

Fiscal Year 2020 and Fiscal Year 2021 Report to Congress
on the Administration of the
Indian Health Service Tribal Self-Governance Program

(Includes FY 2020 and FY 2021 Data)

In Response to:
Section 5394 of the Indian Self-Determination and
Education Assistance Act, as amended

Prepared by the
Department of Health and Human Services
Indian Health Service

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Report to Congress on the Administration of the Tribal Self-Governance Program

A. Introduction

The Fiscal Year (FY) 2020 Report to Congress on the Administration of the Indian Health Service (IHS) Tribal Self-Governance Program and the FY 2021 Report to Congress on the Administration of the IHS Tribal Self-Governance Program are combined in this report and prepared as required in 25 U.S.C. § 5394 of the Indian Self-Determination and Education Assistance Act (ISDEAA) (codified at 25 U.S.C. § 5301 et seq.).

This combined report addresses the administration of the IHS (or Agency) Tribal Self-Governance Program for FYs 2020 and 2021 and provides an accounting of the level of need being funded for each Indian Tribe or Tribal organization under self-governance compacts¹ and funding agreements² authorized under Title V of the ISDEAA.

In FY 2020, approximately \$1.96 billion was transferred to Tribes and Tribal organizations (T/TO) under (105) ISDEAA self-governance compacts and (131) funding agreements. In FY 2021, approximately \$1.98 billion was transferred to T/TO under (105) ISDEAA self-governance compacts and (131) funding agreements.³

In 2020, one more Tribal organization, the Round Valley Indian Tribes - Round Valley Indian Health Center, Inc., located in the California Area, IHS, entered into the IHS Tribal Self-Governance Program.

¹ A “Self-Governance compact” is a legally binding and mutually enforceable written agreement that affirms the government-to-government relationship between a self-governance Tribe and the United States. A compact shall include general terms setting forth the government-to-government relationship, including such terms as the parties intend to control year after year. It is negotiated in a manner consistent with the Federal Government’s trust responsibility, treaty obligations, and the government-to-government relationship between Indian Tribes and the United States. 25 U.S.C. § 5384; 42 C.F.R. §§ 137.30-31.

² A “funding agreement” is a legally binding and mutually enforceable written agreement that identifies the programs, services, functions, or activities (PSFAs), or portions thereof, that the self-governance Tribe will carry out, the funds being transferred from service unit, Area, and/or Headquarters levels in support of those PSFAs, and such other terms as are required or may be agreed upon pursuant to Title V, 25 U.S.C. § 5385; 42 C.F.R. § 137.40.

³ Office of Tribal Self-Governance (2022). Amounts were collected via a data extract from the Office of Tribal Self-Governance Funds Management System, in May 2022.

B. Background

Title V of the ISDEAA allows T/TO to assume operation of certain IHS programs and to receive not less than the amount that the Secretary, Department of Health and Human Services (HHS) (Secretary), would have otherwise provided for the direct operation of the programs for the period covered by the contract. For both FY 2020 and FY 2021, approximately 42 percent of the Agency's annual appropriation was compacted through Title V of the ISDEAA.

The following are specific elements of the annual report as required by statute [25 U.S.C. § 5394 (b)]:

- The relative costs and benefits of self-governance;
- Funds specifically or functionally related to the provision by the Secretary of services and benefits to self-governance participants;
- Funds transferred to each self-governance Indian Tribe and the corresponding reduction in the Federal bureaucracy;
- The funding formula for individual Tribal shares of all IHS Headquarters funds;
- Amounts expended in the preceding FY to carry out inherent Federal functions,⁴ by type and location; and
- Comments on this report received from Indian Tribes or Tribal Organizations.

This combined report to Congress has been compiled using information contained in funding agreements, annual audit reports, and data from the Secretary regarding the disposition of Federal funds. No reporting requirements have been imposed on participating Indian Tribes or Tribal organizations related to this report, as required by 25 U.S.C. § 5394(a)(2) of the ISDEAA.

C. Linkage with other reports to Congress

*The Indian Health Service Fiscal Year (FY) 2020 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes FY 2020 Contract Support Costs Data).*⁵ *The Indian Health Service Fiscal Year (FY) 2021 Report to Congress on*

⁴ The Office of Management Budget (OMB) defines “inherently governmental function” as “a function that is so intimately related to the public interest as to require performance by Federal Government employees” OMB; *Publication of the Office of Federal Procurement Policy (OFPP) Policy Letter 11-01, Performance of Inherently Governmental and Critical Functions*, 76 *Federal Register* 56227, issued on Sept. 12, 2011; *see also* The Federal Activities Inventory Reform Act of 1998 (FAIR), P. L. 105-270 (112 Stat. 2382-2385), codified as a note to 31 U.S.C. § 501. Pursuant to the ISDEAA (25 U.S.C. §5381(a)(4)), “Inherent Federal functions means those Federal functions which cannot legally be delegated to Indian Tribes.” Inherent Federal functions can be located at the Service Unit-, Area-, and/or IHS Headquarters-level. The following is a non-exhaustive list of examples that are functions within the exclusive province of the Agency: determination of Secretarial policy; formulation of the President’s budget; the direction and control of Federal employees; real property management; Federal procurement activities; the conduct of administrative hearings and appeals; and resource allocation.

⁶ Indian Health Service (2020). *The Indian Health Service Fiscal Year (FY) 2020 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards*. This Report is currently under Agency review, and is forthcoming.

*Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes FY 2019 Contract Support Costs Data).*⁶

D. The relative costs and benefits of Self-Governance

The IHS Tribal Self-Governance Program strengthens the government-to-government relationship between the United States and Indian Tribes by enabling each T/TO to choose the extent of its participation in self-governance, and by transferring full control and funding of certain IHS programs, services, functions, or activities (PSFAs), or portions thereof, to Tribal governments.

Under Title V of the ISDEAA, Tribes have the discretion to plan, conduct, redesign, and administer PSFAs, or portions thereof, that they have assumed. As a result, significant variations exist among tribally administered health programs. These benefits can include:

- Creation of a comprehensive approach to health services;
- Increased community engagement;
- Program design driven by the needs and priorities of each Tribal community;
- Improvement in communication and coordination between Tribal programs, resulting in the elimination of service duplication and improved efficiency;
- The ability to leverage self-governance funding, maximize resources, and provide more comprehensive community-wide services; and
- Development of innovative health programs and services.

The costs associated with the Tribal Self-Governance Program are detailed in section E., “*Funds related to the provision of services and benefits to Self-Governance Tribes.*”

Examples of Successful and Innovative Tribal Self-Governance Health Programs:

The American Indian and Alaska Native (AI/AN) population experience a significant amount of health disparities, including a disproportionately higher incidence or rate of COVID-19 related cases,⁷ hospitalizations,⁸ and deaths, as compared to the non-Hispanic White population in the

⁶ Indian Health Service (2021). *The Indian Health Service Fiscal Year (FY) 2021 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards*. This Report is currently under Agency review, and is forthcoming.

⁷ Hatcher SM, Agnew-Brune C, Anderson M, et al. (CDC) (2020). COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1166–1169. DOI: <http://dx.doi.org/10.15585/mmwr.mm6934e1>

⁸ Centers for Disease Control and Prevention (CDC) (January 4, 2020). COVIDView. Age adjusted COVID-19 associated hospitalization rates, by race and ethnicity, United States, March 1 - December 26, 2020. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>

United States, in 2020-2021.⁹ The higher rates of COVID-19 cases among the AI/AN population were attributed to multiple factors, including:¹⁰

- AI/AN Tribal members experience inequitable social determinants of health (e.g., food and housing insecurity, persisting racial inequities, poverty/low socioeconomic status, and historical trauma);¹¹
- AI/AN Tribes are medically underserved, as they receive health care services from a historically underfunded health care system, with a persistent shortage of physicians, nurses and other health care providers;
- There is a shortage of in-patient rooms and space to isolate/quarantine patients infected with COVID-19 in IHS and Tribal hospitals, and lack space or other infrastructures to test patients for COVID-19.
- A number of Tribal members have been diagnosed with chronic disease (e.g., diabetes, obesity and heart disease), other preexisting health conditions and comorbidities;
- Some individuals engage in risky behaviors, such as tobacco, drugs or alcohol consumption;
- Some Tribal members experience transportation barriers (e.g., reside in remote locations with little or no public transportation), which limits access to health care; Many AI/AN individuals work in public-facing occupations, which increases risk for exposure to COVID-19;
- Many Tribal members lack cell, broadband, and internet services, as well as other technology, which prevents access to timely public health information and the ability to schedule health care appointments/services;
- There is a lack of housing in Tribal communities, which results in overcrowded homes where multi-generational or extended families need to share a home, limits the means for social distancing and physical isolation/quarantine, and in turn increases the risk for vulnerable individuals (e.g., elders or children) to contract COVID-19;
- There are a limited number of stores and businesses on most reservations, which hinders the ability to social distance outside the home; and
- Many AI/AN homes lack basic utility infrastructures (e.g., 20 to 30 percent of homes on the Navajo Nation did not have piped water and/or electricity).

During the COVID-19 pandemic, Tribal Health Programs had two options to receive COVID-19 vaccines, from the state or local jurisdiction, or from the IHS.¹² The majority of the Tribes in the

⁹ Anthony S. Fauci, MD, Director, National Institute of Allergy and Infectious Disease, National Institutes of Health (January 7, 2021). Power-point presented during virtual IHS COVID-19 TeleECHO Session, held on January

¹⁰ Denetclaw, W. F., Otto, Z. K., Christie, S., Allen, E. Cruz, M., Potter, K. K., & Mehta, K. M. (2022). Diné Navajo Resilience to the COVID-19 pandemic. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0272089>

¹¹ Historical trauma has been defined as, “intergenerational psychological and biological response to the loss of indigenous lands, people, language and culture due to colonization and genocide.” (Allison-Burbank, J.D., et al., 2022). Measuring the effects of COVID-19 pandemic on Diné and White Mountain Apache school personnel, families and students: protocol for a perspective longitudinal study. BMC Public Health. National Library of Medicine. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/35927650/>

¹² IHS.gov (November 6, 2020). The Director Writes to Tribal Leaders to provide an Update on Indian Health Service COVID-19 Vaccination Efforts. 2020 Letters. Tribal Leader Letter. Retrieved from

lower 48 States chose to work with the IHS for COVID-19 vaccine distribution. Notably, in 2021, the CDC reported that the AI/AN population had the highest first dose vaccination and full vaccination rates of any ethnicity or race in the United States during the commencement of the COVID-19 pandemic vaccination campaign.¹³

The next five “success stories” or “best practices” focus on self-governance Tribes’ COVID-19 response efforts during the years 2020-2021, including but not limited to: carrying-out successful public health and safety measures; implementing efficient vaccine distribution plans; creating culturally appropriate messaging and public health campaigns; developing strong partnerships (e.g., with Federal, State, and local/Tribal entities) and/or utilizing preexisting partnerships, resources and infrastructures to implement multi-prong COVID-19 response plans; utilizing contact tracing and case investigation methods; utilizing culturally grounded community-based health program models; and employing/deploying trusted community health workers (e.g., cultural specialists).¹⁴

Tuba City Regional Health Care Corporation, Navajo Nation. The Navajo (Diné) Nation, is another Tribe participating in the TSGP, with approximately 399,500 enrolled Tribal members.¹⁵ Over 170,000¹⁶ of the Tribal members live on Navajo land or Diné Bikéyah, which covers 27,000 square miles. The Diné Bikéyah spans across northeastern Arizona, northwestern New Mexico, and southeastern Utah, and is larger than 10 of 50 states in the U.S.¹⁷

The Navajo Area, IHS, (NAIHS) is one of 12 regional administrative units of the IHS, with a user population of over 250,000 Tribal members. The NAIHS, consists of five federally operated service units/hospitals, seven full-time health centers and five part-time health stations. In addition to these federally operated facilities, the Navajo health system includes an urban program, the Navajo Department of Health (NDOH) and five Tribal health corporations.

The NDOH has a master contract with the NAIHS, under the ISDEAA (Public Law 93-638). The NAIHS also has contracts and compacts with the five Tribal Health Corporations, which are authorized by the Navajo Nation. The Tuba City Regional Health Care Corporation (TCRHCC)

https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_110_62020.pdf

¹³ Foxworth, R., Redvers, N., Moreno, M. A., Lopez-Carmen, V. A., Sanchez, G. R., & Shultz, G. M. (December 18, 2021). COVID-19 Vaccination of American Indians and Alaska Natives – Lessons from Effective Community Responses. Retrieved from <https://www.nejm.org/doi/full/10.1056/NEJMp2113296>

¹⁴ Contact tracing, case investigation, and community-based health programs are reportedly well-established “best practices” and public health mitigation strategies that have been instrumental in responding to infectious disease outbreaks (e.g., COVID-19 pandemic) (Truong, et al., 2023).

¹⁵ Kahn, C. B., James, D. D., George, S., Johnson, T., Kahn-John, M., Teufel-Shone, N. I., Begay, C., Tutt, M., & Bauer, M. C. (2022). Diné (Navajo) Traditional Knowledge Holders’ Perspective of COVID-19. International Journal of Environmental Research and Public Health. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9964790/>

¹⁶ United States Census Bureau (2024). Navajo Nation Reservation and Off-Reservation Trust Land, AZ—NM—UT. Retrieved from https://data.census.gov/profile/Navajo_Nation_Reservation_and_Off-Reservation_Trust_Land_AZ--NM--UT?g=2500000US2430

¹⁷ Navajo Nation (2024). The Official Site of the Navajo Nation. History. Retrieved from <https://www.navajonnsn.gov/History>

is one of three Tribal Health Corporations that are operating under Title V of the ISDEAA, and participating in the IHS TSGP.¹⁸ The TCRHCC's vaccination program was considered to be a Tribal best practice in COVID-19 vaccination distribution during the pandemic, in 2020-2021.

The TCRHCC is a non-profit community regional referral medical center with 73 bed-capacity, located in Tuba City, Arizona, on the Navajo reservation.¹⁹ The TCHRCC is governed by a board of directors under the Navajo Nation, and has been operating under Title V of the ISDEAA since 2002.²⁰ The TCRHCC's service area is 6,000 square miles. In 2021, the TCHRCC had a user population of approximately 33,800, and reported 193,600 patient visits from Tribal members of the Navajo Nation.²¹ In 2021, TCRHCC reported that they received over 250,000 patient visits at the main campus and at the following satellite facilities: Sacred Peaks Clinic, in Flagstaff; LeChee Health & Wellness Facility, located near Page; a clinic at Bodaway/Gap, Cameron; and the Kaibeto Creek Independent Living Center.

TCRHCC provides comprehensive inpatient/outpatient medical services, such as: primary care; acute care; emergency services; OB/GYN; behavioral health; ophthalmology; orthopedics; dental care and oral surgery; urology; ancillary services; and more. The TCRHCC is also the only level III trauma center serving the AI/AN population, in the lower 48 states, outside of Anchorage, Alaska. The TCRHCC also has a mobile health program that travels to remote regions of the service area.²²

In the years 2020 and 2021, the Navajo Nation was one of the hardest hit areas during the COVID-19 pandemic, with some of the highest rates of COVID-19 cases, and related deaths. Within two months of the first reported COVID-19 case, in Chilchinbeto, AZ, the Navajo Nation had the highest rates, per capita, of COVID-19 cases (30,578) and deaths (1,283) than any state in the U.S.²³

The Navajo Nation demonstrated resiliency by utilizing a number of best practices and building strong partnerships to mitigate the COVID-19 pandemic via a multi-pronged approach. For example, the NDOH partnered with the Navajo Area, IHS, and state(s) public health departments to implement an aggressive vaccination campaign that achieved a high rate of fully vaccinated Navajo Tribal members, and dramatically decreased the number of COVID-19 cases and mortalities.

¹⁸ Indian Health Service (2024). Navajo Area, IHS. Retrieved from <https://www.ihs.gov/navajo/>

¹⁹ Tuba City Regional Health Care Corporation (2024). About us. <https://tchealth.org/about-us/>

²⁰ Walters, J., and Billy, J. (March 17, 2021). TCRHCC COVID-19 Vaccination Program. Tribal best practices in Vaccine Distribution. Health Care Reform in Indian Country. Webinar provided by Self-Governance Communication & Education. Retrieved from <https://tchealth.org/about-us/>

²¹ IHS (June 21, 2004). The numbers for TCRHCC user population and patient visits were provided by the Director, Office of Public Health Services, IHS, via an Email.

²² TCRHCC (2024). About Us. Tuba City Regional Health Care Corporation. Retrieved from

²³ Denetclaw, W. F., Otto, Z. K., Christie, S., Allen, E., Cruz, M., Potter, K. K., & Mehta, K. M. (2022). Diné Navajo Resilience to the COVID-19 pandemic. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0272089>

Shortly after the arrival of COVID-19, the TCRHCC developed a detailed comprehensive COVID-19 vaccine distribution plan. The COVID-19 vaccine distribution planning team consisted of internal stakeholders, which included the following types of TCRHCC staff: administration; clinical; information technology; data analysts; epi response team member; pharmacy; and community and mobile health.²⁴

The COVID-19 vaccine distribution plan developed key processes for five teams to carry out. The clinical and community health team determined user population size, developed a prioritization scheme for vaccinations, and developed a clinical workflow for vaccine administration (i.e., ordering, administering and monitoring). The IT informatics team worked to configure their Electronical Medical Record, to capture the clinical documentation and revenue cycle processes, and provided oversight of data management. The pharmacy team administered vaccine ordering, handling and storage, and provided oversight of vaccine adverse event reporting system (VAERS) and reports. The communications and engagement team developed internal and external communication strategies and education for the community, employees and patients regarding COVID-19 vaccination distribution. The logistics team developed staffing models and schedules, and determined the locations for the COVID-19 vaccine distribution events (e.g., at clinics, vaccine drive-ups, and community blitzes).²⁵ Community blitzes were events where typically hundreds of individuals were vaccinated, including entire families, in one event.

The TCRHCC's COVID-19 planning team also collaborated with a number of partners, to implement the plan, such as the: Navajo Nation Unified Command Group; NAIHS; Federal Emergency Management Agency; local school district; local Tribal Chapters; John Hopkins Center for Indigenous Health; Navajo Nation Emergency Medical Services; and volunteers. Key enablers for the COVID-19 vaccination effort were the: NAIHS, through the allocation of the COVID-19 vaccine; the Senior Leadership Council (SLC) for TCRHCC, who provided support, commitment (e.g., via budget and staff), and prioritized the COVID-19 vaccine program; the electronic health records vendor and data analytics support group, who provided technical assistance to the TCRHCC staff to make the COVID-19 vaccination effort a success.

The TCRHCC also utilized elements of two previously tested models to develop their vaccine distribution plan, which were the: 1. COVID-19 testing drive-up and community blitzes; and 2. Fall flu immunization drive-up and community blitzes. The elements of these two models that contributed to a successful COVID-19 vaccination distribution plan were:²⁶

- Safe: both the COVID-19 testing and the Flu immunization models were conducted as drive-up clinics, so patients remained in their cars. A benefit of using the existing model(s) for the COVID-19 vaccination distribution effort, was that providers, and others, were less likely to contract COVID-19.

²⁴ Walters, J., and Billy, J. (March 17, 2021). TCRHCC COVID-19 Vaccination Program. Tribal best practices in Vaccine Distribution. Health Care Reform in Indian Country. Webinar provided by Self-Governance Communication & Education.

²⁵ *Ibid.*

²⁶ *Ibid.*

- Efficient: as a result of wireless connectivity (e.g., for accessing patient records and reporting), defined roles for staff, and workflows.
- Location: spacious which resulted in good traffic/patient flow.
- Supported Workflows: other areas also followed defined workflows (i.e., patient registration; screening; providers/vaccinators; and education/monitoring).

Developing visual workflows to define roles and outline the process for each role, and to provide a patient flow guide were central to the efficiency and success of the TCRHCC's COVID-19 vaccination distribution plan. The TCRHCC staff developed workflow charts to increase efficiency for COVID-19 vaccination distribution in drive-ups, community blitz events and in clinics, as well.

The TCRHCC conducted COVID-19 vaccine distribution events in clinics, with drive-ups, which were sometimes referred to as community blitzes. The clinic vaccination distribution events were typically smaller events, and provided approximately 200 COVID-19 vaccine doses per day in a limited clinical setting. Whereas the drive-up or community blitz vaccine events provided 200 COVID-19 vaccine doses per hour and required a spacious setting. Community blitz vaccination events often required numerous employees with defined roles to carry out defined processes, such as event controllers, entry station staff, traffic controllers, runners/scribes, provider, registration support, registration staff, vaccine station support; vaccinators, pharmacist, pharmacy tech, parking lot monitors, clinical parking lot monitor, and IT support.

Detailed logistical planning was also required for clinic and drive-up/community blitz vaccine events to ensure essential items were available, such as: vaccine supplies; staffing; network connection; media outreach; clinical supplies; signage; emergency support (e.g., police and EMS); paperwork (e.g., immunization cards, encounter forms, and vaccine packets). Logistical planning also addressed location layouts with workflow plans (e.g., entry station, waiting line, vaccine lines, portable toilets).

The TCRHCC received their first COVID-19 vaccines on December 15, 2020. They followed the CDC, Navajo Nation, and NAIHS, recommendations for prioritization of the COVID-19 vaccination distribution. The COVID-19 vaccine distribution planning team developed the vaccine prioritization plan, which was reviewed by both the SLC and the epi team before it was posted to the TCRHCC Website. The prioritization plan was a 3-phase approach, with the frontline workers and first responders vaccinated first, followed by long-term facilities staff and residents, high risk patients and elders age 75-years and older in the first phase. Tribal members at less risk or the general public (over 16 years of age) were vaccinated in the second and third phases. By March 2021, TCRHCC reported 21,387 COVID vaccines were administered at TCRHCC (1,793 patients had 1 dose and 9,797 patients had 2 doses as of 3/31/2021).²⁷

²⁷ Walters, J., Chief Executive Officer, TCRHCC (June 21, 2024). CEO Walters confirmed these COVID-19 vaccination numbers through the Navajo Nation Epicenter, and provided these numbers to IHS for this Report, via Email.

The TCRHCC used a number of methods to inform Tribal members of COVID-19 vaccine information and events through: word of mouth; brochures and handouts; media posts; text message blasts using texts and notification apps; radio and newspaper ads; flyers posted at Chapter houses, grocery stores and schools; and community townhalls facilitated by providers.

In May 2021, the Navajo Nation reported that 85 percent of Navajo Tribal members, over the age of 16, were vaccinated.²⁸ The success of the vaccination campaign may also be attributed to inclusion of traditional Navajo cultural components into the vaccination effort. For example, the Navajo Nation CHR program utilized trusted Navajo community members to deliver culturally responsive health care, vaccinations and timely public health information on COVID-19 to traditional Navajo Tribal members. Additionally, traditional knowledge holders (e.g., medicine men or women) who are keepers of traditional teachings on how to maintain wellness and balance in life, were critical to helping the Diné people to overcome the hardships associated with COVID-19.²⁹

The Navajo Nation also used culturally appropriate messaging strategies to encourage Tribal members to receive the COVID-19 vaccination. For example, Jonathan Nez, the President of the Navajo Nation during the pandemic, referred to the COVID-19 infection as a monster, similar to the monsters that the Navajo people prevailed over in traditional teachings.³⁰ President Nez encouraged Tribal members to “slay the monster” or COVID-19 by putting on a “shield” or receiving a COVID-19 vaccination to protect themselves, families, and others from the “monster.” The Navajo Nation and other Tribes value, and the culture is attuned to, the welfare of others and the generations that follow. As one Tribal member said, messaging about the vaccines focused on “the elders, and what our ancestors did to get us to here, and it’s now our responsibility to carry on, and the way we do that is to protect our community.”³¹

The Alaska Native Tribal Health Consortium. The Alaska Native Tribal Health Consortium (ANTHC) is a non-profit Tribal self-governance health organization established in Alaska, in 1997, and serves over 180,000 AI/AN people, from 229 federally recognized Tribes across 586,412 square miles.³² The ANTHC is the largest and most comprehensive Tribal health organization in the U.S., employing over 3,000 health service professionals.³³ The ANTHC incorporated innovative and best practices, in partnership with the State of Alaska, to address the COVID-19 pandemic, during 2020 and 2021.

²⁸ Denetclaw, W. F., Otto, Z. K., Christie, S., Allen, E., Cruz, M., Potter, K. K., & Mehta, K. M. (2022). Diné Navajo Resilience to the COVID-19 pandemic. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0272089>

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ Powder, J. (August 2, 2021). Keys to the Navajo Nations Covid-19 Vaccination Success. John Hopkins, Bloomberg School of Public Health. Retrieved [Keys to the Navajo Nation’s COVID-19 Vaccination Success | Johns Hopkins | Bloomberg School of Public Health \(jhu.edu\)](#)

³² Alaska Native Tribal Health Consortium (ANTHC) (2024). Overview. Alaska Tribal Health System. Our-Health-in-Our-Hands. Retrieved from <https://www.anthc.org/wp-content/uploads/2021/01/Our-health-in-our-hands.pdf>

³³ Alaska Native Tribal Health Consortium (ANTHC) (2021). In Service to Our Communities. 2021 Annual Report. Retrieved from https://www.anthc.org/wp-content/uploads/2022/06/AR21_FINAL-Digital.pdf

In 2020 and 2021, the AI/AN population residing in Alaska experienced higher rates of COVID-19 related illness (twice the rate), hospitalization (three times the rate), and death (three times the rate), as compared to the rates of COVID-19 related illness, hospitalization and death for the White population residing in Alaska.³⁴ The AI/AN people living in Alaska also face unique health care challenges such as access to health care, as approximately half of the AI/AN people live in rural remote areas where 90 percent of the communities are inaccessible by road.³⁵

In Alaska, as elsewhere, AI/AN people prevented the spread of COVID-19 by engaging in public health precautions (e.g., social distancing, limiting social bubbles, and masking-up). In late 2020 and into 2021, COVID-19 vaccines were introduced, and the ANTHC, and members of the Tribal health system, coordinated with the Alaska Native Health Board (ANHB) to partner with the State of Alaska in the Alaska's Vaccine Task Force to respond to the COVID-19 pandemic. The State, ANTHC, ANHB, and members of the Tribal health system co-led the COVID-19 vaccination effort to prepare for statewide communication, funding, allocation, and distribution of the COVID-19 vaccines. The ANTHC also coordinated the distribution of COVID-19 vaccines allocated to Tribal health partners.³⁶ On July 13, 2021, the Alaska's COVID-19 Vaccine Monitoring Dashboard reported that 57.7 percent of the AI/AN population, and 47 percent of all Alaskans, had at least one COVID-19 vaccine dose.³⁷

The ANTHC, members of the Tribal health system, the ANHB, and the State of Alaska's partnership has been reported to exemplify a "co-leadership model prioritizing health equity and acknowledging collective historical trauma associated with previous public health (pandemic) emergencies."³⁸ Prioritizing robust partnerships and transparency among Tribal and State leaders to build trust and efficiency were some of the key factors that contributed to the success of the COVID-19 vaccination distribution effort. During the COVID-19 pandemic, the Federal and State governments not only provided resources (e.g., COVID-19 vaccinations and personal protective equipment) for the Alaska Tribal health care system, but they also recognized and respected Tribal sovereignty, which was essential to creating an effective partnership with the ANTHC, the ANHB, and other Tribal health care partners.³⁹

The Alaska Tribal health care system and State partnership was also solution-focused. Together, they identified challenges and solutions, using existing partnerships, community and State resources, and innovative approaches. The Alaska Tribal health care system built the COVID-19 vaccination response approach on pre-existing capacity and infrastructures for health care delivery, pediatric immunizations, flu vaccinations, and community connections. For example,

³⁴ Ward, L. A., Black, K. P., Britton, C. L., Tompkins, M. L., & Provost, E.M. (CDC) (2022). COVID-19 Cases, Hospitalizations, and Deaths Among American Indian or Alaska Native Persons — Alaska, 2020–2021. *MMWR Morbidity and Mortal Weekly Report* 2022;71:730–733. DOI: <http://dx.doi.org/10.15585/mmwr.mm7122a2>.

³⁵ *Ibid.*

³⁶ Alaska Native Tribal Health Consortium (ANTHC) (2021). In Service to Our Communities. 2021 Annual Report. Retrieved from https://www.anthc.org/wp-content/uploads/2022/06/AR21_FINAL-Digital.pdf.

³⁷ National Governors Association (August 25, 2021). Partnering with Tribal Nations for COVID-19 Vaccinations: A Case Study of Alaska. Retrieved from <https://www.nga.org/publications/partnering-with-tribal-nations-for-covid-19-vaccinations-a-case-study-of-alaska/>.

³⁸ *Ibid.*

³⁹ *Ibid.*

COVID-19 vaccinations were delivered to some communities by small plane, ATVs, dog sleds and boats.⁴⁰

Another factor that contributed to the success of the COVID-19 vaccination effort was that the entities comprising the Alaska Tribal health care system had previous experience in working together, and were well prepared to respond to the COVID-19 pandemic. Tribes, villages, and regions led the way in strategy, process, and allocation of vaccines and vaccine options. The Alaska Tribal health care system utilized its resources to meet the unique challenges and the geography of their communities. For example, some entire communities received vaccinations at the same time, to increase vaccine confidence among community members and address logistical challenges. Tribes, villages and communities also identified challenges and shared solutions or best practices for successful implementation of the COVID-19 vaccine response.⁴¹

The ANTHC reported that while the “initial vaccine supply was limited,” Alaska had the highest rate of vaccination administration in the U.S., by the beginning of the year 2021. ANTHC attributed this achievement to the “collaboration and coordination in our communities, especially rural locations.”⁴² Also, the success of Alaska’s vaccination distribution effort can be attributed to the self-governance status of Alaska Tribes and Tribal health organizations, allowing these entities to make important health care decisions, which permitted more individuals to be eligible for vaccinations. Further, the State of Alaska has indicated that it plans to build upon their partnership with Tribes, which was strengthened during the COVID-19 pandemic response, to address future goals, such as “braiding funding for water, sewage, and other infrastructure needs for Tribal communities and Tribal health systems.”⁴³

Muscogee (Creek) Nation. The Muscogee (Creek) Nation (MCN) currently has more than 100,000 citizens,⁴⁴ and is the fourth largest Tribe in the U.S. Established in 1977, the MCN Department of Health’s (MCN Health) headquarters is located in Okmulgee, Oklahoma, and provides various health care services to MCN citizens living on the MCN Reservation. The MCN Health is one of the largest tribally operated systems in Oklahoma with community hospitals serving IHS beneficiaries and the general public, per § 813 of the Indian Health Care Improvement Act and Tribal Resolution 13-150. The MCN Health entered into the TSGP in 2002, and also demonstrated best practices in COVID-19 vaccination distribution during the pandemic.

⁴⁰ Alaska Native Tribal Health Consortium (ANTHC) (2021). In Service to Our Communities. 2021 Annual Report. Retrieved from https://www.anthc.org/wp-content/uploads/2022/06/AR21_FINAL-Digital.pdf.

⁴¹ Alaska Native Tribal Health Consortium (ANTHC) (2021). In Service to Our Communities. 2021 Annual Report. Retrieved from https://www.anthc.org/wp-content/uploads/2022/06/AR21_FINAL-Digital.pdf.

⁴² *Ibid.*

⁴³ National Governors Association (August 25, 2021). Partnering with Tribal Nations for COVID-19 Vaccinations: A Case Study of Alaska. <https://www.nga.org/publications/partnering-with-tribal-nations-for-covid-19-vaccinations-a-case-study-of-alaska/>

⁴⁴ Muscogee Nation (2024). MCN Health. Muscogee Nation Department of Health. Improving the Quality of Life for Our People and Our Communities. Retrieved from [Home - Muscogee Creek Nation Department of Health : Muscogee Creek Nation Department of Health \(creekhealth.org\)](https://www.muscogeehealth.org/)

In 2020–2021, MCN Health served more than 42,000 patients annually. The MCN Health recorded more than 176,815 annual visits through six outpatient clinics, two community hospitals, an in-patient skilled nursing facility and a physical rehabilitation service. The two community hospitals are located in Okmulgee and Okemah, Oklahoma, and are open 24/7, providing health care services to IHS beneficiaries and community members. The MCN Health offers on-site comprehensive health care services, including emergency, primary and urgent care, pediatrics, wound care, physical therapy, diabetes management, dialysis, podiatry, urology, pulmonology, audiology, cardiology, neurology, gastroenterology, dental, optometry, behavioral health, health promotion, disease prevention, and tobacco cessation for IHS beneficiaries.⁴⁵

In 2021, MCN Health acquired and named the Council Oak Comprehensive Healthcare facility. Located in Tulsa, Oklahoma, this 20-acre health care campus has 336,385 square feet dedicated to inpatient, outpatient and specialty services. The campus also includes an administrative building and 153 hospitality suites for patients and families.

In the fourth quarter of 2021, MCN Health established a 65-suite monoclonal antibody infusion center at the Council Oak facility to combat COVID-19 in the northeastern Oklahoma area. During this time, MCN Health partnered with regional and state departments and Federal agencies to treat 358 patients with these lifesaving antibodies.⁴⁶

The MCN Health chose IHS as their distribution partner to distribute the COVID-19 vaccinations, which was consistent with their established supply chain. To develop a COVID-19 response, the MCN Health established a Vaccination Task Force, led by a hospital pharmacist and included medical and administrative leadership. The Vaccine Task Force, in collaboration with IHS, met regularly to discuss COVID-19 vaccine supply, demand and delivery updates, and to develop protocols for distribution.

The Vaccine Task Force’s early planning and activities for COVID-19 vaccine distribution included conducting polling to gauge interest in vaccines, creating priority lists of Tribal patients 65 years and older, engaging in proactive outreach and registration, maintaining a list of people requesting the vaccine to mitigate potential waste, establishing a vaccine information phone line for MCN citizens and patients to sign up for COVID-19 vaccinations, and purchasing cold-storage facilities and tents for multiple drive-up vaccination events.

The Vaccine Task Force also coordinated a public health campaign for COVID-19, which was specifically directed toward Native Americans. The vaccine campaign used messaging such as, “A Stronger Nation Begins with Vaccination,” “Protect Yourself and Others,” and “Native Americans are 3.5 Times More Likely to be Diagnosed with Coronavirus.”

⁴⁵ Muscogee Nation (2024). MCN Health. Muscogee Nation Department of Health. Improving the Quality of Life for Our People and Our Communities. Retrieved from [Home - Muscogee Creek Nation Department of Health : Muscogee Creek Nation Department of Health \(creekhealth.org\)](https://www.creekhealth.org/)

⁴⁶ Muscogee Nation (October 26, 2021). The Muscogee (Creek) Nation Executive Branch FY 2021 Fourth Quarterly Report. Retrieved from [FY-21-4th-Quarter-Report-Final.pdf \(muscogeenation.com\)](https://www.muscogeenation.com/)

Additionally, the Vaccine Task Force weekly vaccine planning included receiving 1500 COVID-19 vaccinations per week on Mondays, scheduling appointments for patient vaccinations on Tuesdays and Wednesdays, and holding weekly vaccination events on Thursdays through Saturdays. As more vaccination doses became available, MCN Health developed an online scheduling tool for large scale events which were held on weekends. Vaccination distribution was then offered to Tribal citizens ages 18 and older, to non-Native household members and to care-givers of Native American households. On March 17, 2021, the MCN Health reported they had administered approximately 21,000 first and second doses of COVID-19 vaccinations.⁴⁷

The MCN Health reported that by September 20, 2021, they had held 14 patient, 14 employee, and 11 community COVID-19 vaccine distribution events throughout the Muscogee (Creek) Nation's Reservation. The MCN Health also reported that 32,786 COVID-19 vaccines had been administered to patients and employees, as of September 27, 2021. Fifty-two percent (19,962) of Tribal citizens/patients and employee had received their first dose and forty-two percent (18,083) of Tribal citizens/patients and employees had received their second dose of the COVID-19 vaccine.⁴⁸

Spirit Lake Tribe. The Spirit Lake Tribe entered the IHS TSGP in 2016, and is another self-governance Tribe that utilized best practices to respond to the COVID-19 pandemic. In 2020, the Spirit Lake Tribe had 7,564 enrolled Tribal members, and approximately 3,500 of these Tribal members resided on the Spirit Lake Dakota Reservation, located on the southern shores of Devils Lake, in east-central North Dakota.⁴⁹ The Spirit Lake Tribe provides a broad range of health services at a number of locations, including the Spirit Health Center, located at Fort Totten, schools, wellness centers, and elderly services. Health care services are provided through venues such as direct services, telehealth, referrals, and purchasing care, and include: primary care; ancillary care; emergency medical services; pharmacy; podiatry; eye and vision care; diabetes prevention, control, and treatment; nutrition; physical, occupational, respiratory and speech therapy; oral/dental health services; behavioral health; and more.

In Spring of 2020, the Spirit Lake Tribe implemented a number of measures to minimize the spread of COVID-19, including closing the Tribe's casino, and COVID-19 rates remained relatively low. However, following the Fourth of July weekend, when many Tribal members attended social gatherings, Benson County, the Spirit Lake Dakota Reservation's primary county, had the highest rate of new COVID-19 cases in North Dakota. While Spirit Lake became the first "municipality" in North Dakota to mandate mask-wearing, COVID-19 rates continued to climb.⁵⁰ By the end of July, the Spirit Lake Tribe also instituted a curfew, and

⁴⁷ *Ibid.*

⁴⁸ Muscogee Nation (October 26, 2021). The Muscogee (Creek) Nation Executive Branch FY 2021 Fourth Quarterly Report. Retrieved from [FY-21-4th-Quarter-Report-Final.pdf \(muscogeenation.com\)](https://www.muscogeenation.com/FY-21-4th-Quarter-Report-Final.pdf)

⁴⁹ The Spirit Lake Tribe (2021). Our Tribe/Spirit Lake Nation. Retrieved from <http://www.spiritlakenation.com/our-tribe/>

⁵⁰ Kolpack, D. (August 7, 2020). Virus spikes take North Dakota tribes back to 'square one'. Associated Press. Retrieved from <https://apnews.com/article/virus-outbreak-north-dakota-lakes-c033659810c4a3963e57024e70298265>

ramped up COVID-19 testing, and mandated a stay-at-home order for individuals diagnosed with COVID-19, in an effort to mitigate the spread of COVID-19.

In response to a sharp increase in the incidence of COVID-19 on the Spirit Lake Dakota Reservation, the Spirit Lake Tribe launched a tribally managed program, using a COVID-19 Incident Command System, with assistance from the Centers of Disease Control and Prevention (CDC), in September 2020. Under the Spirit Lake Tribe's COVID-19 Incident Command System, staff conducted comprehensive COVID-19 case investigations, provided COVID-19 education, and implemented contact tracing to ensure timely execution of "critical epidemic control measures."⁵¹ The Spirit Lake Tribe encountered several challenges during the implementation of their COVID-19 case investigations and contact tracing program. For one, the program required daily continuous staffing to effect timely mitigation of the spread of COVID-19, which proved challenging with such a high rate of COVID-19 diagnoses among community members. Another challenge for the COVID-19 case investigation and contact-tracing program was obtaining, and maintaining, information from COVID-19 patients and their close contacts.

To address these challenges, Spirit Lake community members were recruited to work as investigators, contact tracers, and to perform outreach, as they had extensive knowledge of how to reach community members, particularly when their location information was incomplete. Additionally, community members were trusted by the community and provided culturally appropriate guidance or education on the need to isolate or quarantine, which improved the response rates about COVID-19 exposures.⁵² Spirit Lake Tribe community members who served as contact tracers, followed-up with patients, and their close contacts, frequently by telephone to monitor their health status and symptoms. To monitor symptoms, contact tracers utilized a free two-way text-messaging platform (CDC's Text Illness Monitoring system, version TIM2) to query enrolled patients and contacts daily about their COVID-19 symptoms. If participants reported COVID-19 symptoms or failed to respond, then Spirit Lake Tribal Health authorities were alerted.⁵³

An additional challenge that the Spirit Lake Tribe experienced in responding to COVID-19, was that multi-generational families often resided in the same household, and limited space hindered compliance with in-home isolation/quarantine CDC guidelines. In an effort to mitigate the spread of COVID-19, the program disseminated essential supplies (e.g., over-the-counter medications, personal protective equipment, cleaning supplies, groceries, and thermometers), as well as health information (e.g., mask use, isolation/quarantine procedures, daily temperature

⁵¹ Matthias, J., Charboneau, T., Shaffer, C., Rusten, J., Whitmer, S., de la Paz, J., Dykstra, J., Pathmanathan, I., & Stowell, D. (CDC) (2020). COVID-19 Case Investigation and Contact Tracing Program — Spirit Lake Tribe, North Dakota, September–November 2020. *Morbidity and Mortality Weekly Report*. Retrieved from <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7014a4-H.pdf>

⁵² *Ibid.*

⁵³ Matthias, J., Charboneau, T., Shaffer, C., Rusten, J., Whitmer, S., de la Paz, J., Dykstra, J., Pathmanathan, I & Stowell, D. (CDC) (2020). COVID-19 Case Investigation and Contact Tracing Program — Spirit Lake Tribe, North Dakota, September–November 2020. *Morbidity and Mortality Weekly Report*. Retrieved from <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7014a4-H.pdf>.

logs) to homes. Further, an estimated 100 individuals (10 percent of patients or close contacts) were identified, by the COVID-19 case investigation and contact tracing program, as being unhoused or experiencing unstable housing. To ensure these individuals could isolate/quarantine, the program provided temporary shelter and meals at a motels (e.g., at the Tribe's casino).⁵⁴

According to the CDC, from September 29 through November 20, 2020, the monitoring system reported that, among the Spirit Lake Tribe, a total of 317 persons received a confirmed COVID-19 diagnosis, and another 129 (19.3 percent) of 667 persons identified as close contacts subsequently received a COVID-19 diagnosis. Additionally, 254 (80.1 percent) of 317 persons who received a COVID-19 diagnosis and 420 (78.1 percent) of 538 close contacts who were not diagnosed with COVID-19, were contacted and instructed to isolate/quarantine, in accordance with CDC guidelines, by program staff within 24 hours of being diagnosed with COVID-19 or receiving COVID-19 test results. During this time, the incidence of COVID-19 peaked and plateaued within the Spirit Lake Tribe (520–600 COVID-19 cases per 100,000 individuals per week), reflecting a 1.5-fold increase in the incidence of COVID-19 across the State of North Dakota (from 455 to 1,137 COVID-19 cases per 100,000 individuals per week). The COVID-19 rate, among Spirit Lake Tribal members was 1.5 percent more than the average COVID-19 rate across North Dakota for the same time period.⁵⁵ Counties where Spirit Lake Tribal members resided in North Dakota, were also found to have higher rates of COVID-19 related hospitalizations.⁵⁶

The CDC reports that, regardless of these challenges and high rates of COVID-19 diagnoses among Tribal members, the Spirit Tribe effectively provided timely COVID-19 case investigation and contact tracing, symptom monitoring, isolation/quarantine, and support services to Tribal members to control COVID-19 risks. Research has indicated that as this Tribally operated COVID-19 case investigations and contact tracing program was efficient in controlling COVID-19 risks among the Spirit Lake Tribal members, and that this program could be replicated in similar Tribal communities to respond to the COVID-19 pandemic.⁵⁷

⁵⁴ *Ibid.*

⁵⁵ Matthias, J., Charboneau, T., Shaffer, C., Rusten, J., Whitmer, S., de la Paz, J., Dykstra, J., Pathmanathan, I & Stowell, D. (CDC) (2020). COVID-19 Case Investigation and Contact Tracing Program — Spirit Lake Tribe, North Dakota, September–November 2020. Morbidity and Mortality Weekly Report. Retrieved from <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7014a4-H.pdf>

⁵⁶ Khan, M. M., Deb Nath, N., Schmidt, M., Njau, G., and Odoi, A. (2023). Geographic disparities and temporal changes of COVID-19 hospital risks in North Dakota. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10061029/>

⁵⁷ Matthias, J., Charboneau, T., Shaffer, C., Rusten, J., Whitmer, S., de la Paz, J., Dykstra, J., Pathmanathan, I & Stowell, D. (CDC) (2020). COVID-19 Case Investigation and Contact Tracing Program — Spirit Lake Tribe, North Dakota, September–November 2020. Morbidity and Mortality Weekly Report. Retrieved from <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7014a4-H.pdf>.

Pascua Yaqui Tribe. The Pascua Yaqui Tribe (PYT) joined the IHS TSGP in 2018, and is another self-governance Tribe that demonstrated best practices during their response to the COVID-19 pandemic. For one, the PYT participated in the Guadalupe Community Response Team (GCRT), a multi-sectoral public health partnership, to mitigate the high rate of COVID-19 in the town of Guadalupe, Arizona, and secondly, the PYT achieved public health accreditation from the Public Health Accreditation Board (PHAB), at the height of the pandemic, in the years 2020 and 2021. During this time, the PYT had 21,307 enrolled Tribal members, residing in nine communities located mostly in the southeastern region of Arizona, near Tucson, and in Guadalupe, southeast of Phoenix.⁵⁸

The Pascua Yaqui Health Service Division (PYHSD) provides direct health care services (e.g., adult medicine, family medicine, pediatrics, lab/radiology, and transgender health) through the El Rio Pascua Yaqui Health Center and the Yoeme Managed Health Plan to access a number of other El Rio Health Centers, programs, and other resources (e.g., the Phoenix Indian Medical Center). As the PYT is located in proximity to the Tucson and Phoenix Metropolitan Areas, Tribal members can access numerous health resources (e.g., specialty care) within driving distance. The PYHSD supplements these direct services by also operating state programs such as the Arizona Long Term Care System, Special Supplemental Nutrition Program for Women, Infants and Children and Tobacco Cessation.⁵⁹

To effectively manage and sustain these health care services, the Pascua Yaqui Tribe collaborates with a number of Federal, State and local entities, such as the IHS Phoenix Indian Medical Center, Phoenix and Tucson IHS area offices, Arizona Health Care Cost Containment System Arizona's Medicaid equivalent), El Rio Health Centers local hospitals, various private health care providers, the Veterans Administration, and more than 20,000 PYT Members.⁶⁰ As mentioned earlier, a number of social and health determinants exist that have contributed to the high rates of morbidity and mortality resulting from COVID-19 among the AI/AN population. In Arizona, the AI/AN population's rate of COVID-19 infection was 1.8 times higher than the rate of COVID-19 for the non-Hispanic White population.⁶¹

On March 19, 2020, the Pascua Yaqui Tribal Council issued a Tribal resolution, No. C03-66-20, which declared an emergency and activated an Incident Command System (ICS) in response to the COVID-19 pandemic. The ICS was overseen by Mr. Rueben Howard, the Executive Director of the Pascua Yaqui Health Services Division, and members also included Fire Chief Carlos Flores, Police Chief Michael Valenzuela, and others. The ICS was initially authorized by

⁵⁸ Pascua Yaqui Tribe (2023). Membership at a Glance. Retrieved from <https://www.pascuayaqui-nsn.gov/wp-content/membershipataglance.pdf>

⁵⁹ Pascua Yaqui Tribe (2023), 2021 Pascua Yaqui Tribe Community Needs Assessment. Retrieved from [CHNA_Final_Report_4-28-21-For_Website.pdf \(pascuayaqui-nsn.gov\)](https://www.pascuayaqui-nsn.gov/CHNA_Final_Report_4-28-21-For_Website.pdf)

⁶⁰ Pascua Yaqui Tribe (2023). Membership at a Glance. Retrieved from <https://www.pascuayaqui-nsn.gov/wp-content/membershipataglance.pdf>.

⁶¹ Truong, J. M., Meyer, L. G., Karirirwe, G., Cori, C., Dennehy, T. J., Williams, R., Jackman, J., Clement W., Collins, J., Gettel, A., Holquin, G., Kulaga, J., Ledesma, D., Levy, S., Maroofi, H., Perez, V., Prete, K., Schlum, K., Thompkins, C., Vital R., Zamora, S., & Megan, J. (January 30, 2023). Developing an Equitable COVID-19 Response: Lessons Learned from a MultiSectoral Partnership in Guadalupe, AZ. National Library of Medicine. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9902804/>

the Pascua Yaqui Tribal Council to provide communication to the Pascua Yaqui Tribal community about the response to and resources for the COVID-19 pandemic, ensuring all information was accurate, up-to-date, and funneled through a central source, and to coordinate resources to mitigate the impact of COVID-19 on the PYT.⁶²

The town of Guadalupe, in Maricopa County, has a population of approximately 6,700 residents, with 36 percent of the population self-identifying as being members of the PYT, and 71 percent self-identifying as from Hispanic descent. Research has indicated that the town of Guadalupe is considered a medically underserved community and that residents may be more vulnerable to negative outcomes of infectious disease, due to existing structural health inequities in the community. In general, Guadalupe residents experience a higher incidence of poverty (3 times the rate), higher housing density (16.5 times more residents per square mile), and lower access to technology than the surrounding Maricopa County.

During the first week of June, 2020, the town of Guadalupe also declared a State of Emergency and activated an Incident Command Structure in response to a significant increase in new COVID-19 cases that was 13.9 times higher, topping out at 25.4 times higher, COVID-19 infection rates than the surrounding population of Maricopa county. Immediately following the declaration of a State of Emergency, a network of community, Tribal, academia, and public health partners established the GCRT to mitigate the high rate of new COVID-19 cases. The GCRT met weekly, and the five partner organizations included leadership from the PYT, the town of Guadalupe, the Maricopa County Department of Public Health (MCPDH), the Arizona State University Student Outbreak Response Team (ASU SORT), and Native Health. To their advantage, the GCRT partner organizations had previous experience collaborating together on other projects, and had existing health care expertise and established health care networks embedded in the town of Guadalupe.

The GRCT objectives were to: (a) improve equitable access to health and support services; (b) create innovative and rigorous outreach efforts; and (c) develop partnerships to improve public health capacity. The GCRT created a community-driven program that focused on enhancing access to public health activities that were linguistically, culturally, and geographically appropriate for residents of Guadalupe. The GCRT provided services and resources, such as: COVID-19 testing and vaccination events; culturally appropriate public health communications and COVID-19 guidance; contact tracing and door-to-door case investigation; care packages (e.g., groceries, masks, and COVID-19 test kits) to households to ensure safe at home isolation/quarantine practices; and other resources (e.g., social support).⁶³ Also, to ensure and support indigenous sovereignty and data justice, the GCRT developed

⁶² Pascua Yaqui Tribe (2020). Get the Latest COVID-19 Information and Resources. Retrieved from <https://covid19.pascuayaqui-nsn.gov/>

⁶³ Truong, J. M., Meyer, L. G., Karirirwe, G., Cori, C., Dennehy, T. J., Williams, R., Jackman, J., Clement W., Collins, J., Gettel, A., Holquin, G., Kulaga, J., Ledesma, D., Levy, S., Maroofi, H., Perez, V., Prete, K., Schlum, K., Thompkins, C., Vital R., Zamora, S., & Megan, J. (January 30, 2023). Developing an Equitable COVID-19 Response: Lessons Learned from a MultiSectoral Partnership in Guadalupe, AZ. National Library of Medicine. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9902804/>

integrated and transparent data infrastructures, which were particularly useful for contact tracing and case investigation activities.

Each of these five GRCT partner organizations carried out a vital equitable role in the design, implementation, and evaluation of the GCRT COVID-19 response plan. The PYT's role included working with Native Health to provide: tailored training on cultural sensitivity to ASU SORT; culturally appropriate community education and outreach; coordination of COVID-19 testing and vaccination events (from June 2020 to December 2021), and medical surveillance. Additionally, the PYT leadership, along with PYT Cultural Specialists, and the town of Guadalupe coordinated and facilitated community engagement in the GCRT COVID-19 activities.⁶⁴ Further, the PYT contributed more than two million dollars to support the Guadalupe response effort, in 2020-2021.

During public health crises, it is important to use evidence-based interventions that support and build upon the many experiences, ways of knowing, and perspectives of AI/AN communities, as they have experienced historical trauma or oppression and may generally distrust the research and biomedical systems. Therefore, the GCRT utilized a culturally grounded community-based health program (CBHP) model that deployed community health workers, such as the PYT Cultural Specialists, to provide outreach and culturally appropriate training to other partner organizations who were working with Pascua Yaqui Tribal members (e.g., conducting contact tracing, case investigation, and providing other in-home services). This CBHP model has shown to: increase collaboration among stakeholders; build trust among community members; advance and sustain successful implementation of public health policies and interventions; and increase equitable access to health services for medically underserved populations during a public health emergency.

Public health messaging and communication was also an essential and effective component of the GCRT COVID-19 response. The PYT Cultural Specialists shared that, initially, they experienced challenges in balancing Yaqui cultural preservation with the COVID-19 guidance that was provided at the local, state and Federal levels. Therefore, the PYT, acted through self-determination to create culturally appropriate COVID-19 guidance (e.g., for cultural gatherings such as wakes or funerals), to ensure that the guidance prioritized the physical health and spiritual well-being for Tribal members. Messaging and communication to convey COVID-19 and public health information was shared through various platforms and mediums, such as PYT's official Facebook site and website, fliers, infographics, and public service announcements (PSAs) (e.g., videos featuring Pascua Yaqui Tribal leaders posted on social media). These PSAs highlighted the strengths of the PYT, and the importance of uniting to overcoming the COVID-19 pandemic.

Additionally, to build trust among the Pascua Yaqui Tribal members, the PYT Cultural Specialists developed other accessible, culturally appropriate, and relevant public health communication materials, such as information on: COVID-19 safety protocols (e.g., isolation/quarantine guidance); enrolling and scheduling for COVID-19 vaccine appointments;

⁶⁴ *Ibid.*

and how to access other COVID-19 resources. The PYT Cultural Specialists created safety guidance, in consultation with Pascua Yaqui Tribal leaders, to reduce exposure to COVID-19 (e.g., through aerosol transmission) and to promote disinfecting and sanitizing protocols (e.g., using hand sanitizer and proper handwashing). Examples of safety guidance or protocols included: moving wakes to open-air tents, rather than holding in-homes wakes; encouraging individuals to wear masks during cultural ceremonies and shortening the length of ceremonies; and advising families to social distance and face in the same direction when partaking in meals unmasked.

The PYT's culturally grounded approach to messaging also focused on the importance of protecting the elders and youth of the community for continued cultural preservation of the Tribe. For example, the PYT ways of knowing and cultural preservation rely heavily on elder storytelling and family conversations to pass cultural knowledge on to the youth. Also notable was that one of the PYT's core values of "including all and excluding none" served as the foundation for a unified GCRT COVID-19 response, which highlighted the importance of providing services to all members of the community.⁶⁵

From March to December 2021, approximately 2,300 individuals were vaccinated in 17 COVID-19 vaccination events, through the efforts of the GCRT, in the town of Guadalupe. By December 2021, over 40 percent of the residents of Guadalupe received COVID-19 vaccinations. Research data indicates that the GCRT's COVID-19 response program mitigated the COVID-19 rates, in the town of Guadalupe. For example, there was a reduction "in the case rate ratio comparing Guadalupe to Maricopa County, where the weekly case rate ratio, on average, was sustained at <3, by May 2021. By the week of September 26, 2021, the case rate ratio comparing Guadalupe to Maricopa County decreased further, with a weekly case rate ratio that remained at <1."⁶⁶

During 2020-2021, the PYT also participated in another evidence-based practice, which was participating in the PHAB systematic review process to achieving PHAB accreditation. Following the completion of a systematic review process, where PYT mitigated deficiencies and built capacity to meet the PHAB national standards, the PYHSD was awarded initial national accreditation from the PHAB, on August 24, 2021. The PHAB is a non-profit and non-government organization that serves as the national public health accrediting body for health departments or organizations in the U.S. and is funded by the CDC and the Robert Wood Johnson Foundation. Public health leaders, professionals and providers from Tribal, local, state,

⁶⁵ Truong, J. M., Meyer, L. G., Karirirwe, G., Cori, C., Dennehy, T. J., Williams, R., Jackman, J., Clement W., Collins, J., Gettel, A., Holquin, G., Kulaga, J., Ledesma, D., Levy, S., Maroofi, H., Perez, V., Prete, K., Schlum, K., Thompkins, C., Vital R., Zamora, S., & Megan, J. (January 30, 2023). Developing an Equitable COVID-19 Response: Lessons Learned from a MultiSectoral Partnership in Guadalupe, AZ. National Library of Medicine. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9902804/>

⁶⁶ Truong, J. M., Meyer, L. G., Karirirwe, G., Cori, C., Dennehy, T. J., Williams, R., Jackman, J., Clement W., Collins, J., Gettel, A., Holquin, G., Kulaga, J., Ledesma, D., Levy, S., Maroofi, H., Perez, V., Prete, K., Schlum, K., Thompkins, C., Vital R., Zamora, S., & Megan, J. (January 30, 2023). Developing an Equitable COVID-19 Response: Lessons Learned from a MultiSectoral Partnership in Guadalupe, AZ. National Library of Medicine. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9902804/>

national, and territorial levels are involved in, and support, the development of the PHAB national public health accreditation standards.⁶⁷

The PYHSD was one of fifteen public health departments that achieved PHAB accreditation or reaccreditation status, across the country in the year 2021. Health departments not only provide essential health and safety services for their communities, but they also support the public health system, especially during times of crisis. According to the PHAB, these health departments demonstrated their commitment to build capacity in accountability, performance and quality improvement, and emergency preparedness, which was essential to effectively respond to public health emergencies, such as the COVID-19 pandemic, especially as new variants emerged.⁶⁸

Upon receipt of PHAB accreditation, Mr. Reuben Howard said that, "The accreditation process prepared us to quickly respond to the COVID-19 pandemic by encouraging us to examine and update our Public Health Codes and internal processes regarding infectious disease. Our accreditation would not have been possible without the support and guidance of our Tribal leadership and the voices of the Tribal members we serve."⁶⁹ Achieving PHAB accreditation also provided PYT with the expertise and adeptness to coordinate with multiple health care partners to effectively respond to the COVID-19 pandemic in a number of PYT communities located near several metropolitan areas.

E. Funds related to the provision of services and benefits to Self-Governance Tribes

The funds specifically or functionally related to the provision, by the Secretary, of services and benefits to self-governance participants include the IHS budget for administration of the Tribal Self-Governance Program and the funds available to the Secretary to provide services for each Indian Tribe (as reflected by the amount each Tribe in a self-governance funding agreement is eligible to receive) for FY 2020 and FY 2021, respectively.

FY 2020 Data:

- | | |
|--|--------------------|
| (1) IHS, Office of the Director, Office of Tribal Self-Governance line item, FY 2020 appropriation (Dollars in Thousands) | <u>\$5,806,000</u> |
| (2) IHS, Area Offices, total of FY 2020 budgets for Self-Governance activities | <u>\$0</u> |
| (3) Amount available for current Self-Governance Tribes in FY 2020 | |

⁶⁷ Public Health Accreditation Board (July 31, 2021). Fifteen Health Boards awarded Accreditation or Reaccreditation Status by the Public Health Accreditation Board. Cision PRWeb. Retrieved from <https://www.prweb.com/releases/fifteen-health-departments-awarded-accreditation-or-reaccreditation-status-by-the-public-health-accreditation-board-845027666.html>

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

(Dollars in Thousands) ⁷⁰

\$2,015,058

IHS Area Office	All Funds
Alaska	\$635,801
Albuquerque	17,410
Bemidji	93,643
Billings	36,524
California	94,588
Great Plains	33,873
Nashville	95,466
Navajo	78,662
Oklahoma City	630,593
Phoenix	125,422
Portland	115,968
Tucson	57,108
Total	\$2,015,058

(4) Total funds related to the provision of services and benefits to Self-Governance Tribes, in FY 2020 (Dollars in Thousands)
\$2,020,864

FY 2021 Data:

- (1) IHS, Office of the Director, Office of Tribal Self-Governance line item, FY 2021 appropriation (Dollars in Thousands)** \$5,806,000
- (2) IHS, Area Offices, total of FY 2021 budgets for Self-Governance activities** \$0
- (3) Amount available for current Self-Governance Tribes in FY 2021 (Dollars in Thousands) ⁷¹** \$2,034,940

IHS Area Office	All Funds
Alaska	\$651,914
Albuquerque	17,231

⁷⁰ Please note the following: Contract Support Costs (CSC) are not included in this report. The FY 2020 CSC amounts are identified and reported in the *Indian Health Service Fiscal Year (FY) 2020 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards* (Includes Fiscal Year 2020 Data). This Report is under Agency review, and is forthcoming.

⁷¹ Please note the following: FY 2021 CSC amounts are identified and reported in the *Indian Health Service Fiscal Year (FY) 2021 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards* (Includes Fiscal Year 2021 Data). This Report is currently under Agency review, and is forthcoming.

IHS Area Office	All Funds
Bemidji	93,050
Billings	35,429
California	93,178
Great Plains	33,941
Nashville	96,639
Navajo	79,531
Oklahoma City	635,035
Phoenix	125,382
Portland	117,022
Tucson	56,589
Total	\$2,034,940

(4) Total funds related to the provision of services and benefits to Self-Governance Tribes, in FY 2021 (Dollars in Thousands)
\$2,040,746

F. Funds transferred to each Self-Governance Indian Tribe in FY 2020 and FY 2021, and the corresponding reduction in the Federal bureaucracy⁷²
(Dollars in Thousands)

(1) Funds transferred to Tribes for PSFAs assumed under Title V of the ISDEAA for FY 2020 and FY 2021, respectively.

(a) FY 2020

\$1,957,866

IHS Area Office	Funds Transferred
Alaska	\$609,509
Albuquerque	12,938
Bemidji	88,848
Billings	35,707
California	91,435
Great Plains	32,430
Nashville	92,780
Navajo	77,325
Oklahoma City	626,685
Phoenix	122,731
Portland	112,295

⁷² Note: For amounts by Tribe, please see Exhibit A, “FY 2020 Funds Transferred to Each Self-Governance Tribe,” and Exhibit B, “FY 2021 Funds Transferred to Each Self-Governance Tribe.”

IHS Area Office	Funds Transferred
Tucson	55,184
Total	\$1,957,866

(b) FY 2021

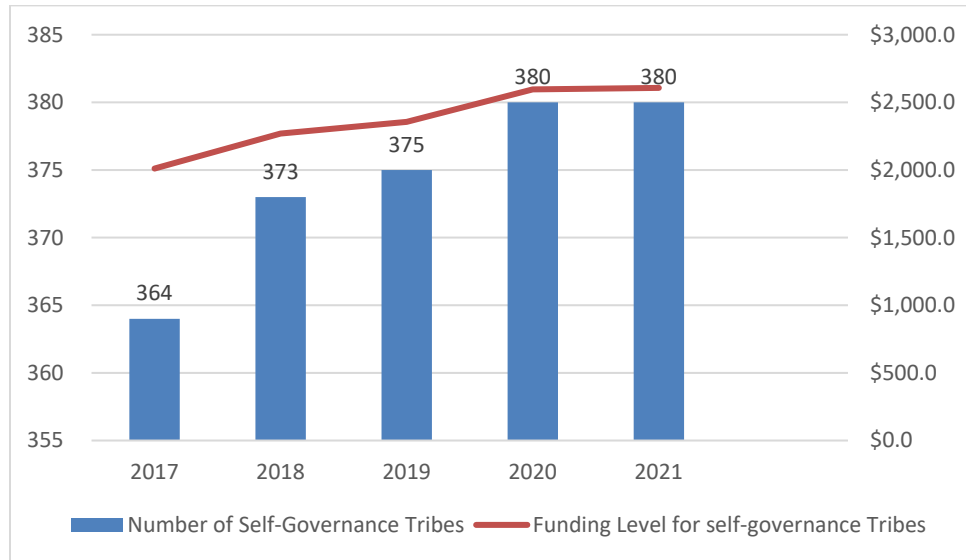
\$1,982,565

IHS Area Office	Funds Transferred
Alaska	\$630,162
Albuquerque	13,009
Bemidji	87,913
Billings	34,626
California	90,035
Great Plains	32,436
Nashville	94,075
Navajo	78,194
Oklahoma City	631,130
Phoenix	123,136
Portland	113,161
Tucson	54,688
Total	\$1,982,565

(2) Corresponding reduction in the Federal bureaucracy

Tribal participation in the IHS Tribal Self-Governance Program increased, resulting in an increased assumption of Tribal shares, and reduced IHS staffing levels, as Tribes hired their own staff to work in tribally operated facilities. However, a separate national trend analysis will need to be conducted, in the future, to capture the accurate rate of reduction in Federal bureaucracy.

Chart 1: Increase in Self-Governance Funding Agreements and Funding Levels: FY 2017-2021.



G. The funding formula for individual Tribal shares of all IHS Headquarters funds

A T/TO may elect to assume responsibility for PSFAs formerly administered by the IHS. A T/TO may negotiate a compact and funding agreement with the Secretary for its share of the funds associated with the PSFAs. The funds for each PSFA may be found in one or more budget line item or items.

(1) Tribal Size Adjustment Formula

The IHS transferred \$36,198 (Dollars in Thousands) in FY 2020 and \$35,711 (Dollars in Thousands) in FY 2021 to self-governance Tribes for their individual Tribal shares of all IHS Headquarters (HQ) funds. For most IHS HQ programs, eligible shares for each Tribe were determined using the Tribal Size Adjustment (TSA) formula developed in the mid-1990s. The amount calculated by the TSA formula was originally determined in proportion to the aggregate user population of each Tribe. A small supplemental amount was added for Tribes with fewer than 2,500 users in partial compensation for inefficiencies related to small size. The amount determined by the TSA formula is termed the Tribe’s “base” IHS HQ shares in subsequent years and is not increased or decreased based on fluctuations in user population. Over time, the base Tribal shares have been adjusted proportionately for inflation or in response to congressional action.⁷³

⁷³ Indian Health Service (April 19, 1995). *Indian Health Manual*. Special General Memorandum. No. SGM 95-2. Policy Decisions for Self-Governance/Self-Determination Project Negotiations-Action. Retrieved from <https://www.ihs.gov/IHM/sgm/1995/sgm-9502>.

(2) Special program formulas

Some IHS programs determine Tribal shares based on special program formulas, including the following:

(a) Purchased/Referred Care, Fiscal Intermediary Formula

Using the Purchased/Referred Care (PRC) Fiscal Intermediary formula, the IHS provided \$1,046 (Dollars in Thousands) in 2020 and \$1,046 (Dollars in Thousands) in 2021 to self-governance Tribes for the processing of PRC claims (health care purchased from non-IHS providers when an IHS beneficiary is eligible for PRC and the care is not reasonably accessible or available within the IHS system). The fiscal intermediary is an IHS contractor that calculates and pays the PRC claims according to applicable authorities.

Tribal Share = A x B

Where

A = Tribal percent of 1993 Total Claims

B = Current Fiscal Intermediary Expenditures

(b) Office of Environmental Health and Engineering (OEHE), OEHE Support

Using the IHS Office of Environmental Health and Engineering (OEHE) Environmental Health Services Support formula, \$1,180 (Dollars in Thousands) and \$1,128 (Dollars in Thousands) were provided to self-governance Tribes in FY 2020 and FY 2021, respectively.

IHS HQ Program funds for OEHE support are allocated to Tribes, when requested, based on each Tribe's pro-rata share of the applicable Area Facilities and Environmental Health Support workload.

H. Total residual⁷⁴ amounts for IHS HQ PSFAS and Budgets for Tribal Shares, identified in the preceding fiscal years (FY 2019) for FY 2020 and (FY 2020) for FY 2021 to carry out inherent Federal functions

Indian Health Service HQ residual amounts were historically determined after Tribal Consultation and recommendations provided by the Joint Allocation Methodology Workgroup (in the 1990s). Also annual incremental increases were added in proportion to funding identified for inflation and pay costs.

Some examples of inherent Federal functions include, but are not limited to:

- Budget and Strategic Planning – Budget Formulation, Budget Execution;

⁷⁴ “Residuals” are portions of the budget linked to inherent Federal functions. (for definition of “inherent Federal function” - see footnote 5, page 4 of this report).

- Personnel Management – Appointment, oversight, control, and direction for Federal employees;
- Contracting – Control and oversight over all pre-award and post-award Agency contract functions;
- Legal Counsel – Legal advice and related services; and
- Property Oversight – Control of acquisition, use and disposition of Federal property, records management

(1) In FY 2019, IHS HQ identified a HQ residual amount of \$32,153,537.

FY 2019 IHS HQ Residual Amounts

IHS HQ PSFA	Sub-category	Residual
01 – Hospitals and Clinics	0146 – Records Management, Property & Supply	\$ 1,117,224
13 – Direct Operations	1301 – Direct Operations - Rockville	25,789,111
24 – Facilities & Environmental Health	2401 – Sanitation Facilities Construction Support	1,365,964
	2402 – Environmental Health Services Support	1,257,637
	2403 – Facilities Operations Support	1,040,952
	2404 – Facilities and Engineering Support	1,582,649
Grand Total		\$32,153,537

(2) In FY 2020, IHS HQ identified a HQ residual amount of \$32,262,947.

FY 2020 IHS HQ Residual Amounts

IHS HQ PSFA	Sub-category	Residual
01 – Hospitals and Clinics	0146 – Records Management, Property & Supply	\$ 1,117,224
13 – Direct Operations	1301 – Direct Operations - Rockville	25,789,111
24 – Facilities & Environmental Health	2401 – Sanitation Facilities Construction Support	1,394,446
	2402 – Environmental Health Services Support	1,283,860
	2403 – Facilities Operations Support	1,062,657
	2404 – Facilities and Engineering Support	1,615,649
Grand Total		\$32,262,947

I. Comments on this report received from Indian Tribes and Tribal Organizations

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