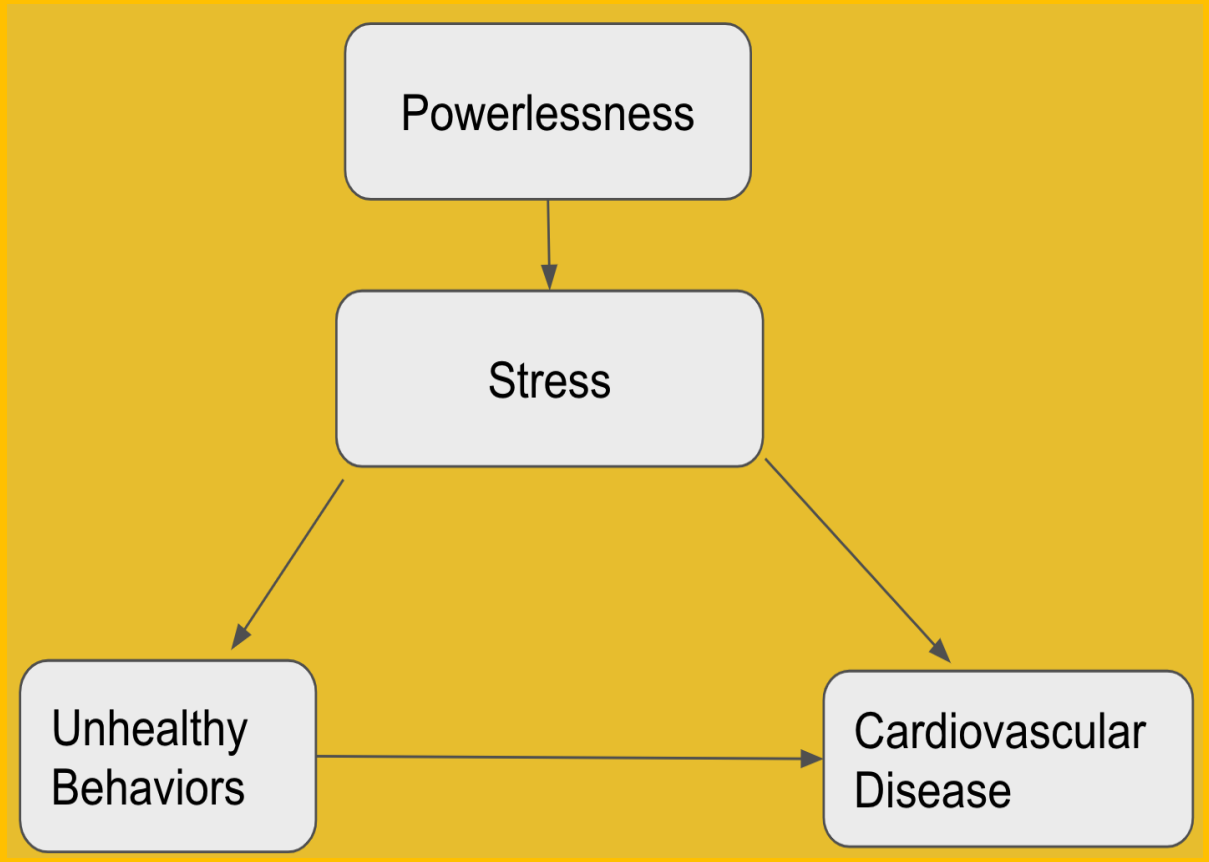
Advisory Committee on Infant and Maternal Mortality Meeting
Shakopee Mdewakanton Sioux Community
September 14, 2022

Mary J. Owen, Tlingit, MD
Associate Dean of Native American Health
Director, Center of American Indian and Minority Health
University of Minnesota Medical School

Return of AI/AN items

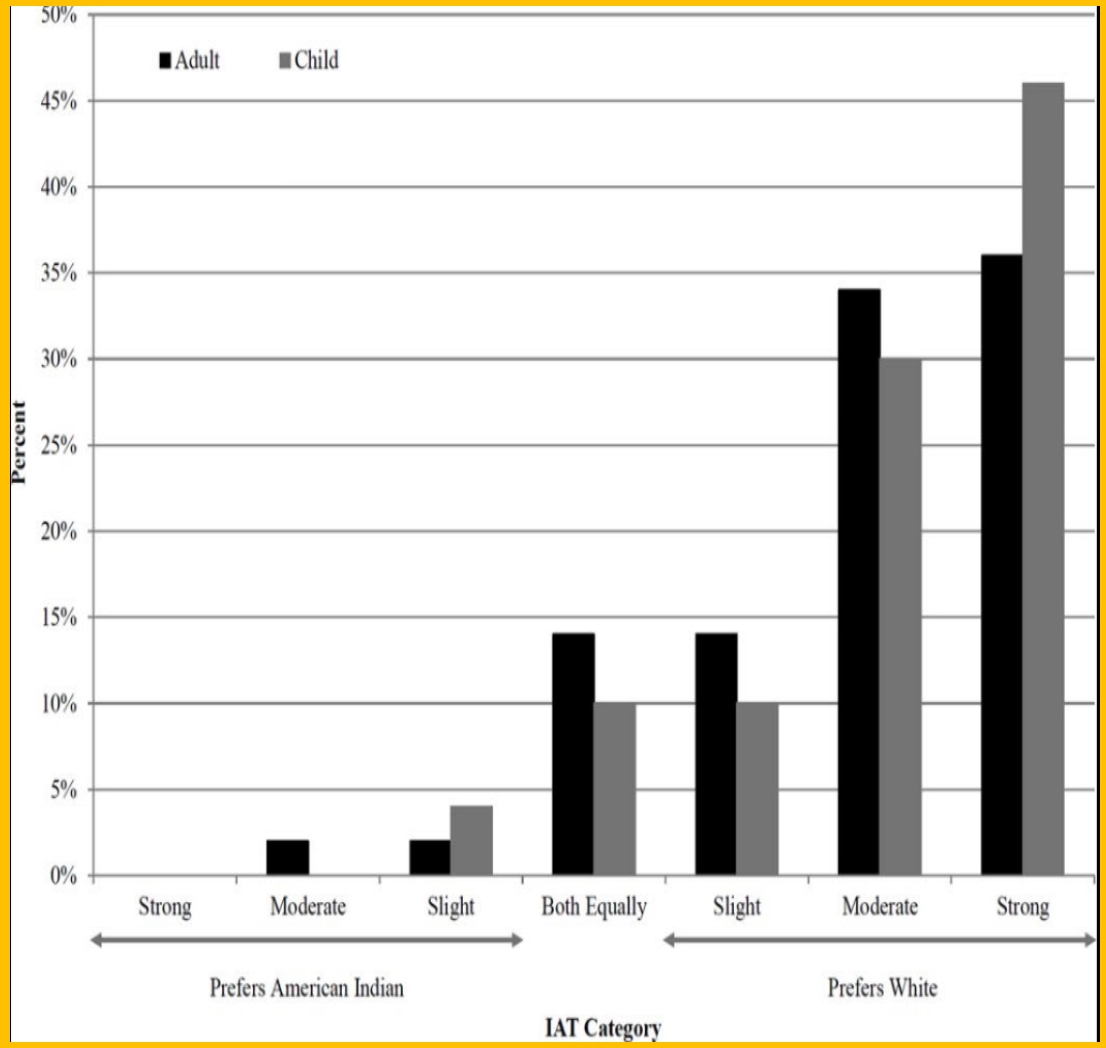
Autonomy as a health factor

"There is more to Poverty than low income and poor material conditions …..Lack of social participation and **inadequate control over your life**, in the sense of not being able to lead the life you want to lead, will lead to chronic stress, which in turn increases risk of a number of diseases, heart disease among them." Marmot (2004, 68-75)



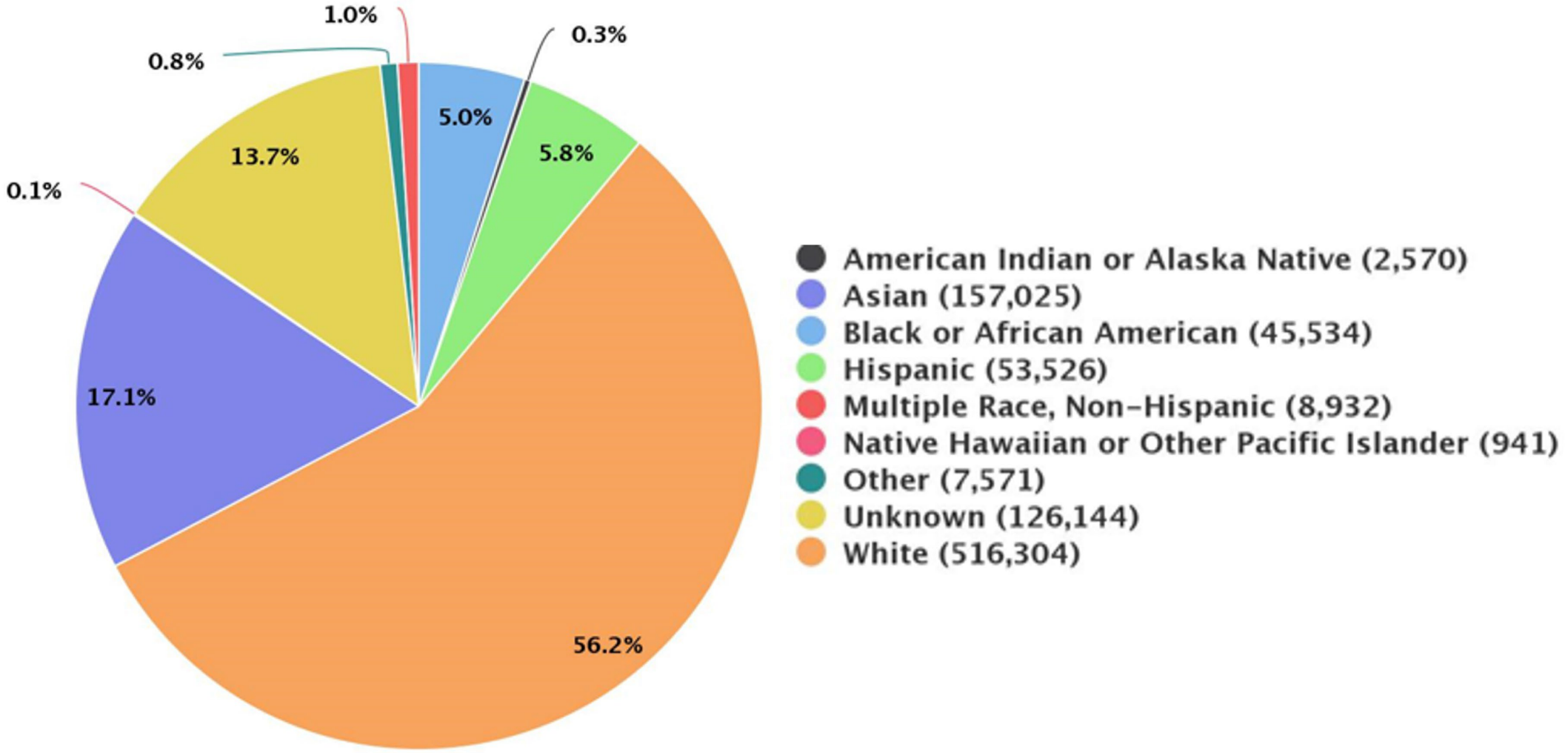
Implicit biases of healthcare providers

- Cross-sectional survey, 154 care providers at five hospitals, Upper Midwest, Implicit Association Test (IAT)
- 84% of providers had an implicit preference for non-Hispanic white adults or children.
- Older providers (≥ 50 years) had lower implicit bias than those middle aged (30–49 years), ($p = 0.01$).
- American Indian children were seen as increasingly challenging ($p = 0.04$) and parents/caregivers less compliant ($p = 0.002$) as the proportion of American Indian children seen in the ED increased.



Puumala, S. E., et al., 2016

Percentage of All Active Physicians by Race/Ethnicity, 2018



Source: https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

U.S. MD-Granting Medical School Graduates by Race/Ethnicity 2017-2018 through 2021-2022 for Men

Table B-4: Total U.S. MD-Granting Medical School Graduates

The table below displays the racial and ethnic characteristics of U.S. MD-granting medical schools by gender from 2017-2018 through 2021-2022. The "Multiple Race/Ethnicity" category includes those who selected more than one race/ethnicity response. Please email datarequest@aamc.org if you need further assistance or have additional inquiries.

Graduate Race/Ethnicity Reponses	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
American Indian or Alaska Native	11	22	17	15	13
Asian	2,071	2,132	2,181	2,211	2,191
Black or African American	464	475	514	563	565
Hispanic, Latino, or of Spanish Origin	557	556	605	605	664
Native Hawaiian or Other Pacific Islander	4	7	2	6	9
White	6,036	5,961	5,748	5,582	5,472
Other	206	209	214	250	204
Multiple Race/Ethnicity	767	823	825	933	926
Unknown Race/Ethnicity	42	44	24	39	91
Non-U.S. Citizen and Non-Permanent Resident	142	139	150	143	133
Total for Men	10,300	10,378	10,280	10,347	10,268

U.S. MD-Granting Medical School Graduates by Race/Ethnicity 2017-2018 through 2021-2022 for Women

Table B-4: Total U.S. MD-Granting Medical School Graduates

The table below displays the racial and ethnic characteristics of U.S. MD-granting medical schools by gender from 2017-2018 through 2021-2022. The "Multiple Race/Ethnicity" category includes those who selected more than one race/ethnicity response. Please email datarequest@aamc.org if you need further assistance or have additional inquiries.

Graduate Race/Ethnicity Responses	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
American Indian or Alaska Native	8	15	17	20	13
Asian	2,070	2,176	2,353	2,482	2,489
Black or African American	652	759	832	878	898
Hispanic, Latino, or of Spanish Origin	493	510	589	677	638
Native Hawaiian or Other Pacific Islander	7	4	7	4	11
White	4,951	4,941	5,059	5,151	5,275
Other	154	180	191	230	177
Multiple Race/Ethnicity	751	778	908	958	1,047
Unknown Race/Ethnicity	39	24	16	42	84
Non-U.S. Citizen and Non-Permanent Resident	136	170	138	137	150
Total for Women	9,262	9,557	10,110	10,579	10,782

Number and Percentage of U.S. Medical School Applicants in 1980 and 2016 by Race or Ethnicity

1980

Race or Ethnicity	Number	Percent
American Indian or Alaskan Native	156	0.4%
Asian	1,643	4.6%
Black or African American	2,507	7.0%
Hispanic or Latino	1,764	5.0%
White	29,256	81.1%
Total	36,083[1]	--

[1]Total includes 757 (2.1% of applicants) unknown and non-U.S. citizens and nonpermanent residents not included in the analysis.

2016

Race or Ethnicity	Number	Percent
American Indian or Alaskan Native	127	0.2%
Asian	10,906	20.6%
Black or African American	4,344	8.2%
Hispanic or Latino	3,300	6.2%
White	25,544	48.2%
Total	53,042[2]	--

[2]Total includes 8,821 (16.6% of applicants) Native Hawaiian or other Pacific Islander, multiple-race, other, unknown, and non-U.S. citizens and nonpermanent residents not included in the analysis.

Source: AAMC, Analysis in Brief, Volume 17, Number 3

Number and Percentage of U.S. Medical School Matriculants in 1980 and 2016 by Race and Ethnicity

1980

Race or Ethnicity	Number	Percent
American Indian or Alaskan Native	63	0.4%
Asian	579	4.0%
Black or African American	999	6.0%
Hispanic or Latino	807	4.9%
White	13,884	83.7%
Total	16,587[1]	--

[1]Total includes 155 (9% of matriculants) unknown and non-U.S. citizens and nonpermanent residents not included in the analysis.

2016

Race or Ethnicity	Number	Percent
American Indian or Alaskan Native	54	0.3%
Asian	4,475	21.3%
Black or African American	1,497	7,1%
Hispanic or Latino	1,335	6.3%
White	10,828	51.5%
Total	21,030[2]	--

[2]Total includes 2,841 (13.5% of matriculants) Native Hawaiian or other Pacific Islander, multiple-race, other, unknown, and non-U.S. citizens and nonpermanent residents not included in the analysis.

Source: AAMC, Analysis in Brief, Volume 17, Number 3

The American Indian and Alaska Native Dentist Workforce in the United States

Published in final edited form as:
J Public Health Dent. 2017 March ; 77(2): 125–135. doi:10.1111/jphd.12186.

The American Indian and Alaska Native Dentist Workforce in the United States

Elizabeth Mertz, PhD, MA [Associate Professor],
UCSF School of Dentistry

Cynthia Wides, MA [Research Analyst], and
UCSF School of Dentistry

Paul Gates, DDS, MBA [Chairman]
Bronx-Lebanon Hospital Center Dental Department

Abstract

Objectives—The purpose of this paper is to describe the American Indian/Alaska Native (AI/AN) dentist workforce, the general practice patterns of these providers, and their contributions to oral health care for AI/AN and underserved patients.

Methods—A national sample survey of underrepresented minority dentists was conducted in 2012 and received a 34.0% response rate for self-reported AI/AN dentists. Data were weighted for selection and response bias to be nationally representative. Descriptive and multivariable statistics were computed to provide a workforce profile. Comparisons to Census data and published information on dental students and dentists were used to examine practice patterns.

Results—The AI/AN dentist workforce (weighted n=442) is very diverse with 55 reported individual tribal affiliations. Tribal heritage was provided by 96.4% of AI/AN dentists (n=426), and of these, 93.9% (n=400) reported an affiliation with only one tribe. The largest share of AI/AN dentists were born in the U.S. (98.2%, n=434), married (75.6%, n=333), and had dependent children under age 18 (52.0%, n=222). Only 0.9% (n=4) of AI/AN dentists spoke a traditional AI/AN language in patient care, while 10.6% (n=46) were raised on tribal land or reservation. Initial practice in the Indian Health Service was reported by 15.8% of AI/AN dentists while 16.2% report currently practicing in a safety-net setting, and 42.0% report working in a practice that primarily serves underserved patients.

Conclusions—AI/AN dentists provide a disproportionate share of care for AI/AN populations, yet the number of AI/AN dentists would need to increase 7.4 fold in order to meet population parity.

U.S. Health Occupations by Race/Ethnicity, 2011-2015

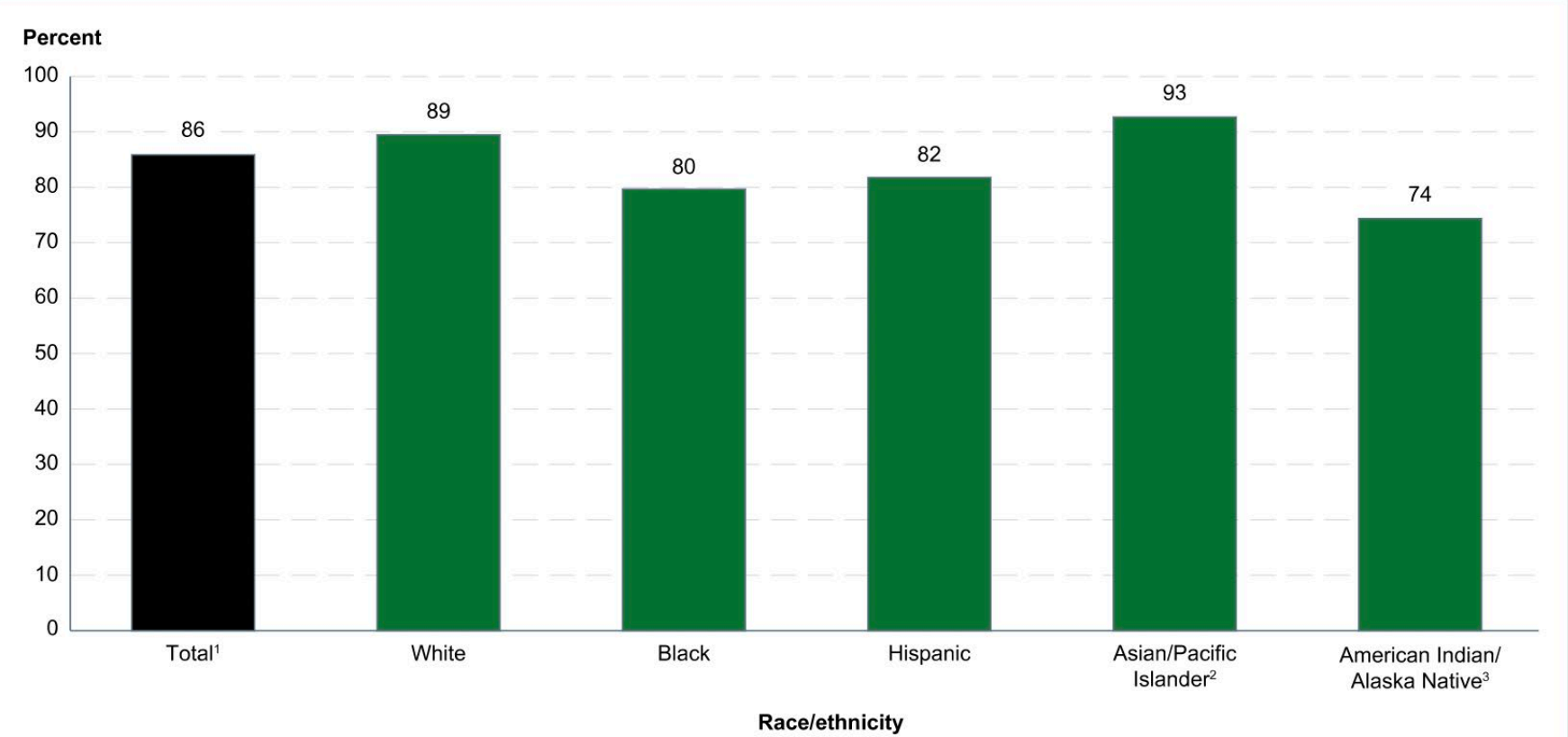
Table 2: U.S. Health Occupations[1] by Race/Ethnicity, 2011-2015

	Hispanic	Non-Hispanic					
		White	Black	Asian	American Indian/ Alaska Native	Native Hawaiian and Other Pacific Islander	Multiple/ Other Race
U.S. Workforce[2] (#)	25,776,728	102,850,895	18,597,223	8,534,837	902,977	251,578	2,910,645
U.S. Workforce[2] (%)	16.1	64.4	11.6	5.3	0.6	0.2	1.8
Health Occupations[3]							
Community and Social Services Occupations							
Counselors	10.7	64.6	18.8	2.8	0.8	0.1	2.2
Social Workers	12.0	60.6	21.5	3.0	0.8	0.1	2.0
Life, Physical, and Social Sciences Occupations							
Psychologists	6.3	83.5	4.9	3.4	0.2	(0.0)	1.6
Health Diagnosing and Treating Practitioners Occupations							
Advanced Practice Registered Nurses[4]	4.5	84.0	5.7	4.1	0.2	NR	1.3
Chiropractors	3.7	86.7	1.9	5.4	0.5	NR	1.8
Dentists	6.1	74.8	3.0	14.3	(0.1)	NR	1.7
Dietitians and Nutritionists	8.5	68.7	15.0	6.0	0.3	(0.1)	1.4
Optometrists	3.9	78.4	1.8	13.7	NR	NR	1.8
Pharmacists	3.7	70.4	5.9	17.9	0.2	0.1	1.8
Physicians	6.3	67.0	4.8	19.6	0.1	0.0	2.1
Physician Assistants	10.0	72.7	7.1	7.3	0.6	NR	2.2
Occupational Therapists	4.0	83.8	4.4	6.6	0.2	NR	1.1
Physical Therapists	4.8	77.8	4.4	11.1	0.2	(0.1)	1.6
Respiratory Therapists	7.9	70.1	12.8	7.0	0.5	NR	1.7
Speech-Language Pathologists	6.2	86.1	4.1	2.2	0.3	NR	1.0
Registered Nurses	5.7	73.5	10.4	8.4	0.4	0.1	1.5
Health Technologists and Technicians Occupations							
Dental Hygienists	7.5	83.4	3.1	4.2	0.2	NR	1.5
Diagnostic Related Technologists and Technicians	9.6	75.7	7.8	4.9	0.4	(0.1)	1.5

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. Sex, Race, and Ethnic Diversity of U.S, Health Occupations (2011-2015), Rockville, Maryland.

Adjusted Cohort Graduation Rate (ACGR) for Public High School Students, by race/ethnicity: 2018-19

Figure 2. Adjusted cohort graduation rate (ACGR) for public high school students, by race/ethnicity: 2018–19



Source: U.S. Department of Education, Office of Elementary and Secondary Education, Consolidated State Performance Report, 2018-2019; and National Center for Education Statistics, ED*Facts* file 150, Data Group 695, and ED*Facts* file 151, Data Group 696, 2018-2019. See *Digest of Education Statistics 2020*, table 219.46.

Doctrine of Trust Responsibility

- United States Supreme Court interpretation of a body of nearly 400 treaties between the US government and Indian tribes
- The US government has a responsibility to uphold its agreements Indian tribes by both respecting the autonomy of tribes and providing for their health and well-being
- Persistence of Doctrine: 1983, US. v. Mitchell, "the undisputed existence of a general trust relationship between the United States and the Indian people" which "has long dominated the government's dealings with Indians."; 2003, United States v. Navajo Nation; 2003, United States v. White Mountain Apache Tribe

Well-Being Scorecard

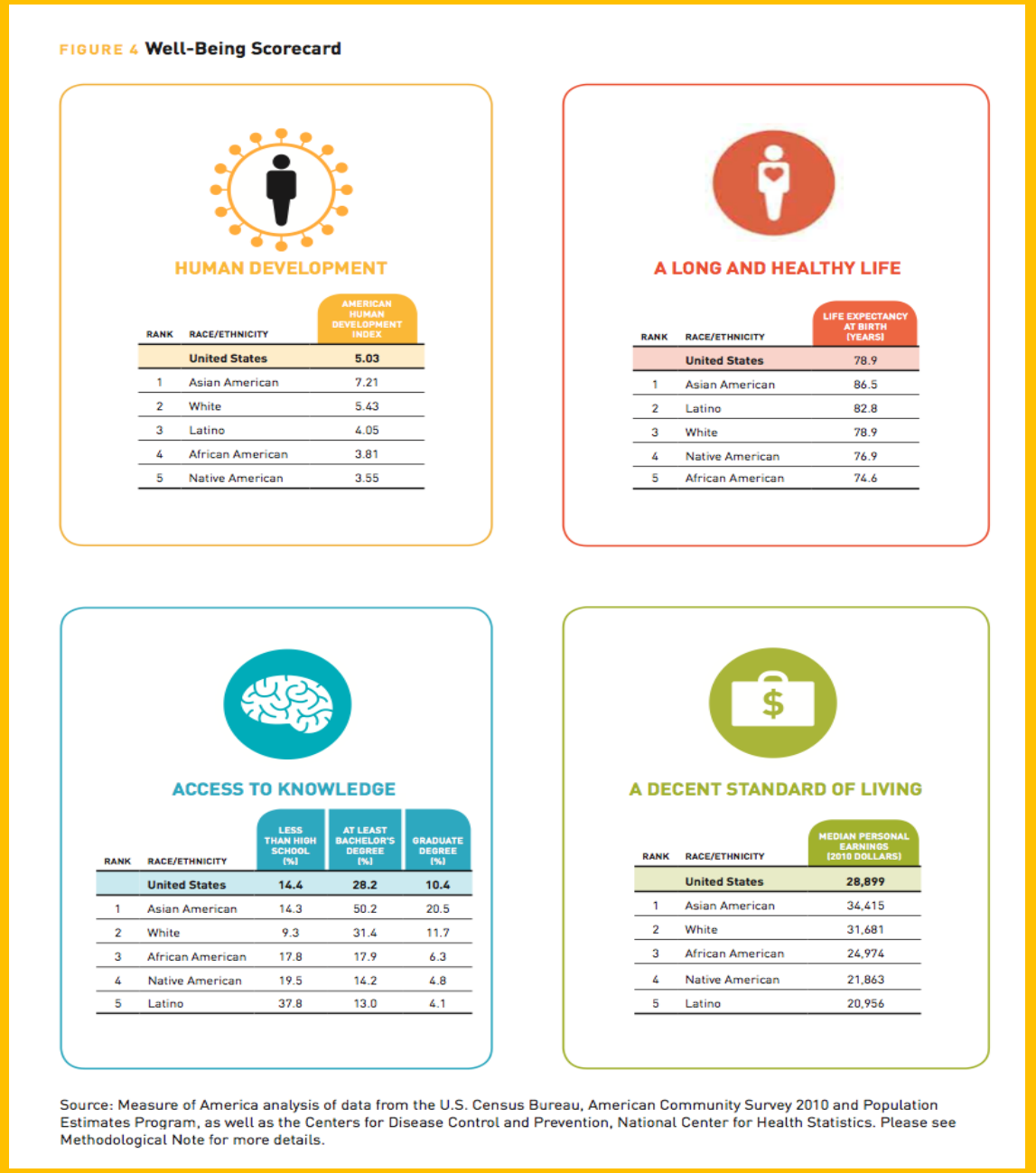


FIGURE 4 **Well-Being Scorecard**

HUMAN DEVELOPMENT

RANK	RACE/ETHNICITY	AMERICAN HUMAN DEVELOPMENT INDEX
	United States	**5.03**
1	Asian American	7.21
2	White	5.43
3	Latino	4.05
4	African American	3.81
5	Native American	3.55

A LONG AND HEALTHY LIFE

RANK	RACE/ETHNICITY	LIFE EXPECTANCY AT BIRTH (YEARS)
	United States	78.9
1	Asian American	86.5
2	Latino	82.8
3	White	78.9
4	Native American	76.9
5	African American	74.6

ACCESS TO KNOWLEDGE

RANK	RACE/ETHNICITY	LESS THAN HIGH SCHOOL (%)	AT LEAST BACHELOR'S DEGREE (%)	GRADUATE DEGREE (%)
	United States	**14.4**	**28.2**	**10.4**
1	Asian American	14.3	50.2	20.5
2	White	9.3	31.4	11.7
3	African American	17.8	17.9	6.3
4	Native American	19.5	14.2	4.8
5	Latino	37.8	13.0	4.1

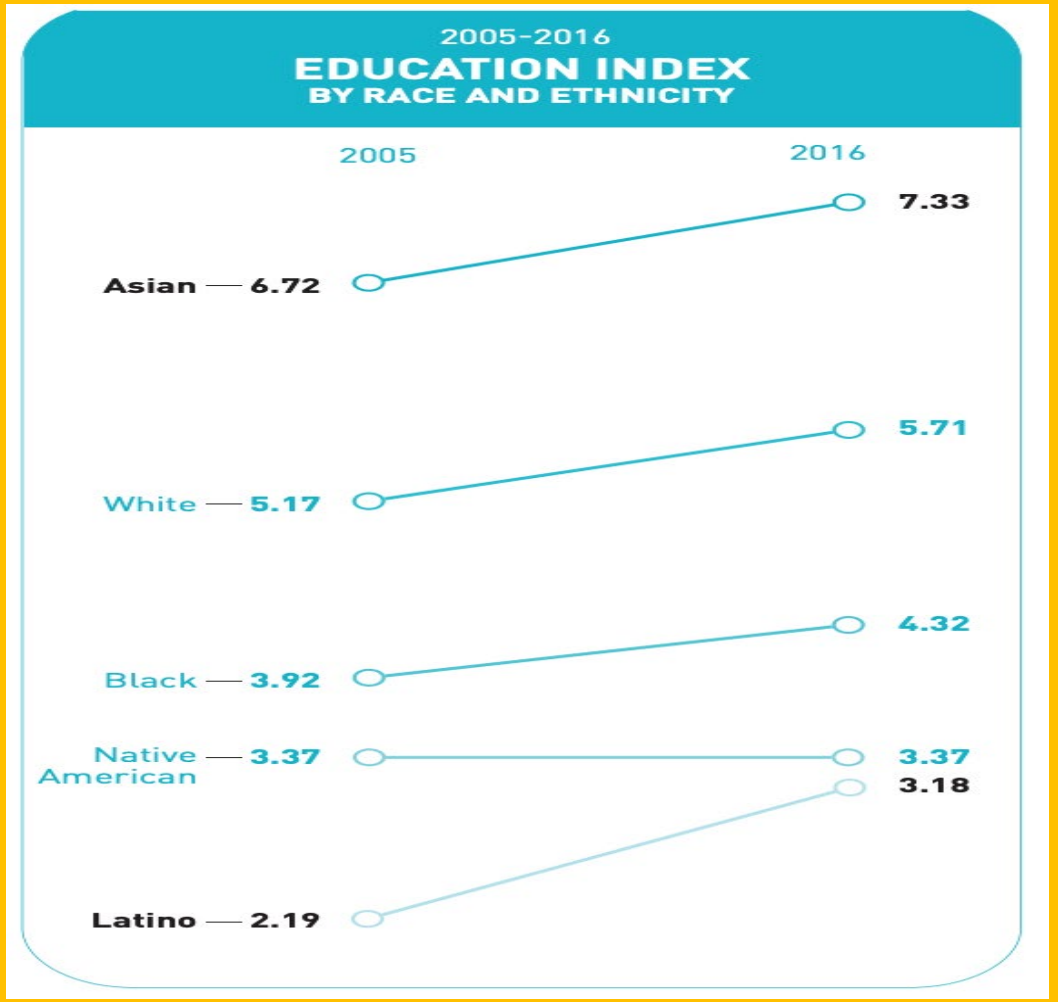
A DECENT STANDARD OF LIVING

RANK	RACE/ETHNICITY	MEDIAN PERSONAL EARNINGS (2010 DOLLARS)
	United States	**28,899**
1	Asian American	34,415
2	White	31,681
3	African American	24,974
4	Native American	21,863
5	Latino	20,956

Source: Measure of America analysis of data from the U.S. Census Bureau, American Community Survey 2010 and Population Estimates Program, as well as the Centers for Disease Control and Prevention, National Center for Health Statistics. Please see Methodological Note for more details.

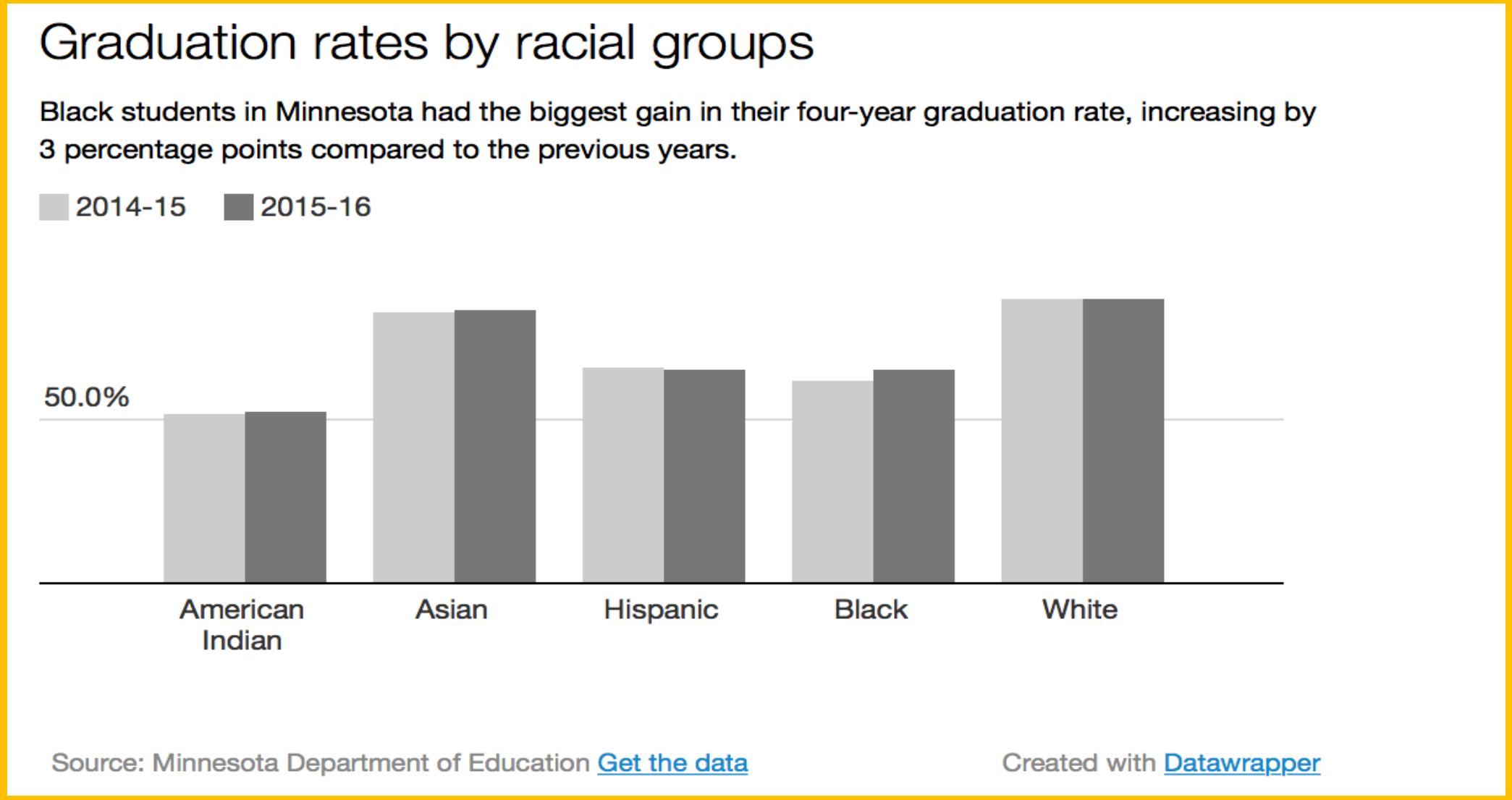
Educational Systems

2005-2016 Education Index by Race and Ethnicity



Lewis, Kristen, and Rebecca Gluskin. Measuring America: Ten Years and Counting. New York: Measure of America, Social Science Research Council, 2018.

Graduation Rate by Racial Groups



Boarding Schools: 1860-1978

- By 1909, 25 off-reservation boarding schools, 157 on reservation boarding schools and 307 day schools were in operation (Adams, 1995: 57-58)
- Attendance mandatory, forcibly taken from homes
- Forced to worship as Christians and speak English
- Rampant sexual abuse
- Truth Commission on Genocide in Canada report: 50,000 Native children murdered, beating, poisoning, hanging, starvation, strangulation, medical experimentation, rape. (**Boarding School Abuses, Human Rights, and Reparations**)
- https://boardingschoolhealing.org/

U.S. Schools Are Teaching Our Children That Native Americans Are History

U.S. SCHOOLS ARE TEACHING OUR CHILDREN THAT NATIVE AMERICANS ARE HISTORY

Professor Sarah Shear examined the academic standards for elementary and secondary school education in all 50 states.

LISA WADE · UPDATED: JUN 14, 2017 · ORIGINAL: DEC 3, 2014

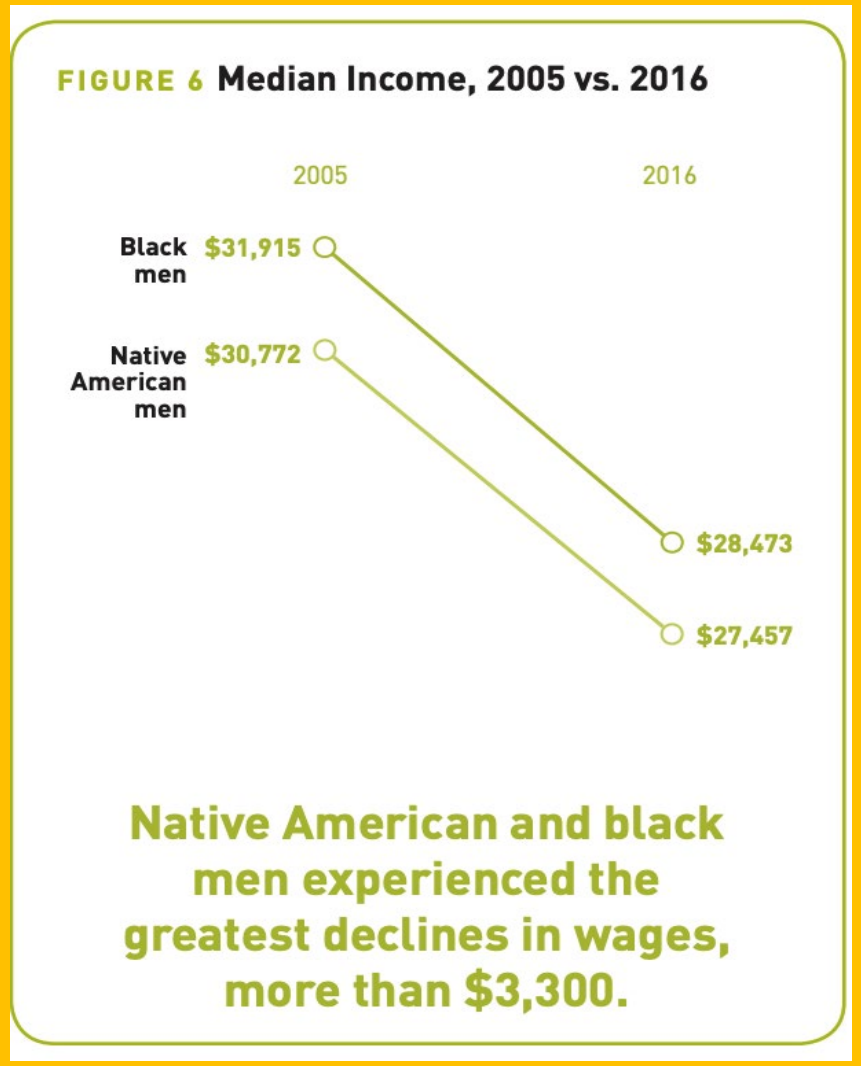
(Photo: seagames50/Shutterstock)

https://psmag.com/social-justice/u-s-schools-teaching-children-native-americans-history-95324

Economy

Center of American Indian and Minority Health | caimh.umn.edu | 218-726-7235 caimh@d.umn.edu

Standard of Living as Measured by Median Earnings



Lewis, Kristen, and Rebecca Gluskin. Measuring America: Ten Years and Counting. New York: Measure of America, Social Science Research Council, 2018.

Indian Land for Sale

Termination: 1953-1968

- Termination of the federal government's trust relationship: elimination of federal benefits & support services
- Between 1953 and 1966, termination of trust relationship with 109 tribes
- Each tribe was ordered to give away all their land and property to tribal members
- Reservations were no longer and the tribal members and the land came under the jurisdiction of the state
- Public Law 280
- Relocation (again)

Termination of Menominee Indians: April 30, 1961

Menominee County became the poorest, lacking the tax base to provide basic services such as police, waste disposal, firefighting.

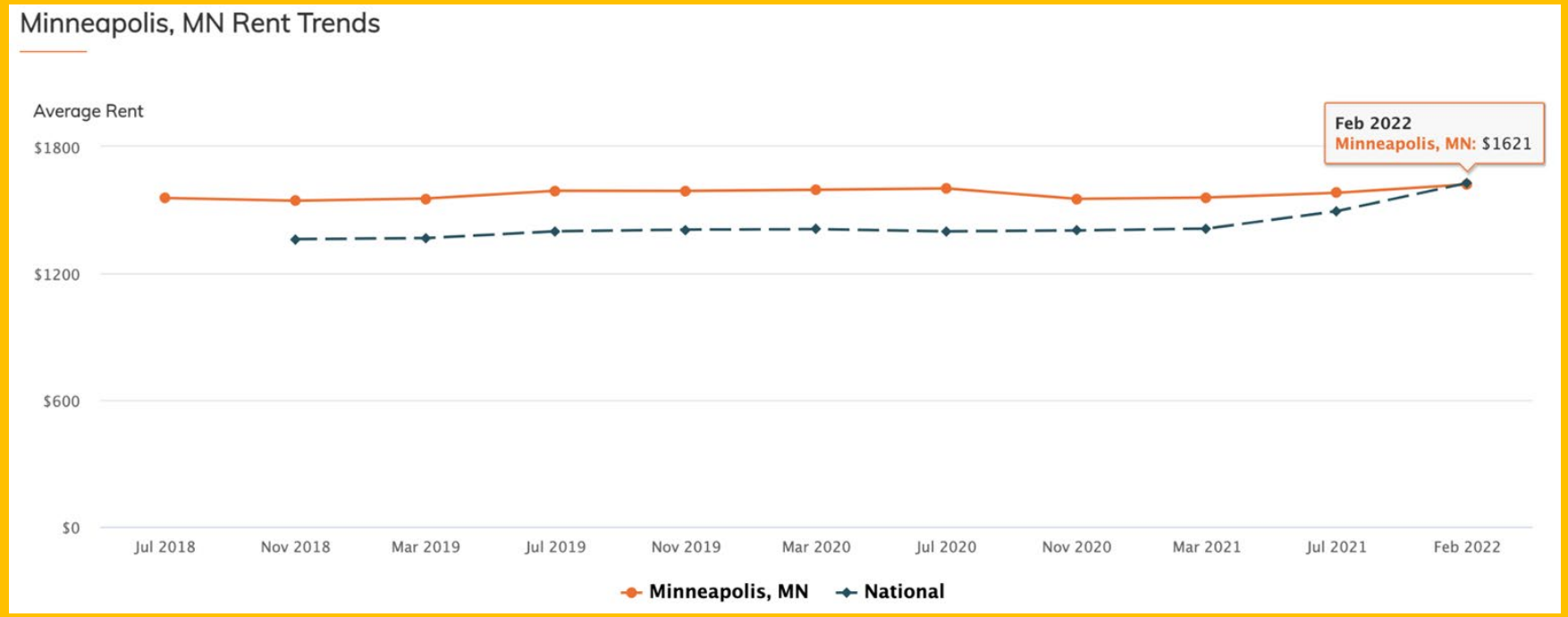
It was the impact on health and education that most harmed the community---the reservation hospital closed and the school drop-out rate increased to 75%, a generation in the tribe with minimal education.

Restoration in December 22, 1973

MINIMUM-WAGE RATE ADJUSTED FOR INFLATION AS OF JAN. 1, 2021

August 28, 2020

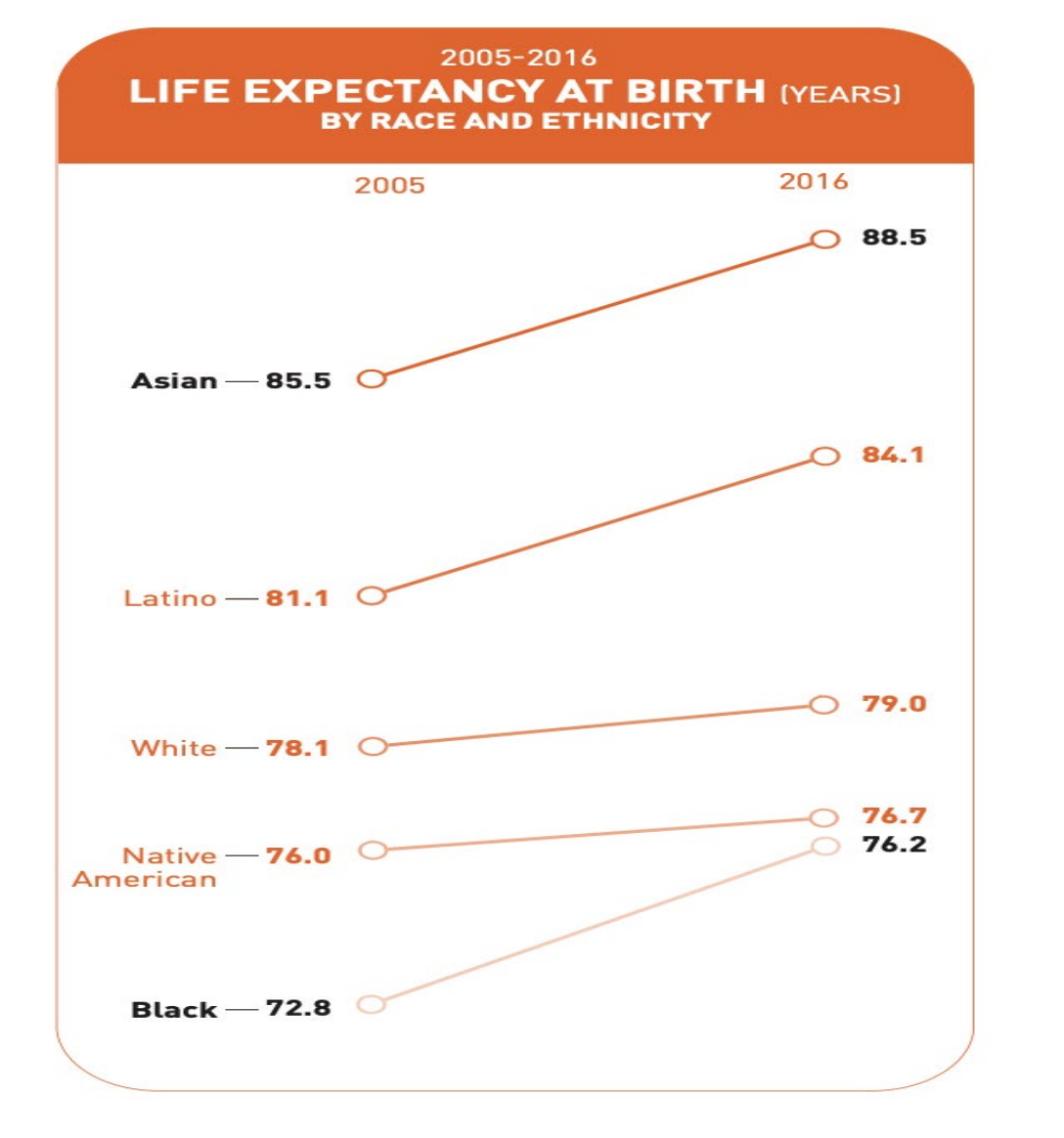
Minnesota's minimum-wage rates will be adjusted for inflation on Jan. 1, 2021, to **$10.08 an hour for large employers and $8.21 an hour for other state minimum wages.**



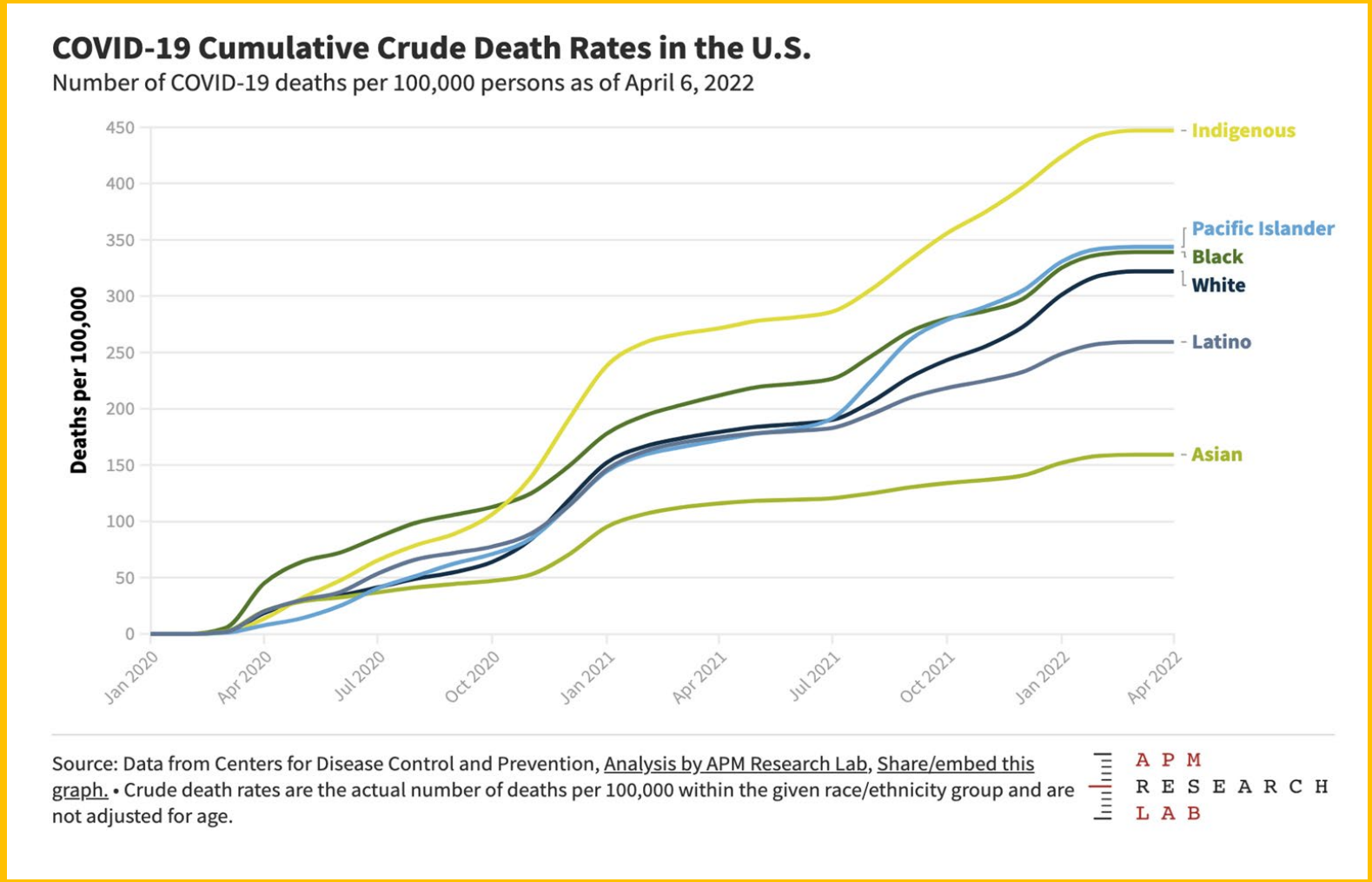
https://www.rentcafe.com/average-rent-market-trends/us/mn/minneapolis/

Healthcare Systems

Life Expectancy at Birth by Race and Ethnicity



COVID-19 Cumulative Crude Death Rates in the U.S.



APM Research Lab: https://www.apmresearchlab.org/covid/deaths-by-race

National Vital Statistics Report on the Mortality Profile of AI/AN Native Population, 2019

National Vital Statistics Reports

Volume 70, Number 12 November 9, 2021

Mortality Profile of the Non-Hispanic American Indian or Alaska Native Population, 2019

by Elizabeth Arias, Ph.D., Jiaquan Xu, M.D., Sally Curtin, M.A., Brigham Bastian, B.S., and Betzaida Tejada-Vera, M.S., Division of Vital Statistics

Abstract

Objectives—This report presents a mortality profile of the U.S. non-Hispanic American Indian or Alaska Native (AIAN) population for 2019. Standard mortality statistics, adjusted for race and Hispanic-origin misclassification on death certificates, are provided along with comparisons with the three major U.S. populations: non-Hispanic white, non-Hispanic black, and Hispanic.

Methods—The data used to produce the mortality statistics shown in this report include final mortality data for 2019; July 1, 2019, population estimates based on the 2010 decennial census; the 2018 and 2019 linked birth/infant death data files; and a data set consisting of 2010 decennial census AIAN records linked to mortality data. Age-specific and age-adjusted death rates, leading causes of death, and life expectancy estimates are adjusted for race and Hispanic-origin misclassification using adjustment factors produced from the census-mortality-linked data set.

Results—After adjusting for misclassification, the non-Hispanic AIAN population experienced substantially higher mortality than non-Hispanic white, non-Hispanic black, and Hispanic populations in the United States. Non-Hispanic AIAN persons experienced greater all-cause mortality, higher age-specific death rates at most ages but particularly at younger ages, and higher mortality for most of the top leading causes of death. They also had the lowest life expectancy at birth (71.8) compared with the non-Hispanic white (78.8), non-Hispanic black (74.8), and Hispanic (81.9) populations.

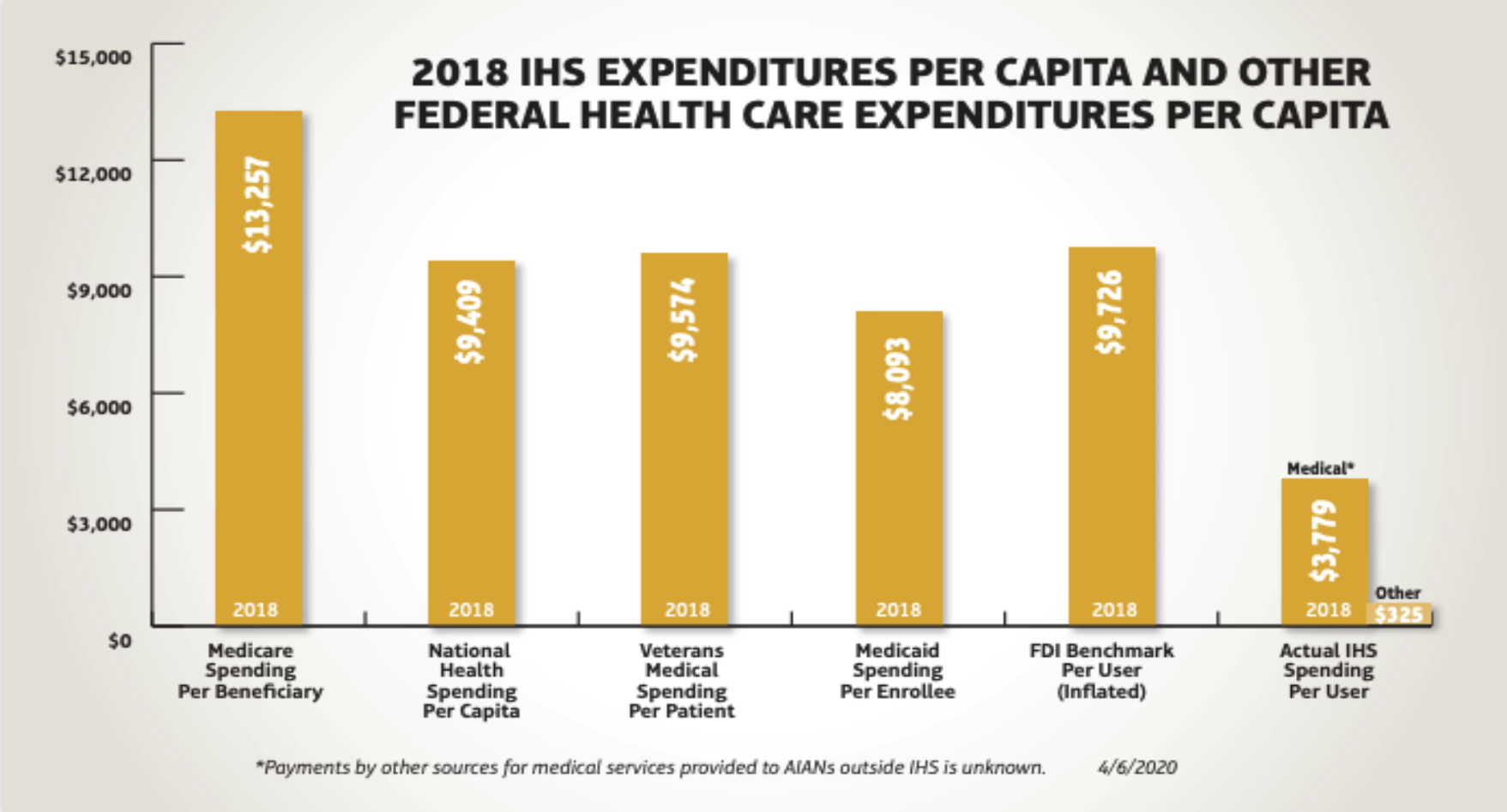
Keywords: cause of death • life expectancy • disparities • race • Hispanic origin • National Vital Statistics System

Introduction

To date, there has been a dearth of published national mortality statistics for the American Indian or Alaska Native (AIAN) population due to poor data quality among this population (1,2). Misclassification of race and ethnicity on U.S. death certificates is the primary source of data problems, although census population estimates also present challenges to the estimation of reliable mortality statistics for the AIAN population (3,4). Previous research has consistently shown that 30% or more of individuals who self-identify as non-Hispanic AIAN are misclassified to a different race and ethnicity group on death certificates (5–7). The main effect of race and Hispanic-origin misclassification on death certificates is substantial underestimation of mortality for this population.

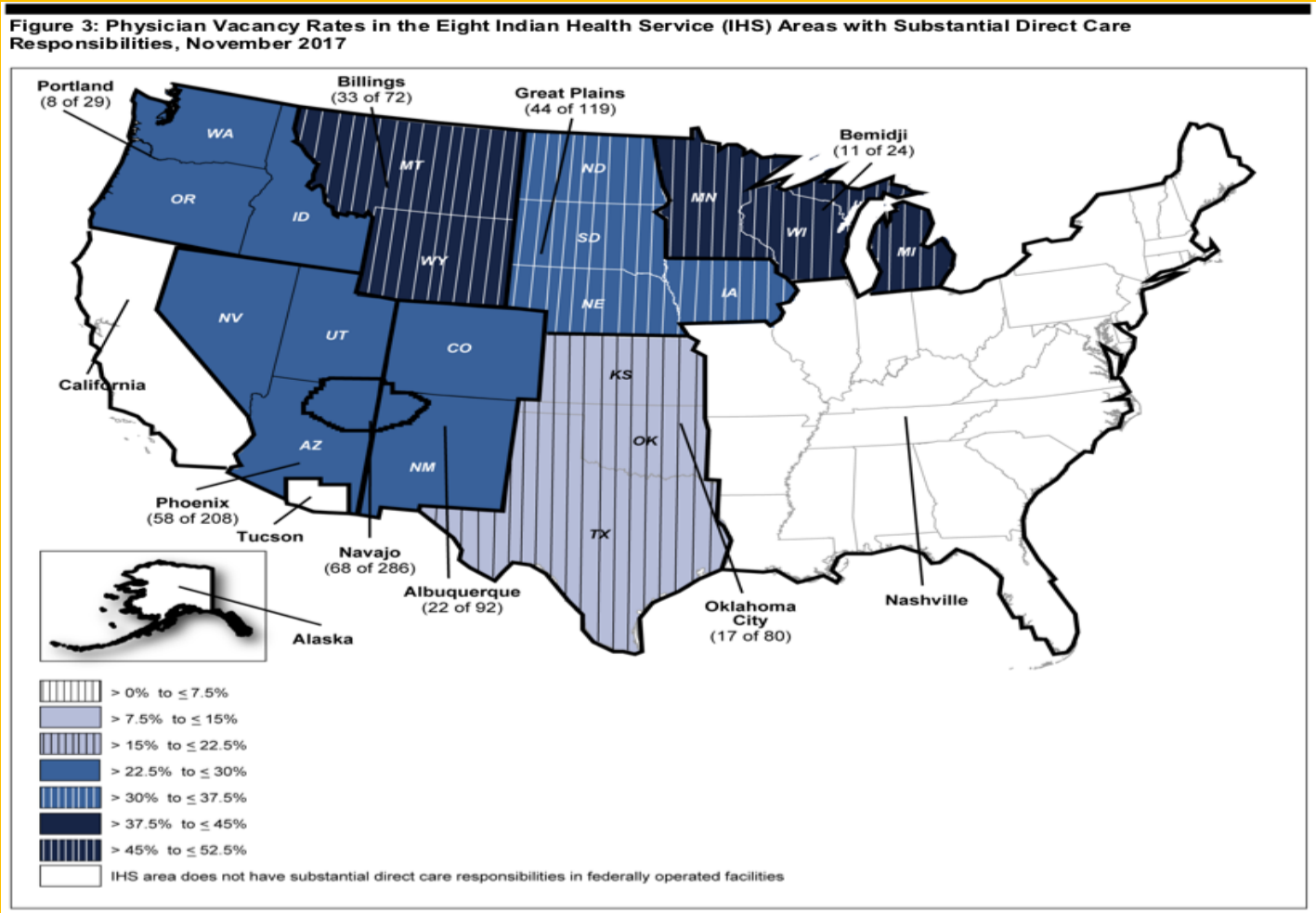
This report presents a mortality profile of the U.S. non-Hispanic AIAN population for 2019. Standard mortality statistics, including age-specific and age-adjusted death rates, leading causes of death, and life expectancy estimates are provided along with comparisons with the three major U.S. populations: non-Hispanic white, non-Hispanic black, and Hispanic. The mortality statistics presented in this report for the non-Hispanic AIAN population are adjusted for misclassification of race and Hispanic origin on death certificates with classification ratios (adjustment factors) produced from a linkage of records of AIAN respondents to the 2010 decennial census with National Vital Statistics System (NVSS) mortality data (see Technical Notes for details).

2018 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf

Physician Vacancy Rates in Eight IHS Areas With Substantial Direct Care Responsibilities, November 2017



https://www.gao.gov/assets/700/693940.pdf

Canada Systemic Racism: Indigenous Woman Taunted by Hospital Staff

Canada: outcry after video shows hospital staff taunting dying Indigenous woman

Joyce Echaquan is seen grimacing as nurses call her 'stupid as hell', renewing calls for country to confront systemic racism

▲ People attend a vigil in front of the hospital where Joyce Echaquan died in Joliette, Quebec, on 29 September. Photograph: Canadian Press/Rex/Shutterstock

Trauma


Center of American Indian and Minority Health | caimh.umn.edu 218-726-7235 caimh@d.umn.edu

“Narrative of dysfunction” Roxanne Dunbar-Ortiz

You cannot view poverty and social dysfunction without examining what led to these conditions, particularly the impacts of colonization

- loss of autonomy and self-determination eroded ability to perform and participate in traditional teachings, healthy society maintaining activities
- “Indian drinking….’world’s oldest on-going protest demonstration.’ Nancy Oesreich Lurie
- Eg., Loss of the Black Hills by the Sioux meant a loss of duties that came with sacred traditions
- Experienced by Indigenous people internationally

Historical Oppression

- Chronic, insidious, and intergenerational experiences of subjugation that have been imposed, and may be normalized and internalized, into the daily lives of many AI/AN communities, families, and individuals. (Burnette, 2015)

NCAI Policy Research Center. (2015). Resilience & Trauma: A Backgrounder. Washington, DC: National Congress of American Indians

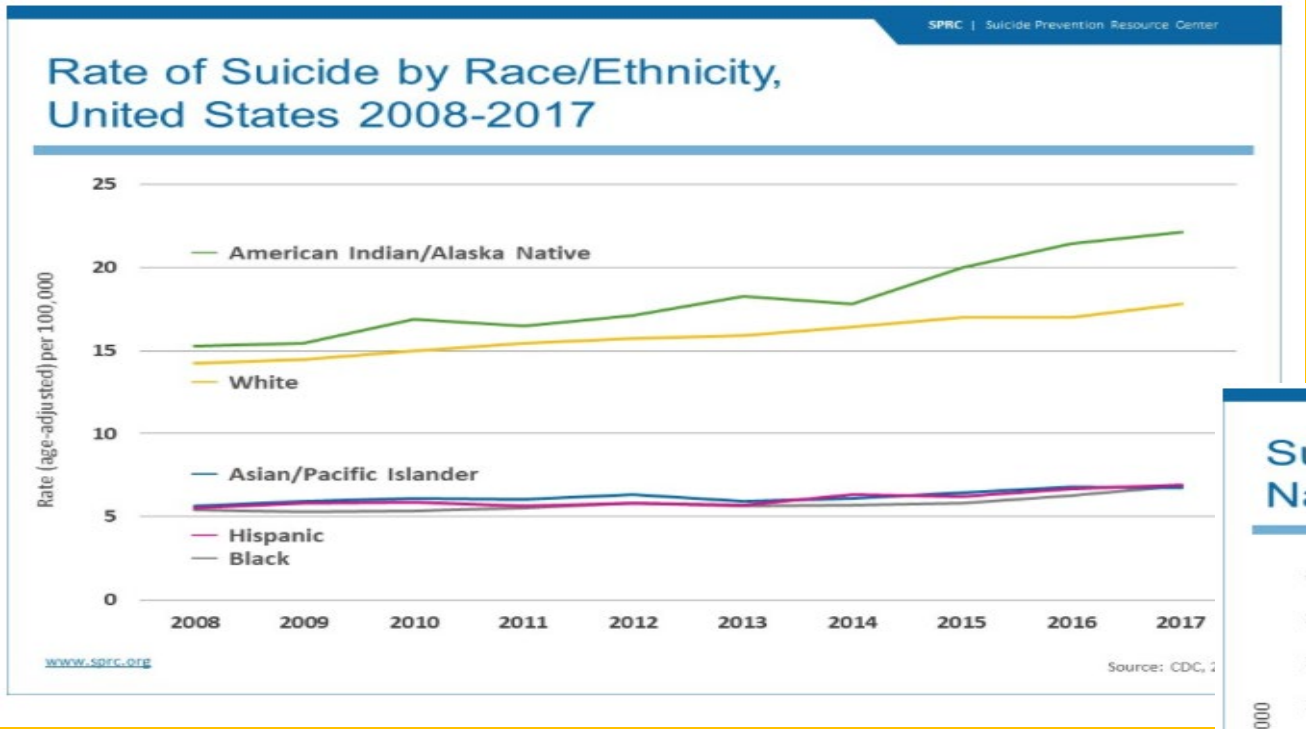
Leading Rankable Causes of Pediatric Deaths and Average Annual Death Rates for AI/AN, Compared with Whites 1-19 Years

TABLE 4—Leading Rankable Causes of Pediatric Deaths and Average Annual Death Rates for American Indians/Alaska Natives, Compared With Whites, 1–19 years: Contract Health Service Delivery Area Counties, United States, 1999–2009

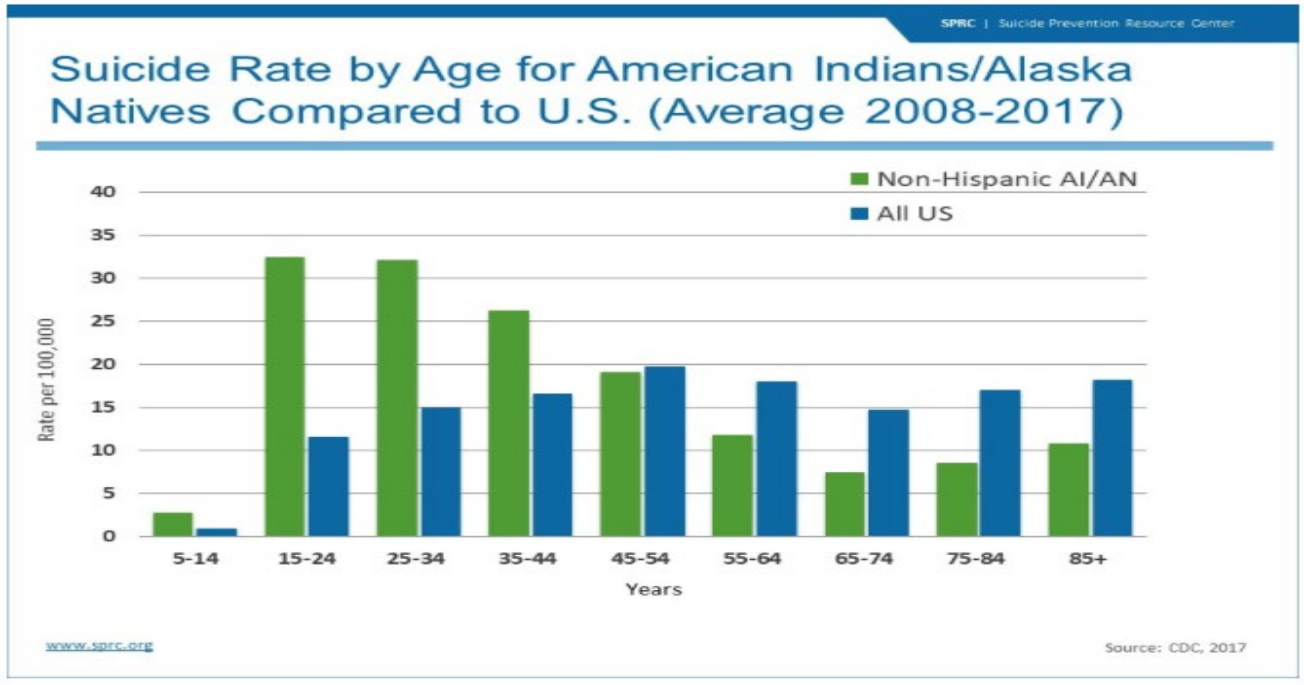
	AI/AN			White		
Age, Years/Cause of Death[a]	Rank	Count	Rate	Count	Rate	AI/AN:White RR (95% CI)
1–4						
Unintentional injuries	1	358	29.3	2257	10.2	2.88* (2.57, 3.22)
Homicide	2	73	5.9	378	1.7	3.48* (2.67, 4.48)
Congenital malformations	3	66	5.4	630	2.8	1.88* (1.44, 2.43)
Malignant neoplasms	4	32	2.7	588	2.7	1.00 (0.68, 1.43)
Diseases of heart	5	28	2.3	173	0.8	2.91* (1.88, 4.36)
Influenza and pneumonia	6	23	1.9	145	0.7	2.87* (1.76, 4.48)
Septicemia	7	22	1.8	104	0.5	3.79* (2.27, 6.04)
5–9						
Unintentional injuries	1	244	15.6	1518	5.2	2.98* (2.60, 3.42)
Malignant neoplasms	2	33	2.1	708	2.4	0.86 (0.59, 1.22)
Congenital malformations	3	28	1.8	257	0.9	2.02* (1.32, 3.00)
Homicide	4	16	1.0	149	0.5	2.00* (1.11, 3.36)
Influenza and pneumonia	5	14	0.9	58	0.2	4.52* (2.33, 8.20)
Diseases of heart	6	11	0.7	114	0.4	1.78 (0.86, 3.31)
Septicemia	7	–	0.6	37	0.1	4.49* (1.91, 9.48)
10–14						
Unintentional injuries	1	309	17.7	2198	6.9	2.57* (2.27, 2.89)
Intentional self-harm/suicide	2	101	5.7	412	1.3	4.50* (3.58, 5.61)
Homicide	3	31	1.8	178	0.6	3.15* (2.08, 4.64)
Malignant neoplasms	4	30	1.7	705	2.2	0.77 (0.52, 1.11)
Congenital malformations	5	22	1.3	272	0.9	1.48 (0.91, 2.29)
Diseases of heart	6	16	0.9	189	0.6	1.56 (0.87, 2.60)
Septicemia	7	13	0.7	58	0.2	4.06* (2.04, 7.50)
15–19						
Unintentional injuries	1	1435	84.6	10 797	32.7	2.59* (2.45, 2.73)
Intentional self-harm/suicide	2	564	33.2	2994	9.1	3.65* (3.33, 4.00)
Homicide	3	232	13.8	878	2.7	5.17* (4.46, 5.99)
Malignant neoplasms	4	76	4.4	1091	3.3	1.34* (1.05, 1.69)
Diseases of heart	5	44	2.6	451	1.4	1.89* (1.35, 2.58)
Congenital malformations	6	27	1.6	343	1.0	1.51 (0.98, 2.23)
Influenza and pneumonia	7	15	0.9	130	0.4	2.22* (1.21, 3.80)

Am J Public Health. 2014 Jun;104 Suppl 3:S320-8. doi: 10.2105/AJPH.2013.301598. Epub 2014 Apr 22.

Suicide Rates for AI/AN Compared to U.S.



[cdc.gov](cdc.gov)



Missing and Murdered Indigenous Women

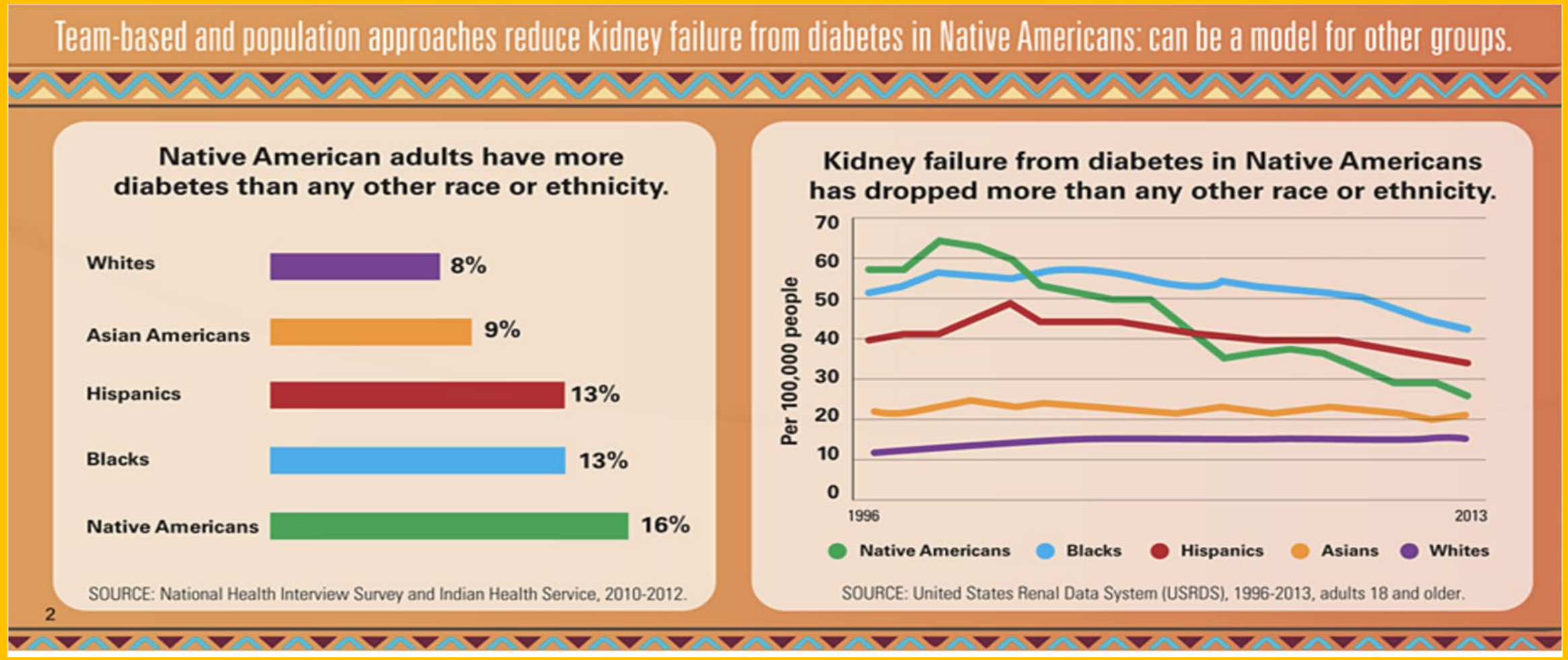
Photo credit: KAIROS Canada

Healing with culture

"Taken altogether, this extended program of research strongly supports two major conclusions. First, generic claims about youth suicide rates for the whole of any Aboriginal world are, at best, actuarial fictions that obscure critical community-by-community differences in the frequency of such deaths. Second, individual and cultural continuity are strongly linked, such that **First Nations communities that succeed in taking steps to preserve their heritage culture and work to control their own destinies are dramatically more successful in insulating their youth against the risks of suicide."**

Chandler, M.J. & Lalonde, C.E. (2008). Cultural continuity as a protective factor against suicide in First Nations youth. *Horizons*. 9(4), 13-24.

Team-Based and Population Approaches Reduce Kidney Failure from Diabetes in Native Americans



https://www.cdc.gov/vitalsigns/aian-diabetes/index.html

Land Repatriation Movement

Indigenous people across the US want their land back -- and the movement is gaining momentum

By Harmeet Kaur, CNN

Updated 6:24 PM ET, Thu November 26, 2020

Democrats Introduce Bill Addressing Cultural Genocide Against Native Americans

Democrats Introduce Bill Addressing Cultural Genocide Against Native Americans

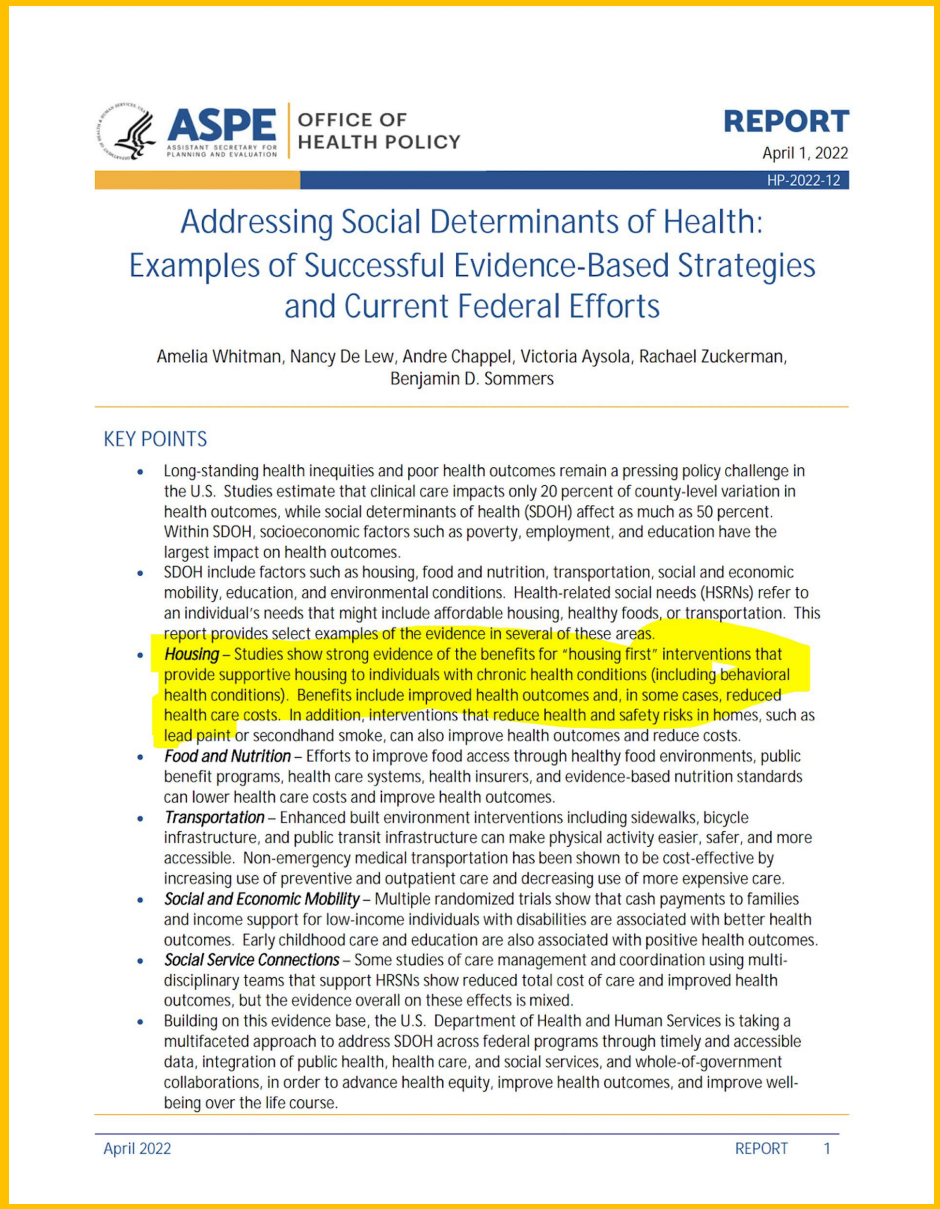
By Jordan Davidson | Oct. 01, 2020 09:50AM EST

POLITICS

*Native American girls from the Omaha tribe attending the Carlisle School in Pennsylvania, the first government-run boarding **school** for Native American children. © CORBIS / Corbis / Getty Images*

ASPE Report Addressing Social Determinants of Health

Office of the Assistant Secretary for Planning and Evaluation, HHS



ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

REPORT
April 1, 2022
HP-2022-12

Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts

Amelia Whitman, Nancy De Lew, Andre Chappel, Victoria Aysola, Rachael Zuckerman, Benjamin D. Sommers

KEY POINTS

- Long-standing health inequities and poor health outcomes remain a pressing policy challenge in the U.S. Studies estimate that clinical care impacts only 20 percent of county-level variation in health outcomes, while social determinants of health (SDOH) affect as much as 50 percent. Within SDOH, socioeconomic factors such as poverty, employment, and education have the largest impact on health outcomes.
- SDOH include factors such as housing, food and nutrition, transportation, social and economic mobility, education, and environmental conditions. Health-related social needs (HSRNs) refer to an individual's needs that might include affordable housing, healthy foods, or transportation. This report provides select examples of the evidence in several of these areas.
- ***Housing*** – Studies show strong evidence of the benefits for "housing first" interventions that provide supportive housing to individuals with chronic health conditions (including behavioral health conditions). Benefits include improved health outcomes and, in some cases, reduced health care costs. In addition, interventions that reduce health and safety risks in homes, such as lead paint or secondhand smoke, can also improve health outcomes and reduce costs.
- ***Food and Nutrition*** – Efforts to improve food access through healthy food environments, public benefit programs, health care systems, health insurers, and evidence-based nutrition standards can lower health care costs and improve health outcomes.
- ***Transportation*** – Enhanced built environment interventions including sidewalks, bicycle infrastructure, and public transit infrastructure can make physical activity easier, safer, and more accessible. Non-emergency medical transportation has been shown to be cost-effective by increasing use of preventive and outpatient care and decreasing use of more expensive care.
- ***Social and Economic Mobility*** – Multiple randomized trials show that cash payments to families and income support for low-income individuals with disabilities are associated with better health outcomes. Early childhood care and education are also associated with positive health outcomes.
- ***Social Service Connections*** – Some studies of care management and coordination using multi-disciplinary teams that support HRSNs show reduced total cost of care and improved health outcomes, but the evidence overall on these effects is mixed.
- Building on this evidence base, the U.S. Department of Health and Human Services is taking a multifaceted approach to address SDOH across federal programs through timely and accessible data, integration of public health, health care, and social services, and whole-of-government collaborations, in order to advance health equity, improve health outcomes, and improve well-being over the life course.

Recommendations

I. Prioritize Health of Indigenous Mothers and Infants:
- Prenatal care supports: transportation, daycare, meals
- **Radical** --- pay people to attend prenatal visits

II. Improve the Living Conditions of Indigenous Mothers and Infants and Assure Universal Access to High Quality Healthcare
- Treatment in pregnancy and long beyond and long before, **Radical** --- treatment availability when needed vs. when available, think of women who might become pregnant and need treatment
- Not only cultural treatment options, but community treatment---involve the entire community
- Mental health services x 100---pre-covid we were short, and not just for folks who are abusing substances or self-medicating. Think trauma
- Collaborate with Department of Education to include accurate and current Indigenous stories in public schools
- TIC training for all HQRCs/public serving centers
- Invest in our communities---we need money and we need to build capacity through programs that train our own---eg., doula training wait list, dental aid programs/training, peer counselor trainings, construction training jobs,….
- Decrease our reliance on grants----help us build capacity
- Fund academic/Tribal health residencies and collaborations---ie., the VA system
- Continue to demand transparency from HHS/IHS, especially regarding PIMC and ACOG

The Indian Health Service and Need for Resources to Implement Graduate Medical Education Programs

VIEWPOINT

The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs

Matthew Tobey, MD
Massachusetts General Hospital, Boston.

Ashley Ott, MD
Massachusetts General Hospital, Boston.

Mary Owen, MD
University of Minnesota, Minneapolis.

The Indian Health Service (IHS) is the only large federal health system to lack formalized partnerships with academic medical centers. This gap hinders the agency's ability to recruit and retain physicians and may contribute to regional physician vacancy rates as high as 46%.[1]

In comparison, the Veterans Health Administration (VHA) has had 75 years of active partnership with teaching hospitals through its Office of Academic Affiliations. An annual budget of more than $1.4 billion in 2014 supports 120 000 annual trainees and 11 000 graduate medical education (GME) positions.[2] Similarly, the Military Health System (MHS) operates more than 20 teaching hospitals and a medical school, the Uniformed Services University. Funding in 2020 for the Uniformed Services University was $169 million, with an additional $315 million allocated to other Department of Defense health education and training programs.[3] These resource differences mirror the lower per-user funding of $4100 compared with $7600 in the VHA and $5200 in the MHS.[4,5]

History

The IHS was established in 1955 and today provides medical care to 2.6 million American Indian and Alaska Native individuals who belong to 574 federally recognized tribes.[4] The US federal government has a trust responsibility, or legal obligation, to provide health services to those individuals. The foundations of that commitment include the US Constitution and the body of treaties signed by the US in exchange for land and natural resources.[6]

> Together, teaching hospital staffing and GME programs can offer the Indian Health Service a foundation for clinical systems and workforce strengthening.

The IHS has partnered informally with teaching physician faculty since the agency's inception. In the 1980s, for instance, teaching hospital teams developed partnerships to overcome ailments with newly developed treatments, such as oral rehydration solution, that have since saved millions of lives around the world. Also, for decades, medical student and resident elective rotations have served the agency as an important physician recruitment tool. Along similar lines, the IHS is formally engaged in addressing gaps in the American Indian and Alaska Native health workforce through the Indians Into Medicine Program and the IHS Scholarship Program, which support American Indian and Alaska Native individuals interested in or pursuing health careers.

Teaching Hospital Physician Staffing

By IHS region, 21% to 46% of 910 physician positions were unfilled in 2018.[1] Staffing shortages have forced IHS hospitals to discontinue some critical services, including in obstetrics and emergency care. Physician shortages have been attributed to limited recruitment incentives, lower salaries, lengthy hiring processes, and geographic isolation.

The idea of leveraging teaching hospital partnerships to address IHS staffing gaps is 45 years old. In 1976, workforce partnerships with teaching hospitals were legislated into the agency's structure via the Indian Health Care Improvement Act. However, Congress has yet to appropriate funds for the IHS to implement the pertinent sections of the act. The consequences of this inaction may be substantial: for instance, partnership with the University of South Dakota was legislated in the act, and in 2010, decades later, the US Senate released a report regarding long-standing staffing and leadership deficits in South Dakota and likened the area's IHS administration to a patient in critical condition.[7]

As an example of emerging partnerships, in 2012, IHS leadership approached an internal medicine team at Massachusetts General Hospital. The physician team met with community leaders in Rosebud, South Dakota, who identified physician staffing as the top priority for a partnership. Today, Massachusetts General Hospital contracts with the IHS to staff 3 full-time rotating faculty physician positions in Rosebud, with each rotation lasting 2 weeks.

As of 2019, similar partnerships accounted for 10% of the agency's physician vacancies,[8] with 8 teaching hospitals serving as clinical partners. The cohort includes the University of South Dakota, which in 2022 is implementing medical student and faculty rotations at the state's IHS sites through a program identical to that which Congress has failed to fund for 45 years. Other teaching hospitals that contract with the IHS to staff faculty positions include University of California San Francisco, University of Minnesota, University of Washington, University of Utah, Mount Sinai Health System, and Boston Children's Hospital.

GME Program Development

The nation's $15 billion in GME funding flows heavily to nonrural, non–American Indian and Alaska Native communities. To address this maldistribution, the Health Resources and Services Administration (HRSA) and Federal Office of Rural Health Policy (FORHP) provide planning funding to aspiring rural GME programs. The Centers for Medicare & Medicaid Services (CMS) offers pathways to expand rural residency positions, although those pathways in many cases do not align with the structure of IHS service units. One successful CMS pathway, the Teaching Health Centers initiative, has facilitated GME program establishment at 2 clinics operated by American Indian and Alaska Native nations and enjoys formal support from the National Indian Health Board.[9] Through its own GME expansion initiative, the VHA is seeking to establish 100 new GME positions in American Indian and Alaska Native care sites, although as of 2022, implementation has been slow.

The IHS Northern Navajo Medical Center in Shiprock, New Mexico, exemplifies the opportunities and challenges facing IHS service units seeking to implement GME programs. This year, the center has recruited residents into the first-ever IHS Accreditation Council for Graduate Medical Education–approved residency, in partnership with the University of New Mexico. However, the hospital has experienced ongoing difficulty in accessing GME funding pathways.

Broader Influence

Together, teaching hospital staffing and GME programs can offer the IHS a foundation for clinical systems and workforce strengthening. In the VHA, the original 1946 policy agreement between teaching hospitals and the VHA noted ambitious goals: to help the agency provide the highest care to veterans, to provide opportunities for veterans to pursue postgraduate study, and to raise the standard of medical practice through GME programs. Regarding these lofty goals, a recent report indicated that the "agreement has been remarkably successful in these domains, perhaps more so than the authors could have anticipated."[2]

Similar outcomes are possible for the IHS. Current teaching hospital partnerships already provide, for instance, support for hospital quality initiatives, free master's degree programs for American Indian and Alaska Native health leaders, free continuing medical education programs, free technical assistance for community health teams, and support of community-driven research efforts. Moreover, the programs have replaced for-profit locum tenens firms, which historically do not reinvest their resources in the pursuit of health equity.

Developing the American Indian and Alaska Native physician workforce is a goal of the Association of American Indian Physicians and the Association of American Medical Colleges.[10] Expansion of IHS/tribal GME programs that prioritize recruitment and support of American Indian and Alaska Native resident physicians could advance this goal and, by so doing, improve trust in local health systems and advance health equity.

Next Steps

As with all IHS-related efforts, formal tribal consultation will be essential to determining the best approach. Complicating that process, given the existing funding and programmatic disparities, few rural American Indian and Alaska Native nations have experience with GME programs and teaching hospital partnerships.

Steps the IHS should consider in discussions with American Indian and Alaska Native nations include

- establishment of an IHS equivalent to the VHA's Office of Academic Affiliations;
- integration of IHS GME efforts with parallel efforts at CMS, VHA, HRSA, and FORHP, including establishment of an HHS-level advisory board to serve that purpose;
- establishment of a technical assistance center to support new teaching hospital partnerships and GME programs;
- establishment of funding opportunities at IHS, HRSA, and FORHP to support teaching hospital partnerships, with consideration for a broad scope of activities that include quality improvement and community health advancement;
- dissemination of information from new and existing partnerships to improve available knowledge.

Congressional action, which will take time, will be essential to achieving many of these potential steps. The experience of existing partnerships should be communicated broadly so that other teaching hospitals might consider similar partnerships for their own trainees and physician staff. Federal agencies should leverage existing authorities to support and encourage such programs to address the physician shortage in American Indian and Alaska Native nations.

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ICWA

- 1978:
  - 25-35% of all AIAN children removed from their homes by state child welfare and private adoption agencies
  - 85% of AIAN children removed were placed outside of their families and communities---even when fit and willing relatives were available
- Still:
  - AIAN children are 4x more likely to be removed by state child welfare systems than non-Native children even for similar circumstances
  - AIAN children are in state foster care at a rate 14 x higher than their rate in the general population

NICWA.org, Setting the Record Straight: The Indian Child Welfare Act Fact Sheet

Teaming Up to Address American Indian and Alaska Native healthcare Professional Shortages

IHEART

Indigenous Health Education & Resources Task Force

Association of American Indian Physicians, Indian Health Service, Association of Native American Medical Students, American Indian Higher Education Consortium, Association of American Medical Colleges

Goal: Improve American Indian and Alaska Native Education and Health outcomes

Objectives:

- Increase the numbers of and effectiveness of existing AIAN pathways programs
- Increase the numbers of AIAN graduating health professionals
- Increase the numbers of AIAN health professionals returning to work in AIAN communities

Aims:

- Develop regional infrastructure to identify educational pathways programs to support and encourage American Indian/Alaska Native students to enter the health professions workforce
- Establish connections within each region to build a network of pathways programs for students and practitioners ranging from kindergarten through employment
- Promote and develop educational pathways programming grounded in Indigenous values
- Highlight models and programs that promote success for Indigenous health students and professionals
- Develop and advocate for local, state, regional, and national policies that support the academic enrichment and advancement of AIAN students
- Establish a sustained series of national meetings to support existing pathways efforts, the development of new programs, and to share successful efforts nationally
- Develop and maintain AIAN health education resource banks:
- Create maps of regional AIAN educational pathways programs
- Create a database demonstrating outcomes from participants in pathways programs

Regional Pathway Hubs

2-Year Post-Secondary Schools
- Community Colleges
- Tribal Colleges
- Post-baccalaureate Programs

K-12
- Private Schools
- Tribal/BIE Schools
- Public Schools

Health Professions Practicum
- Residency Programs
- Pharmacy Practicums
- Nursing Practicums

Health Professions School
- Nursing
- Dentistry
- Pharmacy
- Medicine/DO
- Public Health

Facing Change

Gunalcheesh’

Miigwech

Wopida